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TRAFFORD COUNCIL

AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE MEETING

Date: Tuesday, 25 September 2018

Time: 6.30 p.m.

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

   To note attendances, including Officers, and any apologies for absence.

2. **MINUTES** 1 - 10

   To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 26 June 2018.

3. **DECLARATIONS OF INTEREST**

   Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

4. **SINGLE HOSPITAL SERVICE UPDATE** 11 - 14

   To consider a report of the Deputy Programme Director, Single Hospital Service.

5. **THEME 3 - "WORKING TOGETHER TO SHAPE THE FUTURE OF OUR HOSPITAL SERVICES"** 15 - 20

   To receive a presentation from the Accountable Officer for Trafford CCG.

6. **CARE QUALITY IN CARE HOMES AND THE CARE QUALITY COMMISSION**

   To receive a presentation at the meeting on behalf of Trafford CCG.

7. **COMMUNITY SERVICE PATHWAYS** To Follow

To receive a presentation by Trafford CCG.

8. **TRAFFORD FLU PLAN 2018** 21 - 22

To receive an update from the Public Health Service.

9. **GREATER MANCHESTER HEALTH AND WELLBEING STRATEGY** 23 - 136

To receive an update report from the Public Health Service.

10. **HEALTHWATCH TRAFFORD UPDATE** 137 - 174

To receive an update report from the Chairman of HealthWatch Trafford, and an Enter and View Report on Heathside Retirement Home.

11. **VISIT TO ASCOT HOUSE** Verbal Report

To receive a verbal update from the members who visited Ascot House Friday 7th September 2018.

12. **GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE** Verbal Report

To receive an update from the Vice Chairman of the Committee.

13. **URGENT BUSINESS (IF ANY)**

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

14. **EXCLUSION RESOLUTION (REMAINING ITEMS)**

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of “exempt information” which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and specified on the agenda item or report relating to each such item respectively.

JIM TAYLOR
Interim Chief Executive

Membership of the Committee

Councillors R. Chilton (Chairman), S. Taylor (Vice-Chairman), S.K. Anstee, J. Bennett, Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, A. Duffield, Mrs. L. Evans, Mrs. D.L. Haddad, S. Longden, J. Slater, D. Acton (ex-Officio) and D. Western (ex-Officio)

Further Information
For help, advice and information about this meeting please contact:

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This agenda was issued on **Monday, 17 September 2018** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

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HEALTH SCRUTINY COMMITTEE

26 JUNE 2018

PRESENT

Councillor R. Chilton (in the Chair).
Councillors S. Taylor (Vice-Chairman), S.K. Anstee, Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, A. Duffield, Mrs. D.L. Haddad, S. Longden, J. Slater and D. Acton (ex-Officio)

In attendance

Jill Colbert	Corporate Director Children Families Wellbeing
Jenny Hunt	Public Sector Reform Manager
Cathy Rooney	Director of Safeguarding and Professional Development
Diane Eaton	Director of Integrated Services, Trafford Council & Pennine Care
Karen Ahmed	Director of All Age Commissioning
Heather Fairfield	Chairman, HealthWatch Trafford
Peter Forrester	Head of Governance
Alexander Murray	Democratic and Scrutiny Officer

APOLOGIES

Apologies for absence were received from Councillors J. Bennett, Mrs. L. Evans and D. Western

1. CHAIRMAN AND VICE CHAIRMAN OF THE COMMITTEE 2018/19

RESOLVED: That the appointment of the Chairman and Vice Chairman be noted by the Committee.

2. MEMBERSHIP OF THE COMMITTEE 2018/19 MUNICIPAL YEAR

The Chairman drew Member's attention to the report that had been submitted with the agenda. The report listed the membership of the Committee for the 2018/19 Municipal Year as Councillors, Joanne Bennett, Anne Duffield, Steven Longden, Jane Slater, Mrs. Angela Bruer-Morris, Jane Brophy, Mrs. Laura Evans, Mrs. Denise Haddad, David Acton (Ex Officio), and one Vacancy. The Chairman informed the Committee that since the annual meeting of Council Councillor Stephen Anstee had been appointed to the vacant position.

RESOLVED: That the Membership of the Committee be noted by the Committee.

3. TERMS OF REFERENCE 2018/19 MUNICIPAL YEAR

The Committee received a report detailing the Health Scrutiny Committee's Terms of Reference. Members were advised that there had been no changes since the previous year.

RESOLVED: That the Terms of Reference be noted by the Committee.

4. MINUTES

Heather Fairfield and Councillor Haddad both requested that the minutes be amended to show their attendance at the meeting 13 March 2018.

RESOLVED: That subject to the above amendments regarding attendance the minutes of the meeting held on 13 March 2018 be agreed as an accurate record and signed by the Chairman.

5. DECLARATIONS OF INTEREST

The following declarations of personal interest were made;

- Councillor Brophy in relation to her employment by Lancashire Care Foundation Trust.
- Councillor Bruer-Morris in relation to her employment within the NHS.
- Councillor Chilton in relation to his employment by general medical council.
- Councillor Taylor in relation to her employment by the NHS.

6. CQC ACTION PLAN UPDATE

The Director of Integrated Services for Trafford Council & Pennine Care delivered a presentation to the Committee. The presentation covered the changes which had been made to Trafford Services in response to the CQC local system review conducted in October 2017. The presentation covered the Asset based approach, Ascot House and the structure of services, the Urgent Care Control Centre, Discharge to Assess Pathway, Stabilise and Make Safe Service (SAMS), and Discharge to Assess Beds.

The Committee were informed of the services that were at the Ascot House site and how those services were coordinated to support individuals. There were four social work teams across Trafford with one based in each locality. This meant that each team was near to where the individuals they worked with lived which helped them in a number of ways including being able to link their work with GPs.

The Committee were then told about the Urgent Care Control Room (UCCR). Trafford were the first area to implement a control room of this type. The UCCR was able to track every bed and service available within the community and all related services were based in the same building. The Director of Integrated Services explained the display and daily updates that enabled the UCCR staff to track the activity and coordinate services.

The Trafford discharge to assess pathways were then explained to the Committee. There were 5 pathways available for people to ensure that each resident received the correct amount of support for them. The presentation showed the staff members who were able to put individuals onto each pathway, the conditions which defined which pathway a person should be on, the personalised services available on each pathway, funding for services on each pathway, and additional services which could be accessed on each pathway if needed.

The Director of Integrated Services then described the new discharge to assess bed service that Trafford had implemented. This service involved the Council commissioning a number of beds at Care Homes that would be used to discharge

residents to for a short period of time whilst they were assessed and long term decisions around their care were decided. Trafford had around 40 beds commissioned during Christmas 2017 and had 36 as of the meeting. The reduction in the number of beds was due to residents wanting to stay in at those residences for the long term. The discharge to assess beds were spread amongst 12 providers across the area. The impact of the development of these services had been that since Christmas 2016 Trafford had reduced the average number of delayed transfers of care from over 100 to 25. Whilst this represented a large improvement in the services it was still not in line with the target of 16 set by the CQC.

The Director of Integrated Services then gave the Committee a couple of case studies of people who had been supported by the system and showed how the various elements were now working together to support them. The Director of Integrated Services read out a letter that had been sent to the service by a resident. The letter thanked staff for providing the support and detailed the improvements that she had managed to achieve through reablement, whereby she went from not being able to move unassisted to being able to return to her home.

Following the presentation the Chairman asked whether it would be possible to arrange a visit to for Members to go to Ascot House. The Director of Integrated Services welcomed the proposal and asked officers to arrange dates.

The Chairman asked about the cost to the Council of continually holding the discharge to assess beds. The Director of All Age Commissioning responded that before the Council started this service they had around 100 vacancies on average and now they had 36 discharge to assess beds instead, so the service was saving money. The Director of Integrated Services added that due to new dynamic commissioning arrangements the Council had put in place, new places at care homes could be arranged within 3 days when needed.

Councillor Bruer-Morris asked whether people have to pay to stay in the discharge to assess beds. The Director of Integrated Services informed the Committee that the individuals were given three weeks within the placement free of charge and after that point it would depend upon their circumstances.

Councillor Taylor asked whether this work linked in with the Trafford Coordination Centre (TCC). The Director of Integrated Services told the Committee that the UCCR only linked into TCC when an individual had ongoing needs.

Councillor Anstee stated that the action plan was due to finish in December 2018 and he noted that there were many items still needing to be completed. Given his knowledge of the services, Councillor Anstee was aware of a number of points that had been completed but not updated on the action plan. Councillor Anstee requested for a more complete action plan be brought to a future meeting with additional plans listed against any outstanding actions.

Councillor Duffield asked whether any people were in homes which required improvement. The Director of All Age Commissioning answered that some residents had been placed at homes that required improvement. However, when such a placement was made the Council worked with the home to improve the service.

Councillor Duffield asked what the ongoing challenges were to further reduce the number of delays. The Director of Integrated Services told the Committee that the service was revising the winter plan. Another area that was being looked into was how to support complex individuals to minimise the number of moves that they needed, as each move had a large negative impact upon their health. Trafford were also adding an extra Stabilise and Make Safe provider to the framework.

Councillor Duffield asked whether there were any issues with adaptations. The Director of All Age Commissioning responded that the Council had identified that it was taking a long time for major adaptations to be put in place. The Council were looking to commission places with providers for individuals to stay in whilst adaptations were made.

Councillor Brophy asked about staff vacancies and whether there were delays caused by staffing issues. The Director of Integrated Services stated that there had been a large improvement in staffing numbers and that the Council had worked hard to make Trafford a place where people want to work. Due to this work there had only been a couple of instances where delays had been caused by staffing shortages within Trafford.

Councillor Haddad asked whether there were any plans to help deal with issues around flu. The Director of Integrated Services responded that Trafford already had a plan in place for staff and were in the process of developing a flu plan for the area. In order to have a full update on the flu plan it was suggested that the Interim Director in Public Health attend the next Committee meeting.

RESOLVED:

1. That a visit to Ascot House for Committee Members be arranged.
2. That an updated Action plan be brought to the Committee showing which actions had been completed and containing details of plans for any ongoing actions.
3. That the Interim Director of Public Health attend the next meeting of the Committee to present an item on the Trafford flu plan.

7. TRAFFORD SAFEGUARDING BOARD

The Director of Safeguarding gave an overview of the new joint Safeguarding Board to the Committee. The reconfiguration of the Safeguarding Board had streamlined Trafford's approach and reduced the duplication of work. The changes included the addition of the Interim Director of Public Health to the Board's membership to help the Board take a community approach.

The Committee were told that the Board was to meet quarterly with the Sub Boards meeting more frequently. In the new structure the Sub Boards were to do most of the work to provide assurance and then report their findings to the Joint Safeguarding Board. The Director of Safeguarding informed the Committee of the different issues that came under Board's remit and how these different areas were dealt with by the Sub Boards. The Committee were told that the membership of each Sub Board consisted of experts with in depth knowledge which enabled them to deal with those issues effectively.

Trafford were in the process of looking at how individuals and organisations could learn from safeguarding reviews. The review process for both adults and Children's was also being revised to ensure that it was the "Gold Standard". Trafford had applied to become an early adopter of a new safeguarding approach. If the application was successful it would lead to a small amount of additional funding which could be used to help evaluate the new model.

Councillor Bruer-Morris asked whether Trafford were the only Local Authority implementing a Joint Safeguarding Board. The Director of Safeguarding responded that there were not many other areas doing this at the moment which was why Trafford had taking such a slow and cautious approach.

Councillor Duffield asked whether all of the positions on the main and Sub Boards had been filled and if all people turned up to the meetings so far. The Director of Safeguarding told the Committee that the Corporate Director for CFW had been assisting in the appointments to the last couple of spaces on the Boards which was now complete. As the Board had not met since the new approach had been implemented the Director of Safeguarding was unable to answer the question regarding attendance.

Councillor Acton enquired as to where the expertise around online safeguarding was within the structure. The Director of Safeguarding answered that online safeguarding was covered under complex safeguarding. This was because online safeguarding involved complex external factors which used to select and affect individuals.

RESOLVED: That the report be noted by the Committee.

8. ONE TRAFFORD RESPONSE

The Public Sector Reform Manager described the process by which the one Trafford response model had been created. The design process had involved bringing together front line staff from various organisations where an overlap of users had been identified. Staff members were then looked at the obstacles within the current system and to think about how they could be overcome.

The One Trafford Response (OTR) programme was one of a number of reform pieces of work which looked at how Trafford Council's services collaborate with voluntary services and other organisations. A key focus of the model was to make sure that the approach integrated health and social care services and would work with the Local Care Organisation. The Public Sector Reform Manager advised councillors to look at an animated story board that was available on YouTube after the meeting. The video detailed the story of one man and his attempts to find help and how the OTR enabled him to get to a point where he is looking for employment.

The OTR tried to ensure that anyone who contacted a service within Trafford received the correct service for them. The Council needed to create a robust early help front door service as in the current model 75% of 1000 calls received by the MARAT team actually required early help. The approach also required case holders to attend weekly multiagency meetings to discuss cases and ensure that users were receiving the right support throughout.

A chart was shown to the Committee which displayed the range of issues that the OTR team dealt with and a customer journey through the system. The customer journey highlighted how the OTR approach differed from other approaches and enabled the team to support people in new ways which reduced recidivism.

The pilot service was based in Stretford and Trafford were looking to roll out the model across the north of the Borough. The team had been working on building relationships with organisations in the area to make sure that they understood the new model prior to its implementation. A number of blockages within the system had been identified and the project team were working to resolve those issues so that the model could reach its full potential. One way to circumnavigate some of the blockages was to work collaboratively with organisations such as DWP and THT.

The Public Sector Reform Manager then described the training programme which was to prepare staff to adopt the new model. There were 3 tiers of training; the first was for all staff members, the second was for workers and leaders working within the place based model, and the third was specific training on asset based tools for relevant workers. The final slide of the presentation showed the next steps for the project. These were; Promote agile working from the Limelight Centre in Old Trafford, to recruit a Communication and Marketing Manager, to undertake a cost benefits analysis, to roll out the workforce development offer for staff, to begin the phased approach to implementing an All Age Front Door, and to continue to understand blockages and issues.

Councillor Anstee noted the apparent success of the pilot project and asked whether the technology was in place to enable this approach to be rolled out successfully and whether there were any GDPR issues. The Public Sector Reform Manager responded that the information governance team were working with the all age front door team so that when people contact any service they will have the correct conversation to ensure that their information will handled in line with GDPR guidelines. There had been issues around the IT but they had been dealt during the pilot project.

Councillor Brophy asked about what happened to those who do not give consent to share their information. The Public Sector Reform Manager answered that most people did give consent but when they do not the case worker still keeps the case and they gain support through general conversations between organisations.

Councillor Brophy asked what the programme had achieved and how deliverable it was. The Corporate Director for CFW answered that the OTR programme was one of the biggest changes in the way that public sector services were delivered across the country. Because it was such a great shift it would be hard to say how deliverable it was in any meaningful way at this point. However, all who were involved in the project knew that the new way of working that the OTR used was the way forward and the correct way for services to be delivered.

Councillor Taylor stated that she was in support of the programme and the wrap around services. She then asked how Councillors could help and refer individuals into the service and how did the OTR team work with the standard services.

The Public Sector Reform Manager responded that it was members of the existing workforce who were part of the OTR Team but they were delivering the services differently. This meant that if a Councillor was aware of a person who was already receiving support and they knew who was providing the support then OTR could set up a multiagency meeting to arrange wrap around services. The OTR Team were still waiting for the initiation of the all age front door which would make referrals much easier to deal with.

The Chairman of the Committee noted that this was the last meeting which the Corporate Director of CFW would be attending before she left the Council. The Chairman thanked the Corporate Director of CFW on behalf of the Committee for all of her work over the years and for all she had done for the residents of Trafford.

RESOLVED:

1) That the Committee receive a further update in 3 months.
2) That the Committee thank the Corporate Director of CFW for all of the work that she has done for the people of Trafford.

9. SINGLE HOSPITAL SERVICE

As the Committee had received an update report for information Members were asked if they had any questions to be posed to the Single Hospital Service Project Team. The Chairman of the Committee noted that the acquisition of North Manchester Hospital was going to take longer than was initially planned. The Chairman also noted that, despite the reservations of Members, there were no plans for moving forward which did not involve MFT acquiring North Manchester Hospital. Councillor Duffield stated that the Committee needed to focus on the impact that the plans of the Single Hospital Service would have on Trafford residents and that this should be the focus of future updates. Councillor Mrs Bruer-Morris asked if staff members were going to be moved across the various hospitals within the trust and if they were how they felt about it.

RESOLVED:

1) That the report be noted.
2) That any further updates are to focus upon the impact upon Trafford residents.
3) That the question posed by Councillor Bruer-Morris be sent to the Single Hospital Service for a response.

10. NWAS UPDATE

The Committee had received an update report prior to the meeting and any questions were to be sent to NWAS for a response. The Chairman was disappointed with the level of performance within Trafford. The Chairman was aware that HealthWatch Trafford were going to look into the performance within Trafford and looked forward to seeing their findings. The Chairman wanted officers to arrange a meeting with NWAS to discuss the structure of the service in the area.

RESOLVED:

1) That the update be noted.
2) That a meeting be arranged between the Chairman and NWAS.

11. HEALTHWATCH TRAFFORD PERFORMANCE REPORT

The Chairman of HealthWatch Trafford presented the performance report from April – May 2018 to the Committee. The Chairman of HealthWatch Trafford focused on ongoing issues that had not yet resolved and new issues that had been raised during April and May. The ongoing issues were; nurse led bed based intermediate care, public consultation processes, and phlebotomy. The New Issues raised were concerning Dentistry and Personal Health Budgets.

HealthWatch Trafford had conducted a review of Ascot House (the main intermediate care facility within Trafford) and found that it was not being used as a step up service so people who needed low level care had to go into hospital. There was concern as the Department of Health had released a statement saying 25% of people who were in long term care would have to come out of hospital. Having looked at the capacity of intermediate care services in Trafford, HealthWatch had concluded that there were not enough beds to cope with the projected additional demand.

HealthWatch Trafford had started to look at phlebotomy first by working with the HealthWatch 100 and had then conducted a further piece of work which received over 300 responses. A report was due to be published within the next two weeks and the findings passed onto Trafford CCG. HealthWatch had also received complaints about children's phlebotomy which they were following up.

The Chairman of HealthWatch Trafford had met with the Chairman of the Local Dentistry Committee and had found out that 40% of the Trafford population were not signed up to a dentist. HealthWatch felt that the Bridgewater trust, which was an organisation set up to provide vulnerable people with dental care across Greater Manchester, was not doing all they could to support dentistry within Trafford and had spoken to the Interim Director of Public Health about this. Oral Health was becoming a concern in care homes across Trafford. Despite there being NICE guidelines in place relating to oral health a number of care homes within Trafford were unaware of them.

The Chairman of the Committee thanked the Chairman of HealthWatch Trafford for the report. The Chairman stated that he wanted the Committee to work closely with HealthWatch especially in relation to phlebotomy and dental services within Trafford.

The Executive Member for Wellbeing explained some of the issues of dental services within Trafford and informed the Board that the Health and Wellbeing Board were looking into this area. The Chairman requested that the Committee be kept up to date on the work of the Health and Wellbeing Board in this area.

Councillor Bruer-Morris asked why Trafford did not employ Health assistants at GP practices. The Chairman of HealthWatch Trafford did not know the answer and suggested that it should be asked of Trafford CCG.

Councillor Duffield asked whether HealthWatch had a proposal of what the nurse led intermediate care bed system should look like. The Chairman of HealthWatch Trafford responded that a proposal had been created the previous year which

involved using the George Carnall facility for more intermediate care beds for both step up and step down care.

RESOLVED:

1) That the Chairman of HealthWatch Trafford be thanked for attending the meeting.
2) That the Health and Wellbeing Board keeps the Committee updated on the work relating to dentistry within Trafford.
3) That Councillor Bruer-Morris' question be sent to Trafford CCG for an answer.

12. COMMITTEE WORK PROGRAMME 2018/19

The Chairman asked the Committee whether they had any items that they wanted to add or remove from the work programme for the year. The Committee responded that they were happy with the work programme. The Chairman then told the Committee that there would be a number of task and finish groups over the course of the year and he asked each Member to email any suggestions for topics to officers by the end of the following week.

RESOLVED:

1) That the Committee work programme be agreed.
2) That Members are to email suggestions for task and finish group topics to officers by Friday 6 July.

13. HEALTH UPDATES

The Chairman informed the Committee that since being appointed he had a attended very positive meeting with HealthWatch and had met with the Corporate Director for Children Families and Wellbeing.

The Vice Chairman informed the Committee that she was to be the Councils representative at the Greater Manchester Joint Health Scrutiny Committee.

RESOLVED: That the updates be noted.

The meeting commenced at 6.30 pm and finished at 8.56 pm

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TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **25 September 2018**
Report for:
Report of: **Stephen Gardner, Deputy Programme Director, Single Hospital Service**

Report Title

Single Hospital Service Update

Summary

This report provides an update on the latest position for Single Hospital Service programme. It provides an overview of the work to establish Manchester University Foundation Trust (MFT) as an organisation, an update on the integration activity that is underway, and information on progress with the proposed acquisition of North Manchester General Hospital (NMGH).

1.0 Introduction

1.1 This paper provides an update for the Trafford Health Scrutiny Committee on the Single Hospital Service (SHS) Programme.

2.0 Background

2.1 The proposal to establish a Single Hospital Service for Manchester, Trafford and surrounding areas was built on the work of the independent Single Hospital Service Review, led by Sir Jonathan Michael. The Single Hospital Service Programme has been operational since August 2016.

2.2 The Programme is being delivered through two linked projects:

- Project 1: The creation of MFT through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM). MFT was created on 1st October 2017 and integration of the two predecessor organisations is underway.
- Project 2: The planned acquisition by MFT of NMGH. The acquisition is expected to take place sometime between 1st October 2019 and 31st March 2020.

3.0 Progress to Date

3.1 Integration

3.1.1 Prior to the merger and creation of MFT, key deliverables and outputs were categorised into four major timelines: Prior to Day 1, Day 1-100, Day 100-Year 1, and Year 1 and beyond.

3.1.2 All of the corporate integration plans due to be realised in readiness for Day 1 were successfully delivered, including the appointment of the substantive Board of Directors for

MFT and the development of a new management structure across the hospitals.

3.1.3. Multiple deliverables across corporate and clinical programmes, outlined for completion by Day 100, were successfully achieved. A small number of objectives were re-phased as part of wider integration initiatives for Year 1. Integration plans are now focused on the complex, large services (e.g. cardiology) and how integrated clinical services for MFT can be realised.

3.1.4 The integration work continues to be overseen by the Integration Steering Group (ISG), with representation from the Strategy Team to ensure that the work aligns with the development of the Trust's overarching Clinical Service Strategy and with Greater Manchester initiatives such as Theme 3 (standardisation of acute and specialist services). ISG reports into the Group Management Board.

3.1.5 Progress against the Manchester Investment Agreement improvement targets is also being tracked. This involves regular reports to the ISG, direct contact with operational teams, as well as liaison with Hospital / Managed Clinical Service Chief Executives. The objectives are also being reported to Manchester Health and Care Commissioning (MHCC), which has a formal role in holding MFT to account on behalf of the GM Health and Social Care Partnership.

3.1.6 The first target to be reported on (for Q1 2018/19) was in respect of access to kidney stone treatment. The Urology teams at Wythenshawe and Manchester Royal Infirmary (MRI) Hospitals have continued to work together closely on improving services for patients with kidney stones through increased utilisation of the Lithotripter at Wythenshawe Hospital. At the end of March 2018, on average, 60 patients were waiting longer than four weeks for their procedure. However, by end July 2018, this was significantly reduced with no patients waiting longer than four weeks for their treatment. This position is being maintained.

3.1.7. The second target to be reported on (for Q2 2018/19) is in respect of waiting times for urgent Gynaecological procedures. Additional urgent Gynaecology surgery lists have been established across Wythenshawe and St Mary's Hospital, and these offer women additional choice for their procedures in terms of both time and location. The baseline figure for this metric was 3.3 days, and the objective is to get this down to 2.5 days. Current monitoring suggests that good progress is being made towards this target.

3.1.8 Integration planning for Year 2 and beyond is underway which includes a refresh of the Post Transaction Integration Plan (PTIP). This will be the fifth iteration of the PTIP and it is anticipated that this will be the version of final PTIP for Project One. The Director for the Single Hospital Service will, however, continue to work closely with Group Executive Directors and Hospital/Managed Clinical Services Chief Executives to drive integration plans and embed change as part of the MFT approach to business as usual. In tandem with this, the SHS Team will continue to maintain oversight of integration and ISG will maintain its reporting relationship with Group Executive Team.

3.1.9 As part of the integration work, a Year One post-merger report is currently being produced to evaluate the first year of operation of the new organisation. The report will be shared widely.

3.2 Acquisition of North Manchester General Hospital

3.2.1 The second stage in the creation of a Single Hospital Service is to transfer NMGH, currently part of Pennine Acute Hospitals NHS Trust (PAHT), into MFT.

3.2.2 NHS Improvement (NHS I) has set out a proposal for MFT to acquire NMGH as part of an overall plan to dissolve PAHT and transfer the remaining hospital sites (Bury, Oldham and Rochdale) to Salford Royal NHS Foundation Trust (SRFT).

3.2.3 The transaction process is being managed under the auspices of the national NHS I Transaction Guidance with oversight provided by a Transaction Board established at the end of November 2017. The Board is chaired by Jon Rouse, Chief Officer for the Greater Manchester Health and Social Care Partnership (GMH&SCP). Associated sub-committees / groups have also been established and these have appropriate multi-agency involvement.

3.2.4 The process for MFT to acquire NMGH is complex and requires a significant degree of effort across a range of interactions with stakeholders. Good progress continues with the acquisition process, albeit at a slow pace due to the complexity of the programme. MFT remains committed to acquiring NMGH and is working collaboratively with local and national stakeholders to ensure the transfer of NMGH can be delivered at the earliest practicable opportunity.

3.2.5 Independent vendor due diligence has been carried out on the NMGH site and has highlighted key challenges with regards to the Estate and Informatics, adding to the complexity of the transaction.

3.2.6 The SHS Team met MFT Council of Governors on 28th August 2018 to provide key updates on the progress of the proposed acquisition. The session served as an opportunity for the Council of Governors to learn more about the services and footprint of NMGH.

3.2.7 Staff engagement sessions have been scheduled for all NMGH staff regarding the proposed acquisition. To date, two engagement sessions have taken place, feedback from which has been positive. A summary of FAQs regarding the transaction has recently been published for NMGH staff and further engagement sessions continue to be scheduled.

4.0 Conclusion

4.1 This report provides an update on the progress of the Single Hospital Service Programme. It describes the strong progress made in integration activity across the Trust to enable the timely delivery of benefits for patients. The report explains that MFT is progressing plans to acquire NMGH though this is proving to be a complex process. The Health Scrutiny Committee is asked to note the progress made to date.

Recommendation(s)

The Health Scrutiny Committee is asked to:

(i) Note the current position of the Single Hospital Service Programme.

Contact person for access to background papers and further information:

Name: Stephen.Gardner@mft.nhs.uk
Extension: 0161 701 4963

Background Papers:

Implications

Relationship to Policy Framework/Corporate Priorities	
Financial	
Legal Implications:	
Equality/Diversity Implications	
Sustainability Implications	
Staffing/E-Government/Asset Management Implications	
Risk Management Implications	
Health and Safety Implications	

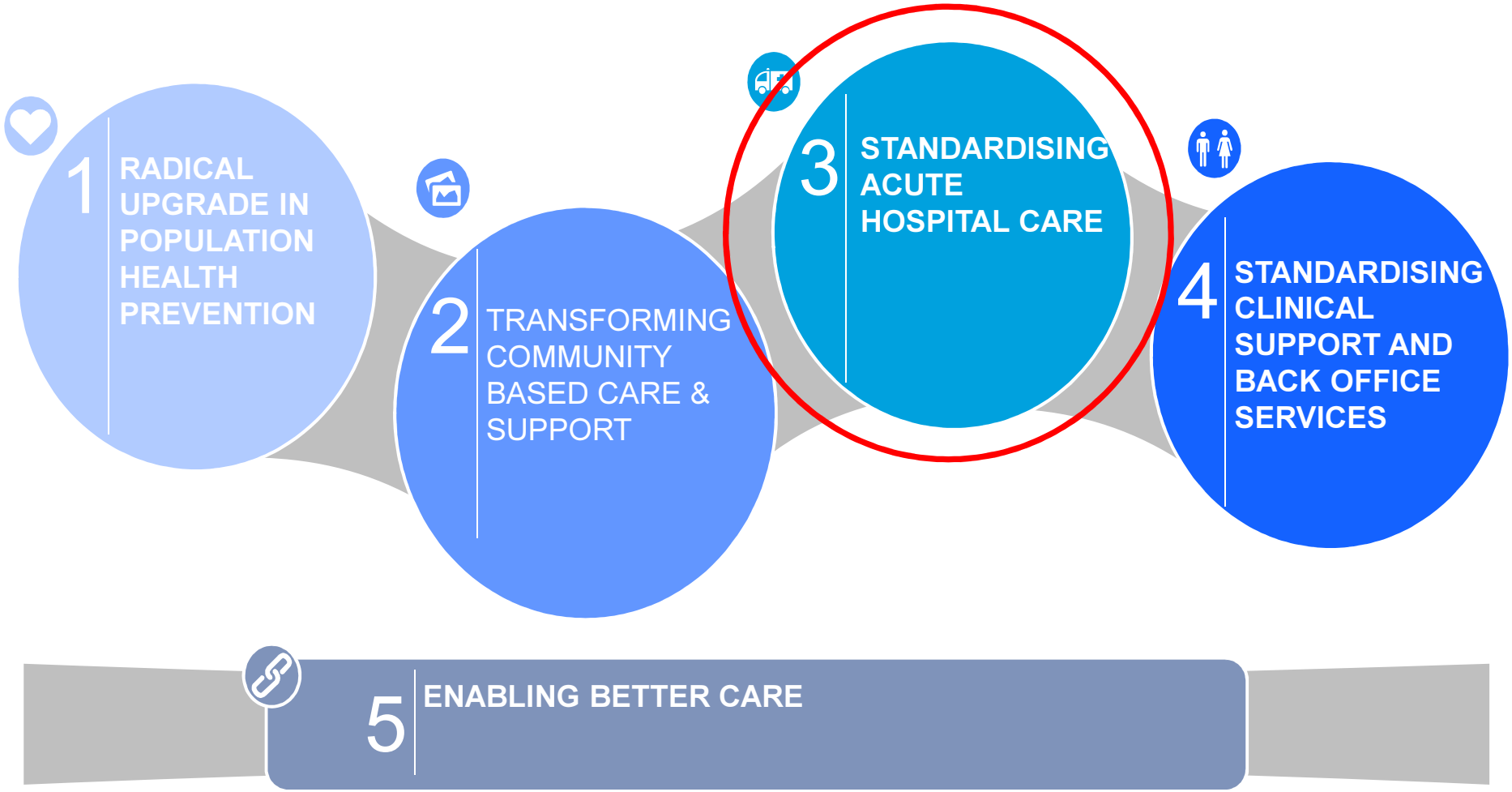
GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

‘Working Together to Shape the Future of our Hospital Services’

September 2018

‘Taking Charge’ identified 5 areas of change



Background

- **Aim:** *'To create a system that, irrespective of where you live or access a service, you will receive acute and specialist care in the right settings'.*

- **Vison:** *The creation of 'single shared services' for acute and specialised services to deliver improvements in patient outcomes and productivity, through the establishment of consistent and best practice specifications that decrease variation in care; enabled by the standardisation of information management and technology."*

- **Services in Scope:**

  Benign Urology, Cardiology, Respiratory, MSK/Orthopaedics, Paediatric Surgery, Breast Services, Vascular and Neuro-Rehabilitation

Why do we need to keep reviewing and adapting our services?

- Thousands of people in Greater Manchester are admitted to hospital when their needs could be better met in the community
- This increases the pressure on our hospitals and means that our highly trained staff are not freed up to do what they do best: provide more specialist care to those who are most ill
- The population is changing, more of the population has developed multiple long-term conditions, the focus has shifted from curing illnesses to helping individuals to live with chronic ill health
- Shortage of clinical staff
- Variations in provision and standards of care
- Significant variation in our estate (i.e. our buildings and where we deliver services)
- Money to pay for health services is limited

Comms and engagement activity to date

- Each work stream has patient, Healthwatch and clinical representation to inform and influence the models of care and a Provider Leadership Team representatives in place for each work stream
- Each CCG, Trust, Healthwatch and third sector partners working collaboratively to engage patients and the public from the design phase via surveys/forums/meetings etc.
- Established Communication and Engagement Reference Group representing all LA's, CCGs. NHS Trusts, Third Sector, and Healthwatch
- Co-produced communication and engagement strategy
- Co-produced a communication and engagement implementation plan
- Production of core messaging repository
- Creation of Patient Reference Group with each Borough represented

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Notes on flu plans 2018/19 for Health Scrutiny

Achieving a good uptake of flu vaccination is an important part of keeping people healthy in the winter, and reducing hospital stays. This requires firstly:

- actions to vaccinate our most vulnerable populations (young children; people with long term health conditions; and people aged 65 and over),
- actions to increase vaccination uptake among key groups of staff, in order both to keep them healthy and to prevent them spreading flu to higher risk people.

The main point for members of Health Scrutiny to note is that the process for flu vaccination is changing this year, with a new (adjuvanted trivalent) vaccine being offered to people aged over 65. This is expected to offer better protection to this group. The previous (quadrivalent) vaccine will continue to be offered to the remaining groups as the evidence is that it gives good protection for the younger age groups,

The supply of the adjuvanted trivalent vaccine is limited and practices and pharmacies had to make their orders for this in the summer. The process for this has been problematic nationally, but in Trafford we are expecting to have just enough vaccine to cover our population, with only one practice failing to place an order successfully. By working with local pharmacies, this practice's patients should be able to access the vaccine.

The trivalent vaccine will be distributed in 3 batches, with 40% available by October, 20% by November and the final 40% by December. Flu does not normally start circulating before this point so there should be time for everyone to be vaccinated. Priority will be given to people over 75, and care home residents, and these people should be vaccinated in October. **Healthy people aged 65-74 may need to wait until November for vaccination; people aged over 65 should be discouraged from asking for the quadrivalent vaccine and instead wait until they are called for the trivalent, as stocks become available, because it is significantly more effective.** This marks a significant change in process from previous years, and we will be monitoring the situation carefully regarding uptake. We are aware that some patients will not be happy with this situation but it is important that the most vulnerable people are offered the protection first. This approach is in line with national guidance.

The process for immunising children remains as in previous years, with the youngest children (aged 2-3) being vaccinated by the GP, and children in reception to year 5 being offered vaccination at school.

We need to continue to encourage health and care staff to take up the offer of vaccination. Anyone with direct patient contact in health and social care (including care home and home care staff) can receive free vaccination. Sessions are being arranged for Pennine Care staff, and home care/care home staff can attend either their GP or a pharmacy (see Appendix below)

In Trafford, we have in the past always had good uptake of vaccination among our older people, we have done less well in people with long term conditions and in our

staff. **We need to continue to promote the benefits of vaccination to all eligible individuals.**

Eleanor Roaf
14.9.18

Appendix
Process for home care/care home staff

NHSE GM have identified funding to provide a free vaccine for all care home/home care workers. To get the vaccine they can go to their GP or pharmacy.

It is hoped that as many GP Practices as possible will sign up. However, if not, then the social care workers registered with a non-participating Practice should be signposted to a Pharmacy/Chemist that is offering flu vaccinations.

All Pharmacies offering flu vaccination are automatically able to give this if they are signed up to give flu vaccination programme.

The social care worker would need to bring ID as proof of employment to Pharmacy in the same way that they would if attending GP surgery. 'ID' can be and ID badge/ letter of confirmation from employer or a pay slip, just as long as it shows proof of employer/job title. (Can be paid or non-paid if they can show ID)

The Greater Manchester Population Health Plan

2017-2021

Greater Manchester

Health and Social Care Partnership

Contents

Foreword

April 2016 was a milestone in Greater Manchester's history. It marked the start of the era in which we take charge of health and social care in our region.

We've said before that that's a huge privilege - it gives us the chance to make decisions locally about how best to spend our £6 billion budget to bring the greatest, fastest improvement to the health and wellbeing of our 2.8 million people. It gives us chance to focus on our people and communities, helping them to take control of and make decisions about their own health, looking after themselves and each other. And it gives us chance to strengthen the links between health, work and economic prosperity. Put simply skilled, healthy and independent people are crucial to bring jobs and investment, we therefore want to support as many people as possible to contribute and benefit from the opportunities economic growth brings.

It's also a huge challenge as we seek to tackle the deep rooted health inequalities and high levels of long term conditions such as diabetes, which mean that Greater Manchester people not only have a shorter life expectancy, but can expect to experience poor health at a younger age than in other parts of the country. In turn this means many thousands of people here are not always able to benefit from that increased prosperity we want to bring to the region.

Our strategic plan, Taking Charge, set out our ambitious goals for everything from community health services, to hospitals, IT and our public sector buildings. This Population Health plan is our commitment to the people who live and work in the ten towns and cities of Greater Manchester - and that includes the carers, the volunteers and the workforce - that we will make changes which we know will work and at the right scale in order to help people have the best start in life, to live well and to age well.

With your support and assistance we can turn this bold and ambitious strategy into an effective plan to transform lives and achieve a healthier Greater Manchester.

Lord Peter Smith
Chair GMHSC Strategic Partnership Board
Leader of Wigan Council

Summary

Vision

To achieve the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people who live in Greater Manchester

Strategic framework

Person and community centred approches	Start Well	Live Well	Age Well	System reform

Health Challenges

- Greater Manchester's population is predicted to increase by 3%, with an ageing profile, and people aged over 70 predicted to increase by 15.2% by 2021.
- Greater Manchester has significant health inequalities both in relation to England averages and across Greater Manchester between local authorities and within them.
- Our life expectancy is below the national average, and we have poorer levels of healthy life expectancy.
- Rates of employment are lower – 70.5% compared with 74% across England.
- Across the life course, risk factors that lead to illness and reduced life expectancy in general are worse than the respective England averages e.g. in 50% of all Greater Manchester local authorities smoking prevalence is significantly higher than the England average of 16.9%, and one in three children in Greater Manchester did not achieve a good level of attainment by the end of Reception.
- 9.8% of adults reported they had a long-term condition or disability that significantly impaired their everyday activities, compared to 8.3% across England.

Taking Charge Together Consultation

- 90% wanted to improve their lifestyles, with most people citing being more active, eating healthier and tackling stress as their key areas of need.
- People were willing to take charge of their own health and wellbeing, but recognised their ability to do so was limited by the wider determinants of health such as income, transport and housing.
- While improving health and social care services was seen as important, people emphasised the role of personal and community support structures. Mental health was seen as equally as important as physical health.
- People recognised that one size does not fit all and that certain groups had additional needs e.g. LBGT.
- They emphasised the importance of self-confidence and self-efficacy in changing health-related behaviours.
- People highlighted the important legislative powers of local government and the role of public sector organisations in creating the right conditions for people to take charge of their own health, and the important role of staff as health ambassadors within local communities.
- They wanted greater use of behavioural insights to identify how people really behave, not how policy makers think they should.

Wider strategic linkages

- Our plan is aligned with the broader approach to reform across Greater Manchester that is predicated on: a new relationship between people and public services; connecting people to the opportunities of growth and reform; place-based integration of services and orientating the system towards early intervention and prevention.
- We are clear that change happens in communities, supported by localities. The priorities for change set out within this plan have been chosen to support the locality delivery described in each of the 10 locality plans.
- While the plan focuses on the programmes of work that the Greater Manchester Health and Social Care Partnership will deliver in collaboration with localities, achieving a radical upgrade in population health will be dependent on both the priorities of this plan and the broader reform of services being taken forward across Greater Manchester.
- Nor can this plan be disconnected from the rest of our health and care transformation programmes, in particular the development of locality care organisations (LCOs) and the primary care strategy will lead to embedding more proactive, person-centred prevention and early intervention practice consistently into the design and delivery of community-based services.

Taking Charge Together consultation	Quick wins	Common theme in locality plans	Economics of prevention
Findings from Greater Manchester people, carers and staff conversations online and face to face, with over 6,000 responses and 50,000 visits online about how they might better take charge of their own health.	Opportunities to implement evidence-based local best practice at scale across other parts of Greater Manchester.	An audit earlier this year of locality plans highlighted areas for standardised approaches across Greater Manchester.	The 'economics of prevention' work was developed by New Economy Manchester and Public Health England and group interventions by their gestation or notional rate of return in order to recognise that dividends for different interventions are likely to be realised over different time periods.

Summary

Greater Manchester Population Health Plan Objectives

Person and community centered approaches

- To build a Greater Manchester framework and support capacity and capability building for person and community centred approaches
- To work in partnership with VSCE sector to develop and test an exemplar social movement focused on cancer prevention.

Start Well

- To support localities to implement the core elements of the Greater Manchester Early Years model, including the development of an IMT proposition to improve data processes to track progress and allow earlier intervention.
- To develop a sustainable, resilient and consistent Greater Manchester approach to stopping smoking in pregnancy.
- To implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and reduce treatment costs within 3-5 years.

Live Well

- To build and test an approach to work and health that improves the integration and alignment of health, employment and other services.
- To test and evaluate the 'focused care' approach model in a number of deprived practices in Greater Manchester with a view to supporting the future expansion and mainstreaming of the new care model, including exploration of sustainable funding mechanisms.
- To develop a whole systems approach to lifestyle and wellness services, including innovative digital options for incentivising and supporting lifestyle behaviour change.
- To deliver the cancer prevention workstream of the national cancer vanguard, testing innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle -based secondary prevention.
- To roll out a lung health-check programme across Greater Manchester.
- To help develop a Greater Manchester city-region approach to eradicating HIV within a generation.

Age Well

- To facilitate the roll-out, testing and evaluation of an approach to tackling issues around poor quality housing.
- To facilitate the roll-out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford.
- To facilitate the roll-out ,testing and evaluation of fracture liaison services, integrated with locally designed falls prevention services in a number of Greater Manchester boroughs.

System reform

- To develop a population health commissioning plan, and develop and test a proposal for a new Greater Manchester population health function including future resourcing model.
- Maximise the social value benefit from health and social care commissioning and contribution of the voluntary, community and social enterprise sector.

Taking Charge

Start Well

More Greater Manchester children will reach a good level of development cognitively, socially and emotionally.

Fewer Greater Manchester babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.

Live Well

More Greater Manchester families will be economically active and family incomes will increase.

Fewer people will die early from cardiovascular disease.

Fewer people will die from cancer.

Fewer people will die from respiratory disease.

Age Well

More people will be supported to stay well and live at home for as long as possible.

Stronger Together

Greater Manchester is a fairer, healthier, safer and more inclusive place to live

Reform health and social care with improved access to quality, integrated services. Greater independence, improved well-being and stronger communities.

Improve early years support for parents to give children the best start in life and help workless parents towards work.

All people are valued and able to fully participate in and benefit from the city regions success. Support unemployed residents into work and enable progression into higher skilled, higher paid roles.

Greater Manchester is known for excellent, efficient and value for money services. Encourage self-reliance and reduce demand on services.

Create the conditions for growth and place Greater Manchester at the leading edge of science and technology. Expand and accelerate the commercialisation of research.

Collaboration and partnerships. Strong collective and individual leadership.

1. Introduction

"The greatest wealth is health"

– Virgil

Greater Manchester's (GM) future success depends upon the health of its population. For too long our city-region has lagged behind national and international comparators when it comes to key health outcomes. Deeply embedded health inequalities, often between communities little more than a stone's throw apart, have blighted individual lives and acted as a drag on our economy.

That is why we are committed to achieving the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people who live here. Each of the towns and cities of Greater Manchester is determined to do this by: helping people to take control of their own and their family's health; connecting people to the opportunities created by economic growth and reform; tackling the root causes of poor health; focusing on improving the health of the most vulnerable; and providing excellent care for people when they need it.

Our plan is unashamedly focused on people and communities. Communities, both place-based and where people share a common identity or affinity, have a vital contribution to make to health and wellbeing. We know that connected and empowered communities are healthy communities. That it is the assets within communities, the skills and knowledge, the social networks and the community organisations that are building blocks for good health and wellbeing. So we have put person and community-centred approaches at the centre of our plan.

This plan sets out our approach to delivering a radical upgrade in population health. It is informed by the best empirical evidence and by the views of the people of Greater Manchester. It sets out the health challenges we face and our approach to population health at the Greater Manchester level.

We are convinced that the key to better population health is to get upstream of the impact of illness and disease in focusing on prevention and early intervention. We are also committed to a life course approach; we believe that from pregnancy right through to ageing we have multiple opportunities to enhance future quality of life.

We are clear that most change happens in communities, supported by local organisations, so the priorities for change set out within this plan have been chosen to add value to the local delivery described in each of the 10 locality plans. The plan then focuses on those programmes of work that Greater Manchester Health and Social Care Partnership (GMHSC Partnership) will deliver in collaboration with localities. It does not seek to duplicate those priorities that are best delivered at the locality level.

The choices we have made in the plan are based on the best available evidence of impact and seek to achieve a balance of short, medium and long-term improvements. There will be some programmes that we will work up in future years, and

others that we will take forward through our commissioning plans and by working with localities.

We know a lot about what we need to do to improve health and wellbeing and reduce health inequalities. The ambition of this plan lies in our desire to implement and embed these proven approaches consistently at scale across Greater Manchester in a way that has never been achieved before. Right now, there are multiple examples of good practice across the conurbation but they tend to be small in scale and operating at the fringe rather than at the heart of the health and social care system. This plan will act as a key driver to re-orientate the system towards prevention and a focus on population health and wellbeing.

1.1 Wider strategic linkages

The overall Greater Manchester Strategy, 'Stronger Together', places reform of services to the public at the heart of our strategic ambition. The subsequent Growth and Reform Plan, devolution agreements, and the Health and Social Care Strategic Plan 'Taking Charge' have restated that commitment to reshaping our services, supporting as many people as possible to contribute to and benefit from the opportunities economic growth brings.

The various elements of the overall Greater Manchester strategy – Stronger Together, the Greater Manchester Spatial Framework (the plan to manage the supply of land for jobs and new homes across Greater Manchester) and the Greater Manchester Local Transport Plan, together with more targeted strategies such as the Greater Manchester Alcohol Strategy, the Greater Manchester Primary Care Strategy and The Greater Manchester Mental Health Strategy – all have important contributions to make to population health. It's not possible, nor is it appropriate, to reference the full range of strategies that contribute to population health in this document. However, we have signposted to the most important strategies and programmes of work for population health wherever possible.

Across Greater Manchester, we are clear that people's lives do not neatly fit into public service sectors. Aligning our reform strategies means we are placing people at the heart of what we do rather than expecting people's lives to neatly map to our organisational boundaries. It also means that this is not just a traditional public health plan, in that it seeks to draw on the widest possible range of services and support options to help people achieve the best possible health and wellbeing outcomes.

Nor can this plan be disconnected from the rest of our health and care transformation programmes and projects. Our aim is that people across Greater Manchester are able to access the right services, at the right time, in the right way to help them tackle challenges they may face and to build on their strengths and assets. We must do this in collaboration, across sectors so that people no longer have to navigate fragmented systems and services. This will mean that when we consider any pathway of care, for any condition or group of conditions, we will think about the whole journey from prevention right through to specialist care.

1.2 Taking charge together of our health and wellbeing

In order to develop the proposals in this population health plan, our starting point is the views and experiences of local people. In 2016, we engaged with Greater Manchester people including the "seldom heard", carers, and health and social care staff by working in partnership with Healthwatch, the Voluntary Community and Social Enterprise (VCSE)

sectors and across all 37 public sector organisations that form GMHSC Partnership. 50,000 visited our websites and more than 6,000 were involved in our conversations face to face from all walks of life in a conversation specifically about health and wellbeing and how they might better take charge of their own health. This innovative engagement exercise generated feedback via crowdsourcing (online conversations) and a health snapshot online questionnaire.

The engagement with seldom heard people, led by a unique partnership between Healthwatch and Greater Manchester Voluntary, Community and Social Enterprise (VCSE), sign-posted these groups to our online conversations. Their feedback included:

It's all environmental: A range of factors commonly defined as wider health determinants were recognised as having either a direct impact on health or on people's ability to adopt healthy behaviours such as healthy eating or exercise. Factors included income and costs, work and employment, transport, housing, skills and education, town and city planning, crime and community safety, pollution, social and cultural norms, climate and weather.

It's all about people: People highlighted the role of social and community support structures, the harmful effects of social isolation and the importance of people as positive role models and motivators. VCSE groups and organisations were seen as key in facilitating social support and providing opportunities for creating meaningful connections.

It's all in the mind: Mental health was given equal, if not more, importance as physical health. Self-confidence, a sense of self-efficacy (especially in relation to perceptions of behaviour change as possible, and likely to result in positive health impacts), and motivation all featured strongly in discussions.

It's all relative: People emphasised the relative nature of health and wellbeing and referred to significant levels of diversity in relation to individual, social and cultural differences as well as transitions across the life course. 'One size does not fit all', and a particular focus was put on the additional access and inclusion requirements of particular communities, such as disabled, Deaf, lesbian, gay, bisexual and trans (LGBT) and young people, and people for whom English isn't their first language.

It's all about equality: Participants drew a direct connection between structural inequality and ill health, in line with mainstream theory on health inequalities. This suggests that addressing structural inequalities in society has to be at the centre of all health improvement work.

It's all about knowledge: While participants generally reported good levels of knowledge about healthy living, they recognised an unmet need for accessible information for particular groups and communities, and for consistent messaging and education from a young age. Also, gaps in knowledge among professionals around particular issues and the needs of particular communities were highlighted.

These conversations have given us a unique insight into the opportunities and barriers that people are experiencing and the key messages and have been fundamental in shaping this population health plan.

Overall, people are willing to take charge of their health and wellbeing while recognising that their ability to do so on an individual basis is limited by other factors, mainly time to do this, place and confidence. While improvements to health and social care services are seen to play a role in this, people put more emphasis on improving personal and community support structures. To find out more visit www.takingchargetogether.org.uk

It follows that creating conditions in which people are enabled to take charge of their own health and wellbeing will require a truly holistic approach based on radical improvements of the physical and socio-economic environment and transformative grassroots community development.

1.3 Greater Manchester's health challenge

Where are we starting? Greater Manchester is the fastest growing economy in the country and is a great place to live and work for many people. Yet people here die younger than people in other parts of England. Our aspirations for good health need to recognise our starting point and also the challenges of an ageing population and the inequalities that currently exist between the most affluent and most deprived parts of the local population.

1.3.1 Demographics

We have an ageing population. Between 2016 and 2021 the number of people aged over 70 living in Greater Manchester is predicted to increase by 15.2%, while the overall population will increase by 3% (figure 1).

Greater Manchester has a diverse population and it is important to recognise how this diversity is dispersed across the areas as this can lead to significant inequality. For example, the 2011 Census shows that local populations have different ethnic characteristics (see figure 2).

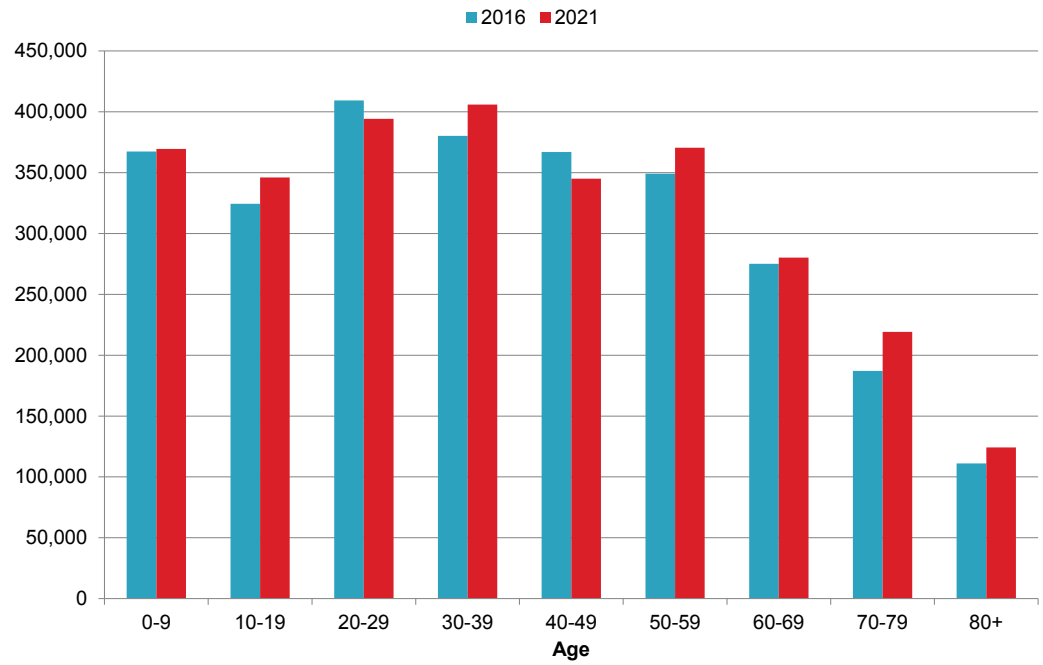


Figure 1: Demographic change over the next five years

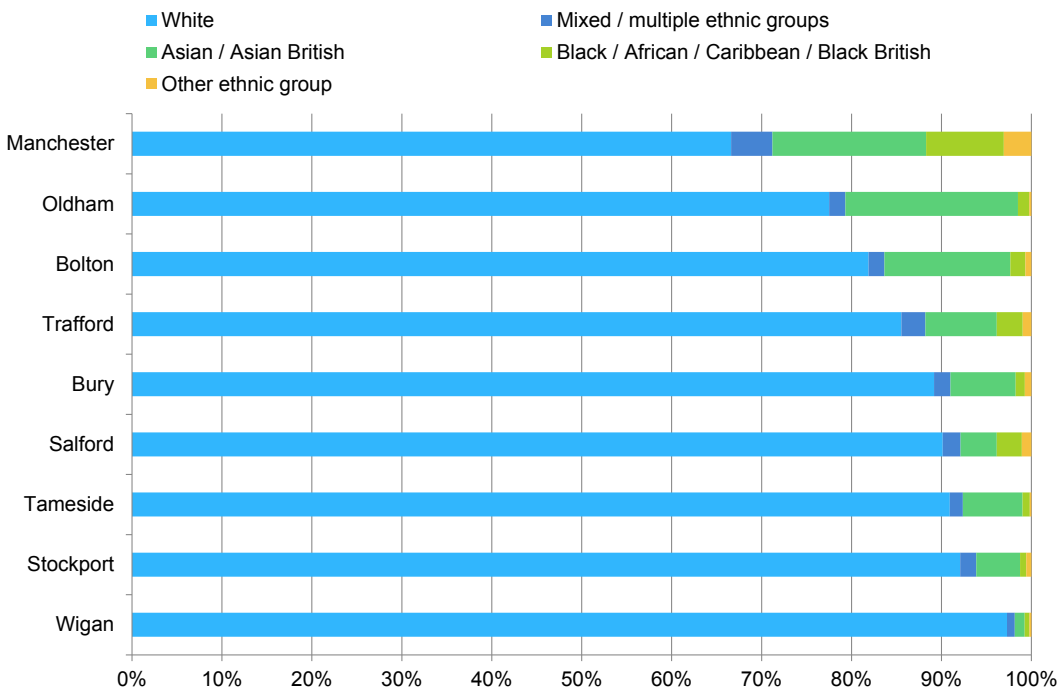


Figure 2: Greater Manchester cultural diversity

1.3.2 Life expectancy and deprivation

Around 680,000 Greater Manchester people live in areas that fall into the 10% most disadvantaged areas in the country, and three local clinical commissioning groups (CCGs) are in the bottom 10 nationally for healthy life expectancy at birth.

Life expectancy varies between local authorities, but also within them. Published figures for the 2009-2013 period show that there is considerable variation between relatively small areas (middle super output areas or MSOAs) within each local authority. The MSOAs with the highest and lowest life expectancies within each local authority are shown in figure 3.

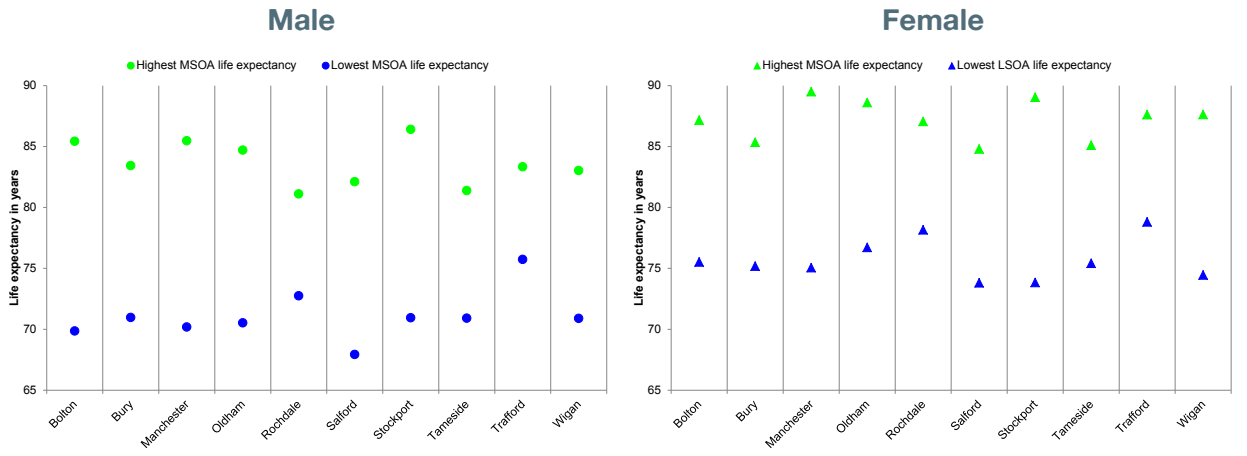
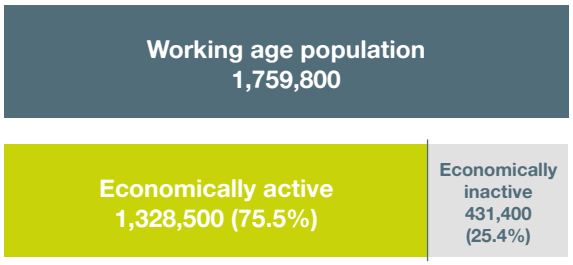


Figure 3: Life expectancy across the localities

1.3.3 Work and health

The benefits of work for your overall health and wellbeing are well understood; being in good work is beneficial for your health. The economic status of Greater Manchester's working age population is shown right.

Disability and long-term health conditions are not a total bar to employment, but the working age population who have health conditions or illnesses lasting more than 12 months are less likely to be in employment than the total working age population. And employment rates are lower in Greater Manchester than across England. In Greater Manchester, 70.5% of the total working age population are in employment compared with 74% across England; similarly, 59.2% of those who have a health condition or illness lasting more than 12 months are in employment compared with 65.3% across England (Active People Survey, July 2015 to June 2016).



Definition of economically active is a measure of the number of people employed or actively seeking employment and able to take up employment if it came along (i.e. on Jobseeker's Allowance).

Figure 4: Economic status of Greater Manchester's population

Participation in the labour market, Greater Manchester, July 2015 to June 2016

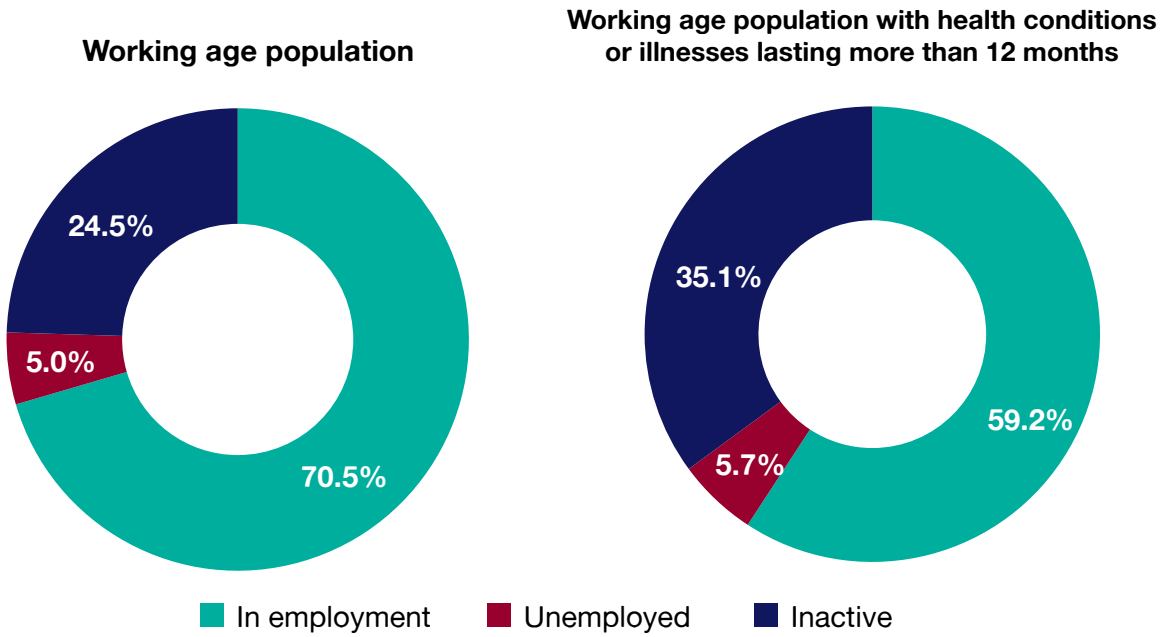
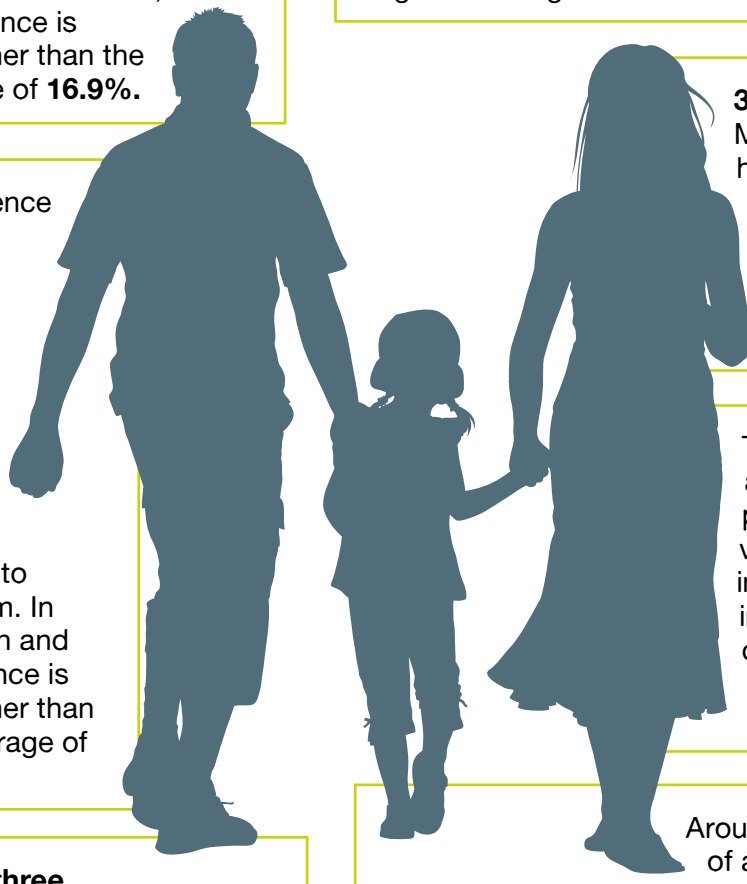


Figure 5: Participation in the labour market

1.3.4 Over the life stages

One in five adults in Greater Manchester smokes. Smoking prevalence in 2015 ranged from **15.1**% in Stockport to **22.7%** in Manchester. In **50%** of Greater Manchester local authorities, smoking prevalence is significantly higher than the England average of **16.9%.**

Across almost all standard published measures of alcohol harm, including alcohol-related mortality and alcohol-related hospital admissions, Greater Manchester local authorities have significantly worse figures than the respective England averages.



35.5% of Greater Manchester children have dental decay, with an average of **1.41** filled, decayed or missing baby teeth in children.

Smoking prevalence in routine and manual occupations is higher than across the general population, and across Greater Manchester it varies from **24.4%** in Wigan to **36.3%** in Oldham. In Rochdale, Bolton and Oldham prevalence is significantly higher than the England average of **26.5%.**

The proportion of adults who are physically active varies from **45.0%** in Oldham to **57.7%** in Stockport, compared with the England average of **57.0%.**

In 2016, **one in three** children in Greater Manchester (over 12,700 children) did not achieve a good level of development by the end of Reception.

Around **two-thirds** of adults in Greater Manchester are overweight or obese. The proportion varies from **61.5%** in Manchester to **69.7%** in Rochdale, compared with **64.8%** across England.

9.8% of adults in Greater Manchester reported they had a long-term condition or disability that limited their day-to-day activities a lot, and a further **9.5%** said that their day-to-day activities were limited a little, compared to England averages of **8.3%** and **9.3%** respectively.

In 2015, **4.6%** of the over-65s in Greater Manchester were recorded as having dementia. The England value is **4.3%.**

1.4 Mental health and wellbeing

The importance of mental health and wellbeing is a recurring theme of our plan and we want to draw this out explicitly from the start. More than anything else, mental health and wellbeing is recognised by local people as fundamental to all our lives and to the communities where we live. It underpins everything we do, how we think, feel, act and behave. It is an essential and precious individual, family, community and business resource that needs to be protected and enhanced.

Wellbeing is about lives going well, the combination of feeling good and functioning effectively. It includes the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, empathy and affection, the development of one's potential, having some control over one's life, having a sense of purpose (e.g. working towards valued goals), and experiencing positive relationships.

Mental health and wellbeing is a key cross-cutting priority of the Greater Manchester strategic plan, 'Taking charge of our health and social care in Greater Manchester' ('Taking Charge'). The Greater Manchester Mental Health and Wellbeing Strategy focuses on early intervention and prevention, supporting people in communities and improving access to services. It takes a 'whole system' view of how to address mental health and wellbeing and in doing so ensures we all have a role to play in transforming outcomes and the wellbeing of local people.

Aligned to this whole system approach, the principles and priorities of the Greater Manchester Mental Health and Wellbeing Strategy are embedded through every section of this plan, recognising that poor mental health cannot be tackled in isolation. The Early Years integrated new model of care supports secure attachment between parent and infant, preventing future problems; the work and health programme supports more people into work recognising the importance of good work to health; the person and community-centred approaches build self-efficacy and resilience, basic building blocks for good wellbeing; and the digital platform to support behaviour change is built on the promotion of self-efficacy and self-care using nationally recognised patient activation measures.

Improving child and adult mental health, narrowing the gap in life expectancy for people with mental health conditions and ensuring parity of esteem for people with mental health conditions are fundamental to unlocking the power and potential of Greater Manchester communities. Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health of Greater Manchester residents.

1.5 Taking charge of our outcomes

We've turned our ambition of achieving the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people into a set of high-level outcomes that are supported by all 37 organisations in GMHSC Partnership.

What do we want to achieve?	How will we know if we've succeeded?
START WELL	
More Greater Manchester children will reach a good level of development (GLD) cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3,250 more children starting school ready to learn, and ultimately better educational attainment by 2021.
Fewer Greater Manchester babies will have a low birth weight, resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in Greater Manchester to projected England rates will result in 270 fewer very small babies (under 2,500g) by 2021.
LIVE WELL	
More Greater Manchester families will be economically active and family incomes will increase.	Raising the number of parents in good work to the projected England average will result in 16,000 fewer Greater Manchester children living in poverty by 2021.
Fewer people will die early from cardiovascular disease (CVD).	Improving premature mortality from CVD to the projected England average will result in 600 fewer deaths by 2021.
Fewer people will die early from cancer.	Improving premature mortality from cancer to the projected England average will result in 1,300 fewer deaths by 2021.
Fewer people will die early from respiratory disease.	Improving premature mortality from respiratory disease to the projected England average will result in 580 fewer deaths by 2021.
AGE WELL	
More people will be supported to stay well and live at home for as long as possible.	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

Table 1: Life course strategic aims

Work is ongoing to develop a set of sub-indicators that will enable us to monitor progress against these high-level outcomes.

1.5.1 Place-based integration and locality working

The ambitions within the 'Taking Charge' health and social care plan are reflected in the work that is already underway to transform and integrate health and social care services in each of the 10 Greater Manchester boroughs. This thinking dates back to 2013 when the Government issued a national commitment to providing jointly delivered and co-ordinated health and community care services, with the explicit aim of improving

the experience of patients, service users, their families and carers. In practice, this means that social workers, district nurses and GP practices – and in some cases wider therapy services and the voluntary sector – will work as a single team to co-ordinate their efforts to support an individual and their family to recover from ill health and maintain independent living.

Some examples of how this should improve people's experience of health and social care include the following.

- People will tell their story once, including the role of any informal family carers, and a 'key worker' will be responsible for co-ordinating the support needed.
- Medical, social and emotional needs will be identified in one process, leading to more timely and appropriate support from the people or services that are best placed to help.
- Hospital discharge will be better co-ordinated from hospital to home, supporting more effective and rounded recovery, including emotional wellbeing and adapting to being back in the home environment.

In Greater Manchester there are a number of boroughs that are moving quickly towards formalising these arrangements by creating new organisations called locality care organisations (LCOs), which means that public sector health and care workers will be employed by one organisation and led by one management team, which will be responsible for community care provision in that borough.

This goes beyond the traditional models of health and care we see now, and will allow people and their carers to take more control over their own health and be more easily connected into existing voluntary and community support and to wider public sector services such as housing, employment, schools and the fire and police services. A 'place' or neighbourhood approach recognises that our health, mental wellbeing and ability to live independently starts with living well day to day, supported by our families and wider community. The basic premise is that if people are supported to live well in their community, connected to family, friends and activities in an environment in which they feel safe and included, they are more likely to sustain a good quality of life and less likely to see a deterioration in their health and independence.

In Greater Manchester we are therefore positively extending the original concept of integrated health and social care to recognise the important role of family, community and place in promoting the health and wellbeing of our population.

1.6 Primary care

High-quality primary care services – general medicine, general dentistry, pharmacy and optometry – have always had an essential role in supporting population health. In many instances, contact with these professionals is a natural opportunity to identify wider health issues or worries and intervene positively at an early stage. Many prevention services such as immunisation and screening programmes are already delivered through GP practices nationwide e.g. flu immunisation, cancer screening. Some health conditions such as diabetes, high blood pressure and cancer can be picked up early through regular eye or dental checks, while the advice and support of pharmacists can help people to self-care or better manage the medicine they need to take to stay well.

However, primary care leaders in Greater Manchester want to embed 'proactive, person-centred' prevention and early intervention practice consistently in how they plan and deliver their services, which should lead to fewer people needing planned or emergency health and social care. The primary care strategy identifies some great examples of best practice in this area and

highlights how they will scale up this work across their 2,000 points of delivery, such as the commitment to roll out the Healthy Living Framework* across all pharmacy, optical and dental practices by April 2018.

Primary care is at the heart of Greater Manchester's new integrated community care and the ambition for primary care mirrors the principles described in the previous section about the importance of place and community and the broad range of factors that influence good health, including the impact of inequality on health and wellbeing. Taken together, this is sometimes described as primary care adopting a 'more than medicine' approach i.e. recognising the non-clinical support that gives people the confidence to improve their health and wellbeing. This will mean:

- enabling different consultations, including health coaching and shared decision making
- expanding the primary care workforce to include health trainers and neighbourhood and community connectors to provide support to people in the community
- connecting people to non-clinical support (community assets). This would include exploring opportunities for social prescribing in primary care to refer patients to 'cook and eat' sessions or housing energy and efficiency measures.

1.7 Acute and specialist healthcare

There are thousands of contacts with acute care and specialist care services in Greater Manchester, and hence many opportunities for primary and secondary prevention interventions to support improving the population's health. Standardising acute and specialist care is one of the themes of the Greater Manchester health and social care reform programme. This offers some transformational opportunities to support population health improvements and reduce health and care service demand in the short to medium term. The development of consistent and best practice specifications, which include prevention activities, will help reduce variation in care, and through the development of the Health Education England programme: Making Every Contact Count initiatives, evidence-based interventions can be delivered to people at a time they are receptive. Examples of such interventions include: smoking (implementing consistently the National Institute for Health and Care Excellence guidance on smoking harm reduction and including smoking interventions in mental health and maternity services); alcohol (brief advice and care teams); and cardiovascular disease (preventing strokes in people with atrial fibrillation).

The scaling up of such interventions across different organisations will maximise the impact and benefits for Greater Manchester and support work being undertaken across the wider system in primary care and neighbourhoods and communities.

1.8 Our Greater Manchester priorities

We know that poor health and disadvantage are inextricably linked and that disadvantage starts before birth and accumulates throughout life. We have therefore structured our programme using the Start Well, Live Well, Age Well approach. Furthermore, we want to bring to life our conviction that connected and empowered communities are healthy communities with some programmes that cross the age range. And finally we need to adapt and change our systems to fit our population health ambitions. Putting all that together, we developed five work programmes, which we have tested extensively with the Greater Manchester system.

1. Person and community-centred approaches

The capabilities of the public are extraordinary. They understand communities'

needs and can identify solutions because they are those communities; they are experts by experience. Their support is vital to developing a sustainable healthcare system and culture that delivers for all.

Person and community-centred approaches mean putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active role in their own health. We aim to put people and communities at the heart of what we do, concentrating on what is most important to them, what skills and attributes they have to offer, and what strengths exist naturally in the people and places we serve.

The VCSE sector will play a central role in the leadership and delivery of this work programme, which aims to develop an infrastructure across Greater Manchester to reliably and consistently deliver social models of support to enable people to live better. The programme includes:

- developing the capacity and capability across Greater Manchester to support the embedding of person and community-centred approaches into the reform of the system
- developing a Greater Manchester framework for action that provides a consistency of approach but also allows flexibility to respond to local needs
- developing an exemplar social movement focused on cancer prevention.

2. Start Well

Building on the principles of early intervention and prevention, the aim of the Start Well programme is to deliver integrated early intervention and prevention services for children across all localities in Greater Manchester. We know that disadvantage starts before birth and accumulates throughout life, so we have developed a new care model for early years that focuses on action in pregnancy and the earliest years of life to give us the best opportunity to successfully reduce health, educational and social inequalities. By establishing a framework for the delivery of appropriate services at the right time, we will support children and families to become healthier, resilient and empowered.

Our Early Years new delivery model is based on universal and targeted services, using evidence-based assessments to identify and intervene effectively to avoid or minimise escalation of need. In addition, this Start Well population health programme is focused on two key drivers of poor Early Years outcomes and inequality i.e. smoking in pregnancy and poor oral health where scaling up evidence-based interventions at Greater Manchester level could enable rapid improvements in health outcomes and deliver economies of scale.

Another recognised area for intervention is our desire to focus on the health challenges for children and young people aged 5-25 years, with mental health and wellbeing a specific focus for this population group. This area of work will be developed further in the next stage of the plan under a Developing Well theme.

3. Live Well

This programme focuses primarily on the opportunities to improve the health of Greater Manchester residents in mid-adulthood, taking into account the pressures and priorities upon this large working age population. Live Well recognises that good work is an essential prerequisite of health, wellbeing and socio-economic outcomes. The wealth of evidence to support employment as a route to achieving good health and mental wellbeing, and the relevance of good levels of health in retaining stable and meaningful employment, makes the work and health proposal a critical component within our population health plan.

Alongside the influence of meaningful

work on the mental and physical health of individuals and families, we also recognise the undermining impact of poverty and socio-economic deprivation on health and emotional wellbeing. These inequalities can range from greater prevalence of unhealthy lifestyle choices to poorer access to health and care services, all of which have a negative impact on health and wellbeing outcomes, leading to shorter life and healthy life expectancy. Our proposal to create a new model of primary care for deprived communities seeks to give health practitioners the time and capacity to offer greater continuity of care and target their service towards medical needs more effectively, but also to connect individuals to the wider support services in their community that could help make a difference to their lives. This will include a focus on some of our most vulnerable groups, including the traveller communities, homeless people, offenders, and asylum seekers and refugees.

Lifestyle and health behaviour presents one of the biggest challenges to good health and wellbeing in adulthood and the accumulated effects of those choices contribute significantly to the ill health experienced in later life as we age. Our population continues to suffer higher than national instances of heart disease, diabetes and other lifestyle-related illnesses. An important component of our Live Well strategy is therefore to find new and innovative methods to stimulate and incentivise healthier behaviours in adulthood. However, achieving population-scale changes in behaviour, which have often become normalised over many years, can be difficult to achieve quickly and needs different approaches. The programme will therefore utilise the natural opportunities in adulthood and new thinking to stimulate 'whole system' approaches to smoking, alcohol, physical activity and obesity.

In addition, we will develop digital platforms for lifestyle and wellness to support individual behaviour change, and we are working with localities to develop a set of standards for integrated local wellbeing services for those people who need a bit more support.

The final elements of the Live Well programme focus on addressing two conditions where early identification and treatment can have a very positive impact on quality of life, health outcomes and life expectancy. These are HIV and cancer. The link between lifestyle risk factors and cancer is also very well documented, and there is a clear opportunity to make the link between lifestyle and reduced cancer risk in later life.

4. Age Well

Greater Manchester is leading the way in its efforts to promote healthy ageing, creating a vision for a society where older age is seen positively and people in later life are empowered to secure a healthy future and good quality of life for themselves. Our specific Age Well proposals aim to support people to maintain good health, wellbeing and independence for as long as possible and the programme focuses on interventions that, when delivered consistently and effectively at scale, will enable this to happen.

Evidence shows that improving the quality and suitability of the home environment can be effective in preventing and reducing demand for health and social care. Equally, enabling people to manage their health and care needs can allow them to remain in their own homes for longer. Creating a home environment that supports people's independence – which is often incredibly important for older people – and remains connected to their local community, friends and family, also has a positive effect on emotional wellbeing and can reduce the risk of social isolation.

We acknowledge that suitable housing actually benefits all people at every stage of their life course; however, our evidence to date has found that interventions directed towards the older population can return particular benefits.

Malnutrition and dehydration are estimated to be very prevalent in the older population but are often hidden or unnoticed. Left unchecked, they can undermine mobility, steadiness (leading to falls), healing and recovery, mental alertness and energy levels. Outcomes are therefore much worse for older people who are malnourished and the same is true of dehydration. The Age Well programme is therefore focusing on this issue and will work with Greater Manchester boroughs to implement community-level, locally led programmes of support to improve awareness and understanding of the impact of malnutrition and dehydration.

Falls are a commonly recognised problem in older age that requires a system response to manage and address effectively, but this is also an area where there is a lot of independent evidence of what works. Fracture liaison services, which identify people at risk of injurious fracture and then co-ordinate services and appropriate care for the individual, are well evidenced and cost effective and are included in the programme for that reason.

5. System reform for population health

It is clear that an ambition of this magnitude around the delivery of the Greater Manchester Population Health Plan requires the support of a population health system that is organised to deliver at pace and scale.

We therefore need to build a single population health system across the Greater Manchester economy – one that maximises both the impact and the capacities of a small and specialist public health workforce, but also supports the embedding of the pursuit of population health as being everybody's business and sees collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public working together as population health systems.

Greater Manchester therefore has the chance to take a co-designed approach to radically reframe the role of population health in the context of a devolved system, creating a unified population health system across 10 localities that is better able to achieve improved health outcomes for the people of Greater Manchester.

In addition to creating a unified leadership system for population health, we need to create a unified approach to commissioning population health that enables us to commission services at the right spatial level, in collaboration with one another, and to improve population health outcomes and health inequalities as well as contributing to a more sustainable public health, health and care system.

We have a number of programmes of work underway to do this, namely:

- the development of a population health commissioning plan that brings together the NHS England commissioning responsibilities set out in Section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan
- the development and testing of a proposal for a new Greater Manchester population health leadership system serving localities, CCGs and Greater Manchester structures that is future-proof and financially sustainable
- reviewing how public sector spend can produce a wider benefit to the community i.e. the social value benefit to the people of Greater Manchester from public sector commissioning and procurement and maximising the contribution made by the VCSE sector.

1.9 Our 'whole system' approach to population health

Figure 6 sets out our 'whole system' approach to population health, recognising the central importance and contribution of a healthy and thriving population to economic growth and prosperity, and, equally, the contribution of economic growth to a healthy population. Our aim is to ensure we have a mutually reinforcing cycle between our growth and health ambitions across all our Greater Manchester plans.

Figure 6: 'Whole system' approach

During 2016 we have:

- swiftly set out our five transformation work programmes – person and community-centred approaches; Start Well; Live Well; Age Well; and system reform
- developed a set of proposals, which we will deliver with the system
- developed programme governance to support decision making and delivery
- aligned our programme to other transformation work that forms 'Taking Charge'
- built cohesion across the wider public service reform programmes, ensuring decisions we take together are cognisant of broader activity across our system
- taken a collaborative view on the outcomes we are seeking to achieve across Greater Manchester, ensuring all the work we do is focused on supporting the achievement of the Greater Manchester strategic outcomes that will improve the life chances of people in Greater Manchester.

The remainder of this document provides a comprehensive delivery plan for those programmes of work to be led by GMHSC Partnership and, where appropriate, signposts to other Greater Manchester-led pieces of work contributing to population health.

This plan was constructed by looking at…

1	**Taking Charge Together consultation**	Findings from consultation with 50,000 Greater Manchester residents about how they might better take charge of their own health
2	**Quick Wins**	Opportunities to implement evidence-based local best practice at scale across other parts of Greater Manchester
3	**Common themes in locality plans**	An audit earlier this year of locality plans highlighted areas for standardised approaches across Greater Manchester
4	**Economics of prevention**	The 'economics of prevention' work was developed by New Economy Manchester and Public Health England on groups' interventions by their gestation or notional rate of return in order to recognise that dividends for different interventions are likely to be realised over different time periods
5	**Work already underway**	Work already underway which now aligns with the population health themes and programme.

All principles **underpinned by the evidence base** where possible

or

utilising innovation to test new approaches to service delivery

Figure 7: 'Whole system' approach

2. Person and community-centred approaches

Patients, peers and communities represent a huge resource. Whether in terms of effective behaviour change at scale, high-quality volunteering, informal networks of care, impactful models of voluntary sector practice or growing social enterprises, there is a significant opportunity within Greater Manchester to support people living with long-term conditions, prevent ill health and reduce costs.

Our starting point is that health and care services need to work alongside individuals, carers, families, social networks and thriving communities. This means working in ways that are 'person and community-centred' – in other words, approaches that put people and communities at the heart of their health and wellbeing.

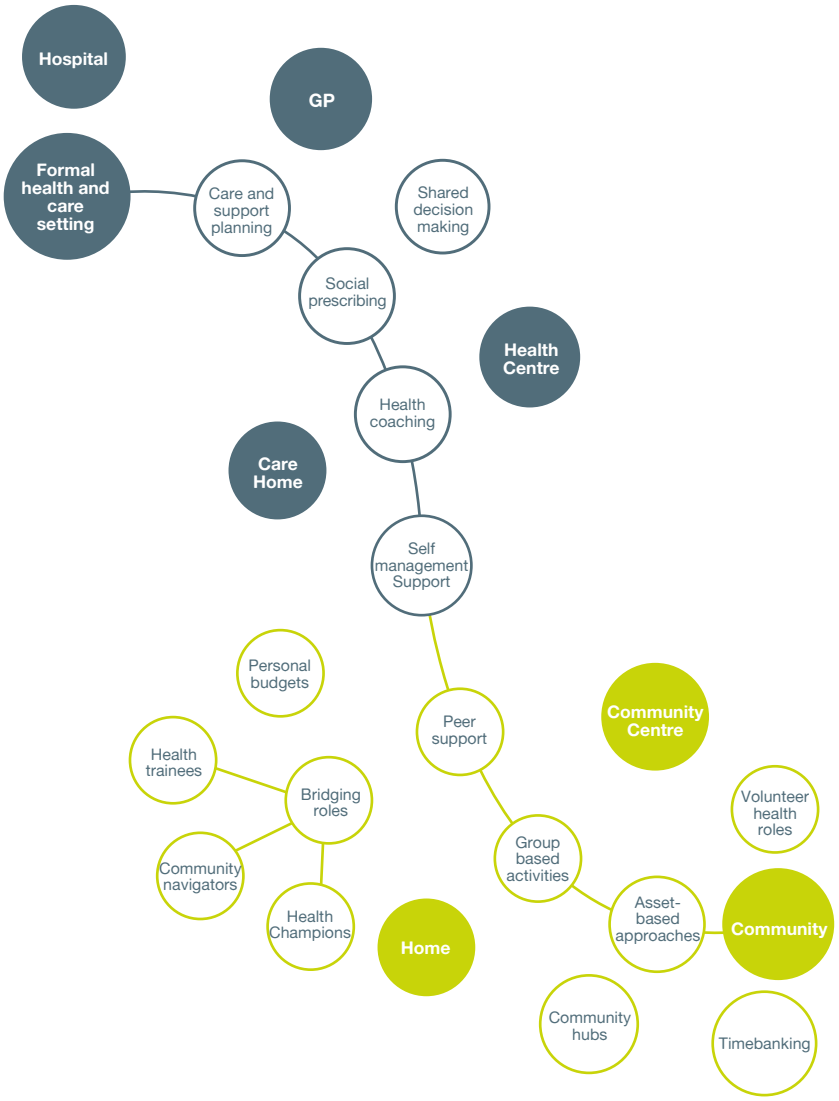
We want our health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets. For this vision to become reality, person and community-centred ways of working need to become widely understood and valued as core to the whole health and care system, not just 'nice to have'. This requires systematic change in the way people access, interact with and experience health and care services, and wider support.

2.1 Background

The NHS Five Year Forward View sets out how the health service needs to change, and argues for a more engaged relationship between health and care services and patients, carers and citizens. NHS England funded the Realising the Value programme, an 18-month programme led by innovation charities Nesta and The Health Foundation to support this vision. Realising the Value strengthened the case for change, identified evidence-based approaches that engage people in their own health and care, and developed tools to support implementation across the NHS and local communities. Two organisations based in Greater Manchester were involved in Realising the Value, and the findings and tools can be built on to deliver the ambitions set out in this Greater Manchester plan.

2.2 What are person and community-centred approaches?

Approaches that are person and community centred include a very broad range of practice, ranging from 'more than medicine' support that complements and enhances clinical care for people with long-term conditions (such as peer support) to everyday community activities that enable people to improve their health and wellbeing (such as a local football team or gardening club). Many of these activities can be enjoyed and engaged in by all citizens, whether or not they have health conditions. They can happen in formal health and care settings, people's own homes and in the wider community.



Source: Realising the Value (2016) Ten key actions to put people and communities at the heart of health and wellbeing

Figure 8: Common examples of person- and community-centred approaches

People can access person and community-centred approaches in a number of ways, such as the following.

- Personalised care and support planning: A systematic process in which people with long-term conditions and their carers work in partnership, very often with health and social care professionals, to identify their treatment, care and support needs.
- Personal budgets: Giving people control over how the money allocated for their health and care is spent.
- Social prescribing: People can receive a 'social prescription' as a way to connect to services and groups outside of formal health or social care.
- Bridging roles, such as health trainers and community navigators: Roles undertaken

by people, often drawn from the local community, who work with individuals to connect them with local services and help them to navigate these services.

Although wide-ranging and varied, these approaches are all focused on genuinely putting people and communities at the heart of health. And for years there has been sustained work by many to work in this way. There is now strong enthusiasm for this to become the norm across health and care, rather than the experience of the few. And there is a growing – and increasingly convincing – body of evidence from research and practice that these approaches lead to better outcomes and significant benefits for individuals, services and communities.

2.3 The case for investment

There is a strong moral and ethical case for person and community-centred approaches for health and wellbeing: put simply, it is the right thing to do. It enables people to have a voice, to be heard, to be connected and to have the opportunity to choose how best to live their lives, and gives them the support to do so.

The other key rationale for these approaches is that they 'work'. They can lead to significant benefits for individuals, services and communities. They can improve individuals' health and wellbeing and reduce demand on formal services such as unplanned hospital admissions, and they can also contribute to wider social outcomes such as employment and school attendance.

There is a clear financial imperative to embed these changes into the fabric of Greater Manchester.

In 2013, Nesta's 'Business Case for People Powered Health' calculated that the NHS could realise savings of at least £4.4 billion a year if it adopted self-care innovations that involve patients, their families and communities more directly in the management of their long-term conditions. These savings represent a 7% reduction in A&E attendance, planned and unplanned admissions, and outpatient attendances.

More recently, the Realising the Value programme has undertaken economic modelling that suggests that implementing person and community-centred approaches at scale has the potential to contribute to efforts to slow the demand pressures on the system. Realising the Value used this economic modelling to develop a tool for commissioners, to assess the potential impact of commissioning person and community-centred approaches in a local area. This will help localities within Greater Manchester that want to commission these approaches to build their business case for doing so.

2.4 Approaches that are asset-based

The family of person and community-centred approaches described above are all asset-based, or strengths-based. This means they have a different starting point to traditional health and care services. Fundamentally, they ask the question 'what makes us healthy?' rather than 'what makes us ill?'

Person and community-centred approaches focus on what is important to people, what skills and attributes they have, the role of their family, friends and communities and, given all this, what they need to enable them to live as well as possible. This includes enabling people to:

- look after themselves better, including understanding their condition, managing their symptoms and improving their diet, and education tailored to particular conditions
- have meaningful relationships that help them improve their health and wellbeing through, for example, peer support networks and community groups
- work collaboratively with professionals, such as collaborative consultations and health coaching.

I understand my situation and can look after myself

I have meaningful relationships with others that help me stay healthy and well

I am working with supportive professionals

Source: At the heart of health; Realising the Value of people and communities (Nesta, 2016)

Figure 9: What defines this way of working

While our health and care system is getting better at drawing on the strengths and assets of individuals and communities to improve and maintain good health, we know that there is still some progress to be made.

We all have a role in making this happen – including community-based and voluntary organisations, faith communities and social enterprises. Many faith-based groups have long-established traditions of providing social, emotional and spiritual support that can be an important part of health and wellbeing, and we are committed to working closely with these groups. Social enterprises play a role in incubating new ideas in health and wellbeing, and in some cases work with people to build their confidence and capability to get back into work.

2.4.1 Co-production, volunteering and social movements for health

The only way to understand and support what matters to people and communities is to work with them, in a variety of ways.

- **Carers.** We need to recognise and value the role of carers, who are a huge asset and resource; by supporting the lives of the people they care for, they sustain and support the wider health and care system.
- **Volunteers.** Volunteers are an increasingly important part of the health and care workforce and there is evidence that high-quality, well-supported volunteering can benefit patients and health and care services, as well as having reciprocal benefits for people who volunteer.

- **Co-production.** The most successful examples of person and community-centred approaches in practice are those developed by people and communities, working with and alongside commissioners and policymakers, to co-design and co-deliver solutions that work. Support and training is needed to support good co-production.
- **Social movements.** Social movements happen when people come together to fight for their rights, solve problems, shift how people think, support each other and demand what they need. There are incredible stories in health of the power of passionate people working together to drive change. For example, over the last few decades the disability rights movement and HIV/AIDS campaigns have challenged social attitudes and have transformed the way the health system responds to these issues. The breast cancer movement has addressed the deep cultural stigma associated with the disease, given women the words to explain their experiences, and changed the culture of care. The value of people getting involved in social movements in this way was recognised in the NHS Five Year Forward View.

2.5 Greater Manchester context

We want to enable more people to take control of their own health and wellbeing, and to help others within their communities to do the same. In 'Taking Charge', we set out our view that changing the relationship between people and public services is vital if we are to enable people to prevent and manage long-term health conditions, maintain their independence, improve their health and wellbeing and, in doing so, live happier and healthier lives while also reducing demand on services.

We know the following.

- Over 560,000 people (30%) of adults in Greater Manchester have one or more long-term condition, and this number is increasing. People within this cohort are often frequent users of health services, accounting for 50% of all GP appointments and 70% of all inpatient bed days.
- Around 70-80% of all people with long-term conditions would benefit from support to manage their condition(s).
- While we often provide great care, at times we focus on people's problems rather than looking to their capabilities and resources.
- Too many people are going into residential and nursing care, particularly from hospital, in part because of a lack of clear and planned alternatives.
- Earlier, community and family-based support could help people to maintain and improve their health and wellbeing.

Greater Manchester has a rich history of working in these areas and has many examples of best practice that could be drawn on, such as those below.

2.5.1 The Wigan Deal

The Wigan Deal has been successful in taking forward a community-centred approach. Driven by the critical need to find fiscal savings, Wigan proposed 'The Deal' with its residents and businesses, creating an informal agreement that through cooperation has addressed the financial pressures while improving resident collaboration and engagement in the use and delivery of services.

2.5.2 People Powered Health in Stockport

Stockport has demonstrated the potential of mobilising communities to help deliver care over a number of years, embarking on an ambitious programme as a selected vanguard site to include social action at the core of the developing new care model. The Stockport approach has four core strands.

- Workforce and organisational culture: Adopting person-centred practice within a strengths-based approach, working with people and communities to co-design solutions to meet rising demand.
- Develop place-based health and community networks of support: Bridging the health and care service model to the communities in which people live to grow more resilient communities with access to targeted prevention.
- Promote social action/health as a social movement: Recognise and include the resource of the people both within and outside of the system as part of the solution.
- Commission differently: Alignment and collaboration over cost and competition as primary drivers.

Stockport is a national exemplar in this area, particularly in terms of being a model of social action led 'from the inside' – from commissioning teams themselves. Stockport is currently working to spread the learning from its approach more widely.

2.5.3 Health as a Social Movement

NHS England's Health as a Social Movement programme aims to support social movements in health and care, and is currently working with six new care model vanguards, two of which are in Greater Manchester:

Stockport Together (multispecialty community provider), which aims to support social movements in Stockport, Oldham and Tameside boroughs and across Greater Manchester, building on the People Powered Health programme to 'hard-wire' social action into a transformed health and care system

The Greater Manchester Cancer Vanguard, which will apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum that is ultimately self- sustaining.

2.5.4 Realising the Value

Realising the Value was a programme funded by NHS England to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets. At the heart of the programme were five sites that exemplify the best of approaches of this kind. Two of these sites were in Greater Manchester:

- Unlimited Potential with Inspiring Communities Together: Unlimited Potential works to deliver, with local people, a range of asset-based approaches in a health and wellbeing context in Salford, such as 'Salford Dadz' – finding new ways to improve the wellbeing of fathers experiencing severe and multiple disadvantages
- Big Life Group with Being Well Salford: Big Life delivers health coaching to anyone who wishes to make changes to two or more of their lifestyle behaviours; this includes low mood, isolation and anxiety.

2.5.5 People Powered Results and Elective Care Rapid Testing (ECRT) programme

NHS England and Stockport Together worked with Nesta on a 100-day innovation programme to improve elective care. The programme aimed to test ways of improving patient experience of, and speeding up access to, elective care, by better managing demand. Challenge focus areas included gastroenterology, cardiology and respiratory, and orthopaedics. Teams were made up of representatives from across the health and care system, including GPs, consultants, nurses, VCSE representatives, mental health professionals and representatives from the council and social care.

2.5.6 Arts, health and social action

Greater Manchester has a long history of interest and action in arts and health. Engaging in arts activity can help people to make social connections, enable self-expression, create the conditions for social action and enable people to have more power over their lives. We intend to position the strong inter-relationship between arts and individual and community health as one of the key foundations of building sustainable and resilient communities across Greater Manchester. As part of the next iteration of the Greater Manchester Population Health Plan we are committed to further developing a programme of activity on arts in healthcare and social care, and in social action on wellbeing, and aim to embed this approach in commissioning of health and social care services and commissioning for wellbeing in Greater Manchester.

These activities are further strengthened with a well-developed, varied and diverse voluntary sector in each area and various Greater Manchester umbrella organisations.

Our challenge now is to make this form of engagement between the public and public services a common and defining feature across the whole of Greater Manchester.

2.6 Opportunity

The capabilities of the public are extraordinary; they understand communities' needs and can identify solutions because they are those communities; they are experts of experience. In Greater Manchester we recognise their support is 'mission critical' to developing a sustainable health and social care system and culture that delivers for all.

We want to work with our partners across the system, including the VCSE sector, to implement high-impact person and community-centred approaches at scale across Greater Manchester. Delivering this will require changes in: commissioning; organisational and clinical processes; workforce development; and the relationships between clinical professionals and the people and communities they serve.

Putting people and communities genuinely in control of their health and healthcare requires a shift away from a traditional biomedical model of health towards a model that takes into account the expertise and resources of people and their communities. In order for this shift to happen, we will need to support a cultural shift across the system and underpin this with a willingness to identify and 'unblock' system barriers and engage system levers at both a Greater Manchester-wide and a locality level.

By engaging differently with the people we serve, we can start to learn what resources, physical and social, are available to support this agenda. We can identify and better support grassroots initiatives through different commissioning processes. We can help to build links to better utilise available assets. And we can learn from carers, patients, families and volunteers what more we can do to support them to start, live and age well.

A further opportunity that GMHSC Partnership has begun to explore is the contribution of housing and the home environment to asset-based working and our people and place-based agenda. Evidence suggests that the right home environment can: improve health and wellbeing and prevent ill health; enable people to manage their health and care needs; and allow people to remain in their own homes for as long as they choose. This area of work will be developed more in our next iteration of the population health plan.

2.7 Plan

A radical upgrade in population health brings with it a need for radical action and solutions – one of which is, as we have described, to shape a new relationship with the people of Greater Manchester.

The VCSE sector will play a central role in the leadership and delivery of this project. We want to mobilise communities and networks to support people on their terms. This will complement medical care by developing an infrastructure to reliably and consistently deliver social models of support to enable people to live better.

The Public Health England (PHE) 2015 report 'A guide to community-centred approaches for health and wellbeing' emphasises that: "Community engagement is more likely to require a 'fit for purpose' rather than 'one size fits all' approach." This is crucial for how we deliver across Greater Manchester, recognising that the form and function of our plan must allow the local flexibility that responds to the specific characteristics of each local community.

2.7.1 Objectives

A number of objectives have been identified at a Greater Manchester level to support the development of person and community-centred approaches locally. These include:

- **Objective 1:** To help build capability and capacity within localities, recognising the need for a consistent approach while allowing sufficient flexibility for localisation
- **Objective 2:** To build a Greater Manchester framework for person and community-centred approaches
- **Objective 3:** To support a strong system leadership commitment to the approach
- **Objective 4:** To work as part of NHS England's Health as a Social Movement national exemplar programme to test and spread effective ways of mobilising people in social movements that improve health outcomes.

2.7.1.1 Approach to delivering objectives

Objective 1: To help build capability and capacity within localities, recognising the need for a consistent approach while allowing sufficient flexibility for localisation.

The project will seek to:

- identify a group of 'explorers/enablers' who can help to seek out the best practice and strengths to build capacity and sustainability from the start
- develop an offer for explorer roles to skill them to do this work
- bring together the organisational development community across health and social care in Greater Manchester to act as a network of supporters.
- provide tools and resources to assist places to understand the conditions for success and assess readiness
- build a menu of development programmes and tools to support shared decision making, strength-based conversations, quality improvement, team coaching and consultancy support, which support systems to understand which approaches are likely to be most effective and in what circumstances
- build place-based support teams and a network of skilled facilitators/enablers to support places
- develop system capacity through approaches such as 'skills pools' and 'time banks'.

Objective 2: To build a Greater Manchester framework for person and community-centred approaches.

This project will seek to:

- map and capture existing practice on asset-based approaches across Greater Manchester
- bring together the 10 localities across Greater Manchester to share best practice within a system-wide learning event
- define key principles to develop a Greater Manchester framework for action that describes consistency of approach, including evaluation
- develop a platform to enable localities and local and national partners to connect with Greater Manchester against an

agreed framework that provides some consistency of approach

- gain agreement from the system to adopt and implement the framework
- launch the framework to cement support across the system for this way of working with people and communities
- from the evidence, identify existing and exemplar communities that offer the potential to invest and build a network of best practice
- develop a network of delivery leads with third sector partners to test and spread innovative solutions.

Objective 3: To ensure a strong system leadership commitment to the approach.

This project will seek to:

- work with the VCSE sector in Greater Manchester to co-produce the leadership model for this work
- work with system leaders to sign up to a statement of commitment to demonstrate strong support to self-care/person and community-centred approaches
- work with system leaders to develop a road map to delivery that will feed into the framework for action
- connect with work underway through the Greater Manchester leadership framework, the nine leadership expectations and the wider Greater Manchester workforce, enabling work to inform the development of the existing and future workforce.

Objective 4: To work as part of NHS England's Health as a Social Movement national exemplar programme to develop, test and spread effective ways of mobilising people in social movements that improve health outcomes.

To develop a network of 20,000 cancer champions by August 2019.

- Work in partnership with the third sector to develop an exemplar social movement, focused on cancer prevention.
- Apply at scale a multi-faceted approach to nurture a citizen-led social movement across the entire cancer prevention spectrum.
- Develop a network of 20,000 cancer champions and expert patients to provide a 'more than medicine' approach.
- Demonstrate 'what works' using rigorous evaluation approaches.
- Support spread by identifying approaches that could be scaled or adapted and adopted in other communities.

2.7.1.2 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving five key outcomes:

- **Outcome 1:** Localities have more local capability, appropriate for their needs and assets
- **Outcome 2:** A Greater Manchester framework for action agreed by system leaders to support local implementation, building on work already underway in each locality
- **Outcome 3:** An agreed roadmap for delivery with strong leadership commitment to deliver
- **Outcome 4:** The development of a mass social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, to include an army of cancer champions networking across the conurbation, driving the cancer prevention agenda
- **Outcome 5:** Digital opportunities tested and evaluated

2.7.1.3 Programme of work – scope

This programme will work with system leaders from across Greater Manchester and partner organisations, including the VCSE sector, to influence and support ways of working at locality level. With an initial focus on asset-based approaches, it has the potential to develop and spread across wider reform and at all levels of the system.

The scope of the social movement work specifically includes all people of Greater Manchester, community groups, charities and volunteers linked to cancer-related activities. The project will also need to connect to Greater Manchester's broader communications work and the digital platform work linked to the proposed Greater Manchester Lifestyle Hub. Similarly, it has the potential to link to the wider Greater Manchester Cancer Vanguard prevention projects, including the lifestyle-based secondary prevention work, the large-scale social marketing project, and the enhanced screening offer for Greater Manchester residents.

3. Start Well

One of the most important foundations for building caring, productive and healthy families and communities is the nurturing of children in early life. In other words, helping children to get a better start is good for them and good for all of us. We are all instinctively motivated to care for and protect our children and promote their future wellbeing. This motivation is increased during pregnancy and when a child is most dependent in early life. However, sometimes this motivation can be missing or frustrated as a result of internal factors such as mental health problems or external factors such as poverty. We need to connect to the deep motivation of parents and provide extra support to parents when this is challenged.

The aim of the Start Well programme is to deliver integrated early intervention and prevention services across all localities in Greater Manchester. We know that disadvantage starts before birth and accumulates throughout life so we have developed a new care model for Early Years that focuses action in pregnancy and the earliest years of life to give us the best opportunity to successfully reduce health, educational and social inequalities. Greater Manchester is leading the way in efforts to prioritise Early Years with significant progress see across all 10 localities.

3.1 Background

It is much more difficult and costly to repair the damage done by child maltreatment in later life than to prevent it during the Early Years. It is estimated that 40% of public funds are currently being spent on problems that could have been prevented earlier. People who suffer adverse events in childhood achieve less educationally, earn less, and are less healthy, making it more likely that the generational cycle of inequality is repeated.

The Marmot Review report 'Fair society, healthy lives' (2010) recommended that 'giving every child the best start in life' was the highest priority to tackle health and social inequalities. In 2013, the WAVE Trust report, 'Conception to age two – the age of opportunity', agreed that the Early Years are the crucial phase of development and the time when early intervention will reap great dividends for society. The way in which we support very young children (0-2 years) shapes their lives and ultimately our society. These reports clearly identify the window of opportunity from pregnancy to age five that establishes the foundations for life, including physical and mental health, social and communication skills, behaviour and future academic success. Indeed, it is not an exaggeration to say that the prosperity of Greater Manchester is dependent on our ability to support the development of the very young much more effectively.

We know that investing in early education is vital to addressing the social gradient in children's positive early experiences. Studies have shown that, by age three, children from low-income families are exposed to an average of 30 million fewer words than children from the most affluent families. Children within affluent families also hear twice as many unique words and twice as many 'encouraging' as 'discouraging'

conversations. This work highlights the importance of integrating early education services and that later interventions, although important, are considerably less effective where good early foundations are lacking.

Early Years investment is proven to be the best route to overcoming intergenerational inequalities. Figure 10 illustrates the rates of return on investment for education and training over a person's working life. The earlier the investment is made, the higher the return on this investment.

A great deal of work has been undertaken in Greater Manchester to understand the costs and benefits of intervening in the Early Years. This work shows that while there will be significant short-term gain, the principal impact of savings to the public sector will be realised up to 10 years after the Early Years period. In the longer term, a failure to effectively intervene to address the complex needs of an individual in early childhood can result in a nine-fold increase in direct public costs. Significantly, the organisations that benefit most from the interventions are not the organisations that traditionally fund the services. Devolution arrangements provide an opportunity to address this. The devolution commitment to integrated partnership working provides significant incentives to invest in transformational reform, removing those barriers that precluded investment in preventive approaches, particularly those where investments provided benefit to other agencies.

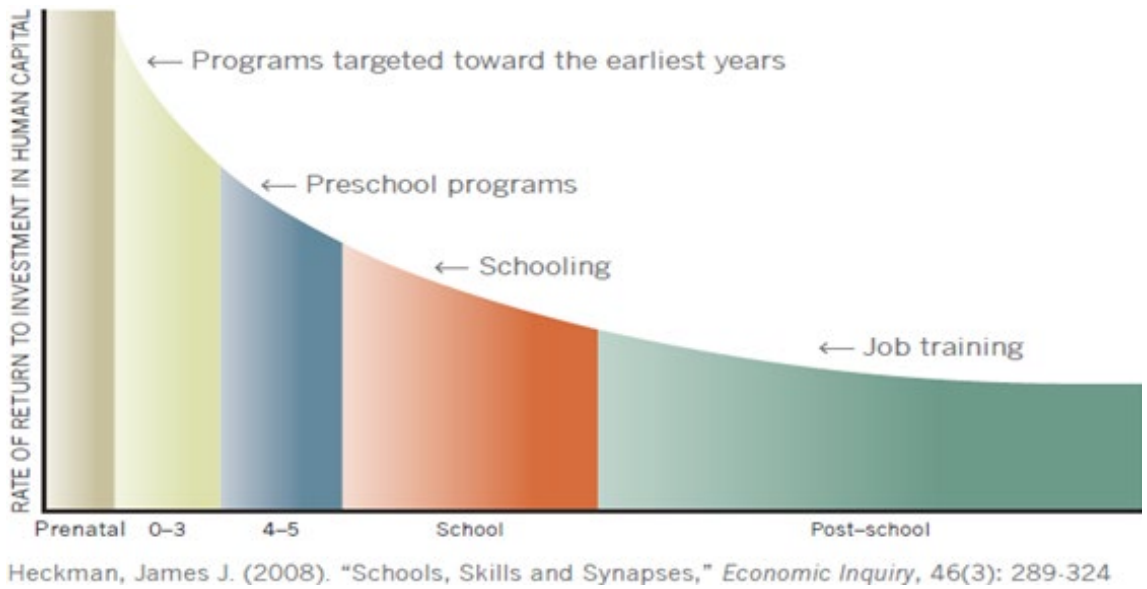


Figure 10: The Return on investment over a life time by education and training

Every **£1** invested in quality early care and education saves taxpayers up to **£13** in future costs.

For every **£1** spent on early years education, **£7** has to be spent to have the same impact in adolescence.

Source: Centre for Research in Early Childhood (2013) The impact of early education as a strategy in countering socio-economic disadvantage

Figure 11 Impact of investing in early years

3.2 Greater Manchester context

We want every child in Greater Manchester to have the best start in life. This means that every child grows up in an environment that nurtures their development, derives safety and security from their parents/care givers, can access high-quality Early Years services and has a belief in their goals and their ability to achieve them. Our ambition is that every child in Greater Manchester acquires the skills necessary to negotiate early childhood and flourish in primary and secondary school, further education and employment.

In Greater Manchester we have set ourselves an ambition of supporting every child to reach a good level of development (GLD) and closing the gap between Greater Manchester and England. Table 2 sets out percentages of children reaching a GLD at age five for the period 2013 to 2016.

% achieving a good level of development (GLD)	2013	2014	2015	2016
Bolton	48	54	61	65
Bury	51	56	66	69
Manchester	47	53	61	64
Oldham	41	52	57	61
Rochdale	42	50	57	63
Salford	53	57	61	65
Stockport	54	62	68	69
Tameside	42	52	58	63
Trafford	61	69	73	73
Wigan	38	55	64	67
ENGLAND	**52**	**60**	**66**	**69**
North West	**50**	**58**	**64**	**67**
Greater Manchester	**47**	**56**	**62**	**66**

Table 2: percentage of children reaching a GLD at age five for the period 2013-2016

Table 2 shows that GLD for Greater Manchester in 2016 is 66% compared to 69% nationally. However, nearly one in every two children in receipt of free school meals is not reaching a GLD. Raising overall attainment for the most disadvantaged and vulnerable groups of children is a challenge for every locality; however, we are encouraged by the fact that the gap between Greater Manchester and the England average has reduced from 5% to 3% over the period.

3.3 A new model of care for Early Years

At the heart of the health and social care reform ambitions is the recognition that we need to see a significant shift in activity; shifting the balance from reactive, crisis services to preventative services that help reduce escalation of need. The Start Well Early Years Strategy was approved by the Greater Manchester Strategic Partnership Board in June 2016 and sets out the Greater Manchester vision for transformational system change and a long-term and sustainable shift from expensive and reactive public services to prevention and early intervention. The strategy aims to reduce duplication and make more efficient use of resources to achieve better outcomes wherever possible within existing budgets, including a vision for integrated leadership, commissioning and delivery.

The need for targeted and specialist services is acknowledged; however, the strategy recognises the requirement for a core universal offer to all Greater Manchester families in the Early Years to identify abuse, neglect, developmental delay, and special educational needs and/or disability at an early stage to ensure swift access to support and interventions.

The overall objective of this work is to increase the number of Greater Manchester children who are school ready, and over the next five years we intend to close the gap between current Greater Manchester performance and the national average for the following selected outcomes:

- to improve the percentage of children achieving a GLD at the end of the Early Years Foundation Stage
- to increase the percentage of children achieving age-related expectations at 2-2½ years (measured using the 'Ages and Stages Questionnaire' (ASQ 3)
- to increase the percentage of two- and three-year-old children who take up their free entitlement in schools and settings that are judged 'good' or 'outstanding' by Ofsted (with a particular focus upon vulnerable groups)
- to improve the percentage of children in receipt of free school meals who achieve a GLD at the end of the Early Years Foundation Stage
- to reduce the number of full-term babies with a low birth weight
- to increase breastfeeding rates at 6-8 weeks
- to reduce the rates of smoking at time of delivery
- to reduce levels of overweight and obesity at age 4-5 years
- to reduce the number of decayed, missing and filled teeth in children aged five
- to reduce attendance at Accident and Emergency for children aged 0-4 years
- to protect vulnerable children and families by ensuring that all general practices meet national targets for childhood routine vaccinations and pre-school flu vaccinations
- to improve parent and infant mental health
- to safely reduce the number of looked-after children (LAC).

3.4 Opportunity

The Greater Manchester devolution agreement, the transfer of health visiting and Family Nurse Partnership (FNP) commissioning to local authorities, free early

education places for disadvantaged two-year-olds, the Early Years pupil premium grant, the Greater Manchester Children's Services Review and the development of integrated services for 0-19 years present a golden window of opportunity to ensure a concerted approach to improving child development.

To reduce the steepness of the social gradient in child development, actions must be universal, but with a scale and intensity that is proportionate to the level of need. The universal components of the Greater Manchester Early Years Delivery Model (EYDM) were fully implemented prior to the transfer of the commissioning responsibility for health visiting to local government in in October 2015. Numbers of health visitors in Greater Manchester rose by 57% between 2013 and 2015, with substantial increases in the delivery of evidence-based assessments and an additional 40% investment of £13 million from NHS England. During the same period FNP programmes were implemented in every Greater Manchester locality, increasing access by almost 300%. Significant workforce transformation to identify need earlier has also been delivered. This increase was urgently required to meet universal requirements; however, there is still a significant amount of unmet need in localities. A self-assessment undertaken within localities has identified that each locality is well placed to build upon this strong foundation by implementing the evidence-based targeted interventions identified as part of the Greater Manchester Early Years delivery model.

There have been significant changes to the provision of free early education during the last three years, including new places for two-year-olds and an Early Years pupil premium for the most disadvantaged three and four-year-olds. Since September 2014, 55% of two-year-olds in Greater Manchester have been entitled to 15 free hours of free early education per week for 38 weeks of the year. Take-up of two-year-old places across the 10 localities varies, with an average 71% of eligible children taking up their free entitlement across Greater Manchester with a local variance of 63-85% (2015).

The Greater Manchester Early Years delivery model presents a unique opportunity to develop system-wide transformation that supports a sustainable shift from expensive and reactive public services to prevention and early intervention. The model aims to reduce duplication and variation and achieve better outcomes within existing budgets; however the challenge of implementing the Early Years model at scale alongside diminishing local authority budgets is recognised and understood.

3.4.1 Programme of work – scope

The Greater Manchester EYDM is an ongoing universal and targeted pathway based on consistent, integrated age-appropriate assessment measures promoting early intervention and prevention, implemented through assertive outreach and improved engagement with families with young children from pre-birth to school. Assessments will be evidence-based, timely and ongoing from pre-conception to five years (see diagram below). Services will identify needs early and intervene effectively to minimise the escalation of need. This is reinforced by a series of evidence-based interventions supporting short and long-term benefits. Implementation of the EYDM has progressed at different rates across all areas of Greater Manchester.

There is a requirement to focus on remodelling existing Early Years services within budgets that are under pressure. This requires new multi-agency delivery models, reducing commissioned activity with no evidence base, and moving public sector money associated with poor outcomes into programmes that rapidly improve the performance across Greater Manchester.

The Greater Manchester Early Years Delivery Model comprises three key components:

1. an eight-stage assessment pathway (see below)
2. a range of multi-agency pathways
3. a suite of evidence based assessment tools and targeted interventions.

When the EYDM is fully implemented across Greater Manchester to a standard of the highest performing localities, families will be in receipt of a proportionate multi-agency tailored response relevant to their level of need. The EYDM has the full engagement of all authorities but commissioning, service delivery and provision remain inconsistent across Greater Manchester, with progress hard to evidence. To increase momentum there is a need to develop a new approach to commissioning Early Years services across Greater Manchester, specifically integrated commissioning of the Greater Manchester EYDM.

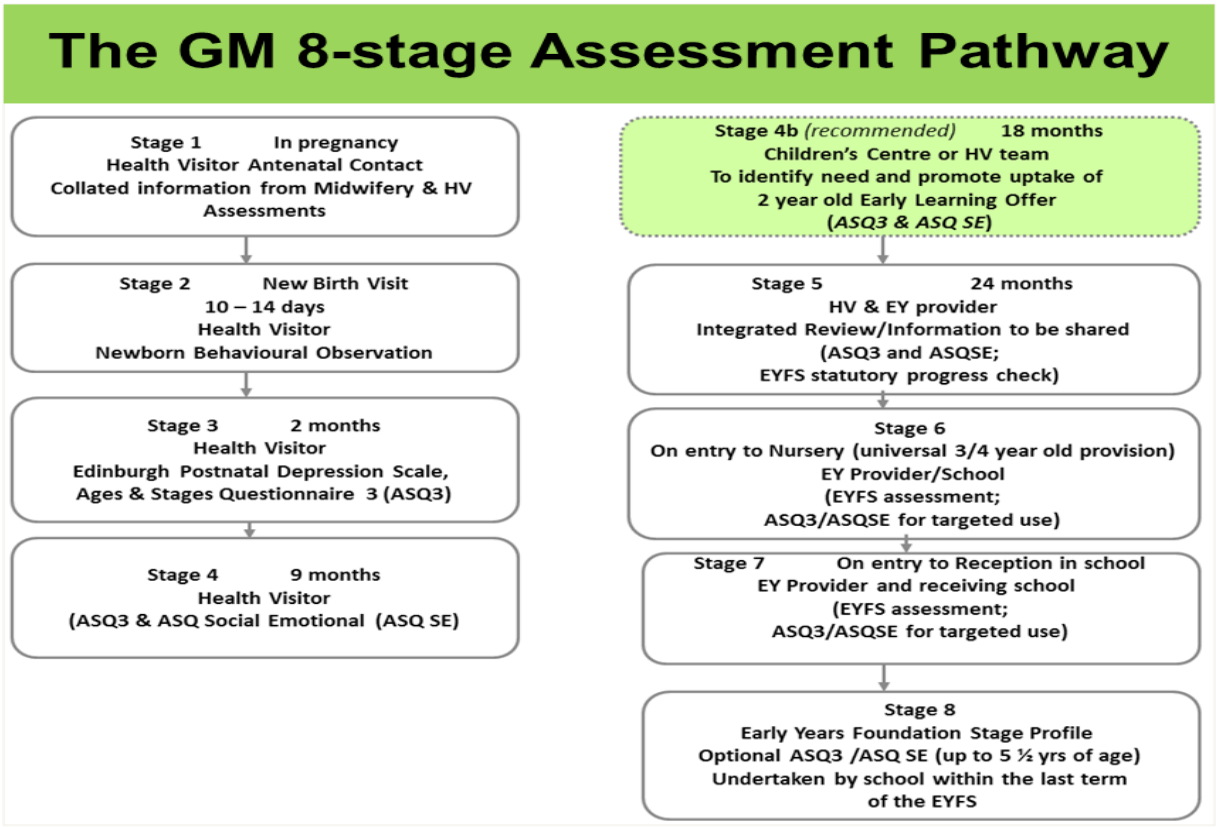


Figure 12: Greater Manchester eight-stage pathway

Figure 13 below sets out the universal, targeted and locally determined components of the Greater Manchester Early Years delivery model of integrated provision.

1: Core model elements Universal entitlements within ALL localities	2: Core model elements Evidence-based targeted interventions/entitlements within ALL localities	3: Core model elements Evidence-based targeted interventions/entitlements within ALL localities
Use of agreed evidence-based universal assessment tools (e.g. ASQ3, EPNDS) Greater Manchester 8-stage New Delivery Model assessment pathway	Use of agreed evidence-based targeted assessment tools	
Maternity services Core Greater Manchester offer: including stopping smoking in pregnancy, PIMH pathways	Family Nurse Partnership	High-needs pathway for vulnerable pregnant women requiring intensive support, including pathway for pregnant teenagers not accessing FNP.
Antenatal and Newborn Screening	Specialist screening and intervention	
Unicef Baby Friendly Initiative: Acute, Community, Neonatal Units and Children's Centres	Breastfeeding support (best practice = peer support service)	
Health Visiting core offer	Health Visiting targeted / early help offer	
Childhood routine immunisations	BCG vaccination	
Free early education entitlement for all 3 and 4 year olds.	Free early education entitlement for the most disadvantaged	Communication -friendly environments / Raising Early Achievement in Literacy (REAL)
Speech , Language and Communication programmes and initiatives (Greater Manchester intervention pathway to be ratified).	Well-Comm	Parent and Child Interaction / Therapy / Elklan / Communication-friendly environments
Evidence- based parenting programmes, including Solihul approach Greater Manchester antenatal parent preparation guidance and classes	Incredible Years Baby (0-1 Bm) Incredible Years Toddler (18m-30m) Incredible Years Pre-school (30m-7 years)	Solihull Parenting Groups / Family Partnership Model / Baby Steps antenatal programme / Mellow Parenting / Perinatal PEEP / Triple P / Baby Links Nurturing / Video Interactive Guidance
Children 's Centre core offer	Children 's Centre targeted offer	Communication-friendly environments
PIMH & Attachment (Greater Manchester intervention pathway to be ratified) Neonatal Behavioural Observation	Neonatal Behavioural Assessment Scale	

Figure 13: Early Years delivery model

The Greater Manchester EYDM will require integrated commissioning arrangements to include a local commitment to commission and deliver all core model elements (1) and (2) within each locality, delivered by multi-disciplinary integrated teams. If evidence-based local targeted variations are in place it is recognised that there may be a desire to retain these at the expense of specific core model elements (2); the model intends to support this flexible approach. Examples of these are listed within local elements (3). Significantly, any services agreed as core components (1) and (2) of the model should not be decommissioned at a local level.

3.5 Smoking in pregnancy

Smoking is 'the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health outcomes' (NHS England National Maternity Review, 2016). A recent North West review that focused on child deaths under one year identified that smoking was the most prominent modifiable risk factor associated with infant mortality. A concerted, collaborative effort to reduce smoking in pregnancy will save babies' lives, improve childhood development and narrow health and social inequalities.

Parental smoking quadruples the chance of children becoming smokers. A system-wide approach to smoking cessation in pregnancy to target the most vulnerable will lay the foundations for securing a smoke-free environment not only in pregnancy but for children throughout their childhood years. Smoking prevalence in the under-20s is reported to be two to three times higher than overall rates, and this translates through into higher smoking rates among young mothers.

The identification of women who are smoking at their booking visit is key if services are going to be able to support a woman to quit smoking. The NHS England 'Saving Babies Lives Care Bundle' guidance recommends universal carbon dioxide (CO_2) monitoring at antenatal booking. Across Greater Manchester the implementation of CO_2 monitoring is variable.

Smoking cessation services are commissioned by local authority public health teams on behalf of their populations. Localities can have several providers of maternity services, which may not be commissioned by coterminous CCGs. Initiatives such as the Saving Babies' Lives care bundle provide opportunities for collaborative commissioning approaches. A single Greater Manchester evidence-based pathway for stopping smoking in pregnancy is needed to support systematic collaboration between CCG commissioners, local authority commissioners and maternity service providers to ensure consistent high-quality provision and access across Greater Manchester.

3.6 Better oral health

Good oral health in children means freedom from pain and discomfort, confidence to smile, talk and socialise without embarrassment, to attend school and be ready to learn. It also means that the requirement for urgent or routine clinical care is greatly reduced. The most common reason for young children to be admitted to hospital is for the extraction of decayed teeth, with many also attending A&E due to dental pain. Improved clinical care pathways would mean that many children who may ultimately receive general anaesthetic for dental treatment would be cared for through appropriate early intervention within primary care.

To achieve the fastest improvement in the oral health of young children we need to implement a co-ordinated programme of universal and targeted interventions across Greater Manchester. There is a strong evidence base for population-level oral health improvement interventions employing a range of measures, at scale, to achieve maximum

population coverage and reduce inequalities. The current cost to the Greater Manchester health system of treating tooth decay in children is approximately £19 million per year. Enabling the most effective use of resources to support evidence-based programmes will require bold decisions to decommission activities that are not supported by the evidence base.

When oral health is poor, children experience pain, infection, sleepless nights and absence from education that affect their ability to learn, thrive and develop. Parents must also take time off work to care for their children. Tooth decay is strongly associated with deprivation and chaotic lives, with some of the most vulnerable children facing very poor oral health. Risk factors include poor nutrition, high consumption of sugar and lack of access to fluoride due to starting toothbrushing late or infrequently.

In 2015, 36% of Greater Manchester five-year-old children had experienced tooth decay, compared to 27% in England. In addition, there are marked inequalities both within and between localities, ranging from 50% in Oldham, to 22% in Stockport. Due to persistently high levels of tooth decay in five-year-olds, Oldham, Salford, Rochdale and Bolton have recently been highlighted as four of the 13 'priority areas' for child oral health in England.

In order to reduce tooth decay in five-year-olds to the England average within five years, we need to ensure the following.

1. Oral health is on everyone's agenda: Our ambition is that every child in Greater Manchester has accessed preventively-focused dental services by the age of 12 months. To achieve this we need greater integration between Early Years services and dental services, with clear pathways to support facilitated access to professionally delivered prevention and early intervention.
2. The Early Years workforce has access to evidence-based oral health improvement training.

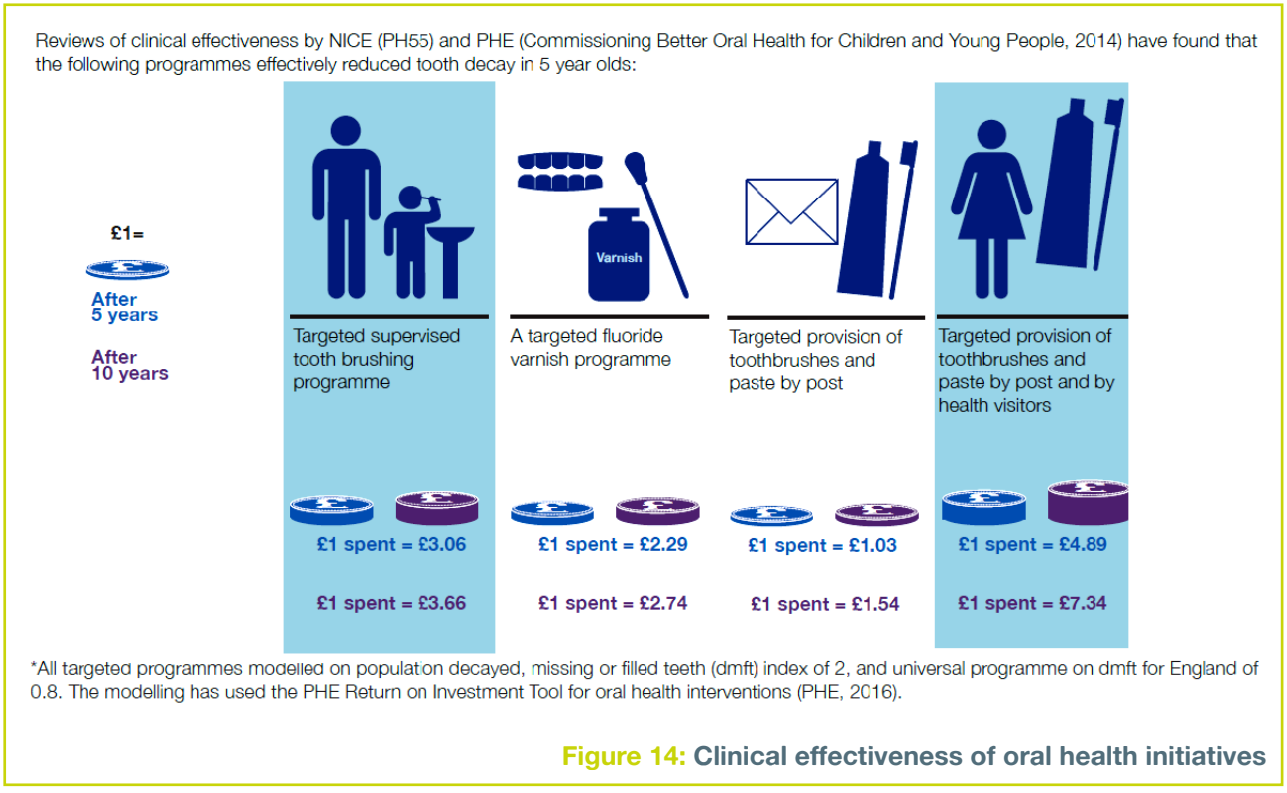


Figure 14: Clinical effectiveness of oral health initiatives

3. Oral health data and information is used to the best effect by all stakeholders.
4. Population-level oral health improvement interventions that have the strongest evidence base are delivered at scale.
5. Child oral health improvement is communicated effectively: Opportunities are identified to communicate oral health information as part of broader communications.

3.7 Developing Well (5-25 years)

While Greater Manchester is taking a pioneering approach to prioritising the Early Years, we acknowledge the requirement to address population health challenges in children and young people aged 5-19 years. Scoping the requirements for 5-25 year olds will require significant partnership working and engagement with schools, further education and higher education establishments and the community and voluntary sector. We intend for this work to be incorporated into phase two of the population health planning process. This will be captured under the theme of Developing Well. Initially, we will champion the aspirations of the Greater Manchester Children's Services Review led by the Greater Manchester directors of children's services. The review aims to support the development of a clear Early Help offer for 5-19 year olds in all Greater Manchester localities that helps children and young people achieve better outcomes and reduces demand for targeted and specialist services. Further work is required to establish the key priorities for young people aged 19-25 years; the initial area of focus will be on young people who remain within education.

Mental health and wellbeing is a key priority across GMHSC Partnership, where it is a cross-cutting theme across all workstreams. The implementation of this workstream will be delivered via the Greater Manchester Mental Health Strategy. Shifting the focus of care to prevention, early intervention and resilience, and delivering a sustainable mental health system in Greater Manchester, requires simplified and strengthened leadership and accountability across the whole system. The Greater Manchester stakeholder survey for the Greater Manchester Mental Health Strategy reported that mental health should be embedded within the school curriculum as part of a wider health and wellbeing approach in schools. There is a requirement for every school and college to identify when a young person may be struggling and to intervene early and effectively to nurture and support young people's mental health and resilience, focusing on key attributes such as self-esteem and empathy. This is vital as 75% of all adult mental health problems start by the age of 18 and only 25% of young people with mental health problems get access to the right support. Improving child and adult mental health, narrowing social, educational and health inequalities, and ensuring parity of esteem with physical health is fundamental to the overall future health and wellbeing of our communities.

To support this we have drafted five key asks of schools, colleges and universities to support the establishment of Greater Manchester standards for local implementation. These are:

1. encouraging young people to develop healthy lifestyles
2. supporting young people (and their families) in developing core resilience to tackle problems and face issues
3. working with other community organisations to provide a strong support network for children and young people
4. being a good employer in proactively supporting the health and welfare of staff
5. getting involved in Greater Manchester work on health and care of young people, so that they can benefit from best practice and mutual support across the region.

3.7.1 Plan

3.7.1.1 Objectives

It is now well understood across Greater Manchester that investing in new models for Early Years services is the right thing to do from a moral, economic, financial, performance and resilience perspective. The next stage of the work will seek to give confidence to system investors that the Early Years model will deliver improved outcomes.

- **Objective 1**: Fully implement the core elements of the Greater Manchester Early Years delivery model within all 10 Greater Manchester localities.
- **Objective 2**: Develop a sustainable, resilient and consistent set of Greater Manchester interventions to stopping smoking in pregnancy.
- **Objective 3**: Develop information management technology (IMT) proposition to improve data processes to track progress and allow earlier intervention.
- **Objective 4**: Implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and reduce treatment costs within 3-5 years.
- **Objective 5**: Develop a clear Early Help offer for 5-19 year olds in all Greater Manchester localities that helps children and young people achieve better outcomes and reduces demand for targeted and specialist services. This objective will be delivered via the Greater Manchester Children's Services Review led by Greater Manchester directors of children's services.
- **Objective 6**: Develop a consistent Greater Manchester approach to improving the mental health and wellbeing of children and young people in education. This objective will be delivered via the implementation of the Greater Manchester Mental Health Strategy.

3.7.1.2 Approach to delivering objectives

Objective 1: Implement the core elements of the Greater Manchester Early Years model within all 10 Greater Manchester localities.

The programme will seek to:

- identify local gaps in the delivery of the Early Years model and develop locality implementation plans
- formulate investment proposals to pursue and agree funding options
- update the cost benefit analysis model
- undertake a commissioning options appraisal
- develop an engagement strategy around achieving the aspiration of the Start Well Early Years Strategy. Specifically, it will seek to scope the vital contribution of schools, community and voluntary organisations and a public health maternity workforce in achieving the objectives of the Start Well Early Years Strategy.

Objective 2: Develop a sustainable, resilient and consistent Greater Manchester approach to stopping smoking in pregnancy.

The programme will seek to:

- scope current approaches to commissioning stop smoking services in pregnancy
- review the evidence and formulate sustainable investment proposals
- commission a Greater Manchester approach to stop smoking services in pregnancy to ensure consistency.

Objective 3: Develop IMT proposition to improve data processes to track progress and allow earlier intervention.

The programme will seek to:

- work with the Greater Manchester-Connect data and information programme

to identify the potential scale, impact and efficiency savings

- explore the opportunities identified within capturing data, storing data and sharing data
- identify localities to test a proof of concept
- develop a Greater Manchester model that will realise efficiencies and enable the workforce to spend more quality time working with families.

Objective 4: Implement evidence-informed interventions at scale in a targeted and consistent manner across Greater Manchester to improve oral health and reduce treatment costs within 3-5 years.

The programme will seek to:

- commission a co-ordinated oral health improvement programme across all of Greater Manchester that focuses on increasing access to fluoride via:
  - supervised brushing in all Early Years settings
  - promotion of brushing with fluoride toothpaste in the home environment via 'take home' packs and information
  - toothpaste distribution by health visitors and school nurses as part of the checks undertaken in the 0-5 year old age groups
- ensure that child oral health is seen as everyone's agenda, with child oral health improvement messages communicated effectively by all stakeholders
- create links between Early Years and dental services, in order to facilitate access to preventively-focused dental care for all Greater Manchester infants by the age of 12 months. This will be achieved by a programme of training and updates to all key health and Early Years staff across Greater Manchester
- evaluate the effectiveness of a programme promoting attendance at local dental practices before a child's first birthday. This programme will involve partnership working between health visitors and local dental practices to promote delivery of evidence-based prevention. This programme will be tested and evaluated in priority localities where levels of dental decay in young children remain consistently high.

Objective 5: Develop a clear Early Help offer for 5-19 year olds in all Greater Manchester localities that helps children and young people achieve better outcomes and reduces demand for targeted and specialist services. This objective will be delivered via the Greater Manchester Children's Services Review led by Greater Manchester directors of children's services.

The programme will seek to:

- develop a Greater Manchester integrated health and Early Help strategy
- engage a wide range of key stakeholders around the development and implementation of the strategy and what it means for their organisation
- develop locality implementation plans to meet the objectives of the strategy.

Objective 6: Develop a consistent Greater Manchester approach to improving the mental health and wellbeing of children and young people in education.

Via the implementation of the Greater Manchester Mental Health Strategy the programme will seek to identify opportunities to:

- implement mental health-promoting activities for children and young people integrated into normal school life

- introduce mental health promotion and mental health issues into the school policy and mandatory curriculum subjects
- offer mental health liaison at all Greater Manchester schools, providing support for teachers when working with children and young people at key life stages.

3.7.1.3 Target outcomes for 2016/17 and 2017/18

Year 2016/17:

- Early Years delivery plans developed in all localities
- Investment proposals developed to deliver core Early Years model in pioneer localities
- Investment proposition developed for a Greater Manchester stop smoking in pregnancy service
- Investment proposition developed for a Greater Manchester oral health improvement programme

Year 2017/18:

- Greater Manchester stopping smoking in pregnancy service commissioned
- Investment proposals developed in remaining localities
- IMT rolled out in initial areas
- Evaluation process developed to give confidence in investment

4. Live Well

As stated previously, this plan is focused around those key points and stages in people's lives when mental and physical health can be most strongly influenced. The aim of the Live Well theme is to support adults to be healthier, empowered and more resilient; key here will be connecting people to the opportunities created by economic growth and reform, behaviour change at scale to respond to the rise in chronic disease, and a real focus on reducing health inequalities.

The programme of work will include addressing key wider determinants of health such as work, focusing on whole system approaches to the key lifestyle risk factors of smoking, physical inactivity, obesity and alcohol that are driving premature mortality, inequality and illness, and developing new service responses that support general practices to work differently with people who face severe disadvantage. In addition, work is focusing on two key mid-adult life diseases that impact on our population – cancer and HIV.

The programme of work outlined in the 'System reform' chapter of this plan to create a unified population health commissioning system for Greater Manchester will also contribute significantly to the delivery of Live Well. By moving away from a fragmented Greater Manchester approach to commissioning more strategic and collaborative approaches at the right spatial level, we have the potential to improve at scale the response to the key lifestyle risk factors for midlife adults.

Greater Manchester is leading the way in its work on adult health improvement, forging groundbreaking strategic partnerships with national bodies such as Sport England to develop insight-led radical new propositions to address our high levels of physical inactivity, and with philanthropic and charitable organisations, focusing on our shared aims of tackling health inequalities. There is a wide range of activity already underway across the system that complements and enhances the projects in the population health plan. They include:

- local care organisations: The new locality care organisations (LCOs), which each of our 10 localities is developing, have a crucial role in delivering proactive, preventative, population healthcare to consistently high standards
- primary care strategy, which encourages a population-based approach to improving health and care through the delivery of place-based care and includes specific proposals on oral health and the introduction of a Greater Manchester Pharmacy Healthy Living Framework
- 'Greater Manchester Moving: the blueprint for physical activity and sport in Greater Manchester', (2015), the foundation to drive forward work across the system to increase physical activity

- Greater Manchester Combined Authority's alcohol strategy, which continues to take forward a programme of work, including licensing, regulation and compliance, and alcohol awareness campaigns
- the Greater Manchester sexual health partnership, which since its inception 13 years ago has driven significant improvements in sexual and reproductive health outcomes and service quality. Recent developments include cluster commissioning arrangements and proposals are currently being developed to secure further improvements and economies of scale by seeking to commission sexual health services at a single Greater Manchester level.

As identified above, a key element of the Live Well work programme will be advancing equality and reducing health inequalities, and therefore focusing on some of our most vulnerable groups, including the Traveller communities, homeless people, offenders, asylum seekers and refugees. This work will build on and align with activity already underway across the system.

Asylum seekers and refugees

Greater Manchester has one of the largest populations of asylum seekers and refugees in the country. It is recognised that this community holds a range of health needs, both physical and mental. Greater Manchester has been working with the North West Strategic Migration Partnership and other stakeholders, such as the Home Office, local authorities and providers, to better define and understand how the needs of asylum seekers and refugees are assessed.

GMHSC Partnership has recently secured funding from NHS England to improve access to routine primary care and address the barriers that many asylum seekers experience in accessing healthcare, leading to increased pressures on emergency services and poorer health outcomes.

Offender health

The Greater Manchester devolution agreement made a commitment to greater collaboration in the planning and delivery of a range of justice provision. An increased role in commissioning offender management services is enabling Greater Manchester to build improved pathways through services, tackling the challenges that can occur at transition points in the system.

Greater Manchester is developing plans for an integrated health and justice pathway, across all points of the criminal justice system, including consideration of mental health (including child and adolescent mental health services), substance misuse and learning disabilities. As an example of these new ways of working, Greater Manchester has recently become the first area in the country where the NHS and police and crime commissioner have worked together to jointly commission integrated police custody healthcare and liaison and diversion services. This is an optimal model that will operate within police custody, at court and in the community for those at risk of entering the criminal justice system.

Homelessness

Homelessness is increasing across Greater Manchester, in terms of statutory homelessness and also rough sleeping, which has been the most evident and visible. We have also seen increasing movement and transience of some elements of the homeless community, reflecting the economic and social conditions in some boroughs, and which is increasingly requiring a cross-boundary response. Plans are being put in place to develop a Greater Manchester homelessness prevention system that will operate across local government geographical boundaries. This means a focus on more effective, proactive investment in prevention and driving down reactive costs. Local services will be integrated in a place-based way to provide people with an individually

tailored pathway, based on their needs, to promote sustainable life chances.

4.1 Work and health

4.1.1 Background

There is a strong association between worklessness and poor health. Being out of work can lead to poor physical and mental health, across all age groups, with major impacts for the individual concerned, their partner and family. Getting back into work improves people's health, as long as it is good quality work.

There is strong evidence that unemployment is generally harmful to health, linked to:

- increasing death rates by 1.5 to 2.5 times
- higher mortality
- poorer general health and long-term limiting illness
- increased alcohol and tobacco consumption
- lower levels of physical activity
- higher rates of medical consultation, medication consumption and hospital admission rates.

Being in work and having a purpose in life have a positive effect on wellbeing. Conversely, being out of work can result in health harms such as the following.

- One in seven men develops clinical depression within six months of losing their job.
- Prolonged unemployment increases the incidence of psychological problems from 16% to 34%, with major impacts on the individual's partner.
- Young people are particularly at risk. Suicides attempts are 25 times more likely for unemployed young men than employed young men, with mental health problems in general much higher among unemployed populations.

There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss. The exception to this can be young people.

- Unemployed young people are particularly affected by 'scarring', when, a bad early experience in the labour market can last for 20-30 years and restrict ability to progress.
- Young people who are not in education, employment or training (NEET) for a substantial period are less likely to find work later in life, and more likely to experience poor long-term health.

Staying in work is key to improving outcomes. National Institute for Health and Care Excellence (NICE) evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to employment, and after two years are more likely to die than return to employment.

The Government published the 'Work, health and disability: Improving lives' Green Paper in October 2016, which recognises the importance of work as a health outcome, and the need to give this greater focus within health services. It sets ambitious targets to halve the gap in the employment rate for those living with long-term health conditions or disability in relation to non-disabled people. The Department of Health and Department for Work and Pensions (DWP) established the joint Work and Health Unit to lead the drive for improving work and health outcomes for people with disabilities and long-term health conditions, as well as improving prevention and support for people absent from work through ill health and those at risk of leaving the workforce.

The NHS Five Year Forward View gives a clear statement on the need for the NHS to do

more to help people to get into, and remain in, employment. It sets out the fiscal impact of health-related absence and benefit claims to employers and taxpayers, and the low employment rate of people with mental health problems. The role of employers, and the NHS in supporting employers, is identified as key to supporting a healthier workforce and reducing long-term costs.

4.1.2 Greater Manchester context

Very high rates of health-related worklessness have persisted in Greater Manchester regardless of the economic climate, and the number of health-related benefit claimants has remained high even during times of economic growth.

Greater Manchester health and social care devolution, as demonstrated in the vision document 'Taking Charge', presents opportunities to further test and embed approaches that integrate employment and health. It is well understood that employment is a key determinant of health at strategic level. Despite this, there is still further work needed to make sure it is given the priority it should have in relation to patient care. This includes a recognition that more should be done around early interventions to improve employment outcomes for those residents at risk of falling out of work due to health or disability and those recently unemployed or inactive due to health or disability.

The scale of the challenge in Greater Manchester is significant. There are approximately 225,000 people in Greater Manchester claiming out-of-work benefits, and of these, 140,000 claim as a result of a health condition. Since 2012, unemployment in Greater Manchester has been reducing overall, but disability-related worklessness has not. There are a further 200,000 families in work and reliant on Working Tax Credit to move them out of poverty. The cost to Greater Manchester of worklessness and the impact of low pay has now reached over £2 billion a year.

- In Greater Manchester, mental health and musculoskeletal issues are the main health problems cited by workless claimants of sickness-related benefits. The Greater Manchester Working Well programme demonstrates that 68% of clients state that poor mental health is their biggest barrier to employment and 62% cite physical health, while 41% state that both mental and physical health issues are equally considered the largest barrier to employment.
- Of the Greater Manchester economically inactive population, 26% are out of work due to long-term sickness, compared to 22% in England as a whole. Levels are highest in Rochdale (32%), and lowest in Stockport and Trafford (20%). Temporary sickness accounts for 3.4% of the Greater Manchester economically inactive population, well above the England average of 2.3%.
- In 2015, nearly a third (31%) of the Greater Manchester working-age population had a health condition or illness lasting more than 12 months, compared to the England average of 29%. However, the Greater Manchester average masks considerable variation across localities, ranging from 27% in Manchester to 37% in Tameside.
- Data from the 2011 Census shows that 7.4% of the Greater Manchester working-age population reported that they had a long-term health problem or disability that limited their day-to-day activity 'a lot'. There is similar variance by locality, ranging from 5.6% in Trafford (equal to the England average) to 8.7% in Rochdale.
- It is estimated that less than 30% of presenting issues at GP surgeries actually require clinical intervention, and 70% of appointments are actually down to issues around wider social determinants ('social prescribing'); furthermore, this figure rises in more deprived areas.

Strong progress has been made with the Government to co-design testing of an alternative approach to welfare to work. The Working Well programme assists those with health-related barriers, and other complex benefit claimants, to secure and sustain employment. Notwithstanding Greater Manchester Working Well's success, it is critical to note that Working Well, and its successor the Work and Health programme, will not have the capacity to address the issue of health-related worklessness at the scale required to make the impact we need in the numbers of claimants within Greater Manchester.

The new DWP/Greater Manchester Work and Health programme aims to deliver to circa 20,000 claimants over five years, which reaches only a small proportion of those with health conditions that need support to return to work. There is a need to focus on what can be achieved at scale through a greater focus on work as a health outcome by taking a different approach to integrating the support offer from the health and social care system with Jobcentre Plus and other key partners.

4.1.3 Opportunity

Our ambition is for work for health to be given the priority it should have in relation to patient care and approaches to improve population health within Greater Manchester. A systematic approach to integrate healthcare provision with programmes designed to address the social and economic determinants of health will better support health outcomes for the individual, and realise the ambitions set out in the GMHSC Partnership Strategic Plan: Taking Charge of our Health and Social Care.

In terms of the opportunities available when looking at the different segments of the population, key areas to focus on are those employees who become ill and are at risk of falling out of employment, those newly out of work who need an enhanced health support offer, and those who are economically inactive with health conditions and get little in the way of support from Jobcentre Plus. It is recognised that there are differing characteristics within this population group that need to be considered, for example, the needs of older workers, or those with particular disabilities. We will be working closely with all partners including the Centre for Ageing Better, and disability and equalities groups, to test and learn what works for whom.

In work but at risk: The current national offer is not meeting local need. The national Fit for Work service, which is available to employers, employees or GPs to refer to once the person has been off sick for four weeks, has struggled to engage general practice or receive referrals from employers; neither does it provide rapid access to treatment.

In contrast, there is evidence from the Manchester Fit for Work service that demonstrates that an earlier intervention offer that meets GP and patient need can be effective. The local service has 86% of Manchester GP practices making regular referrals and is achieving effective outcomes using a biopsychosocial approach. The return on investment demonstrated in an initial cost benefit analysis (CBA) suggests that this model offers good value for money.

We will test the approach at a wider scale in conjunction with discussion around the devolution potential of the national scheme.

Out of work: Currently the most significant gap is systematic support for those with health conditions who are recently unemployed, or economically inactive, such as those in the Employment and Support Allowance (ESA) group and who do not meet the access criteria for Working Well. In Greater Manchester the majority of such claimants are in the Employment and Support Allowance (ESA) Group (84,430) and therefore are unlikely to get much in the way of support.

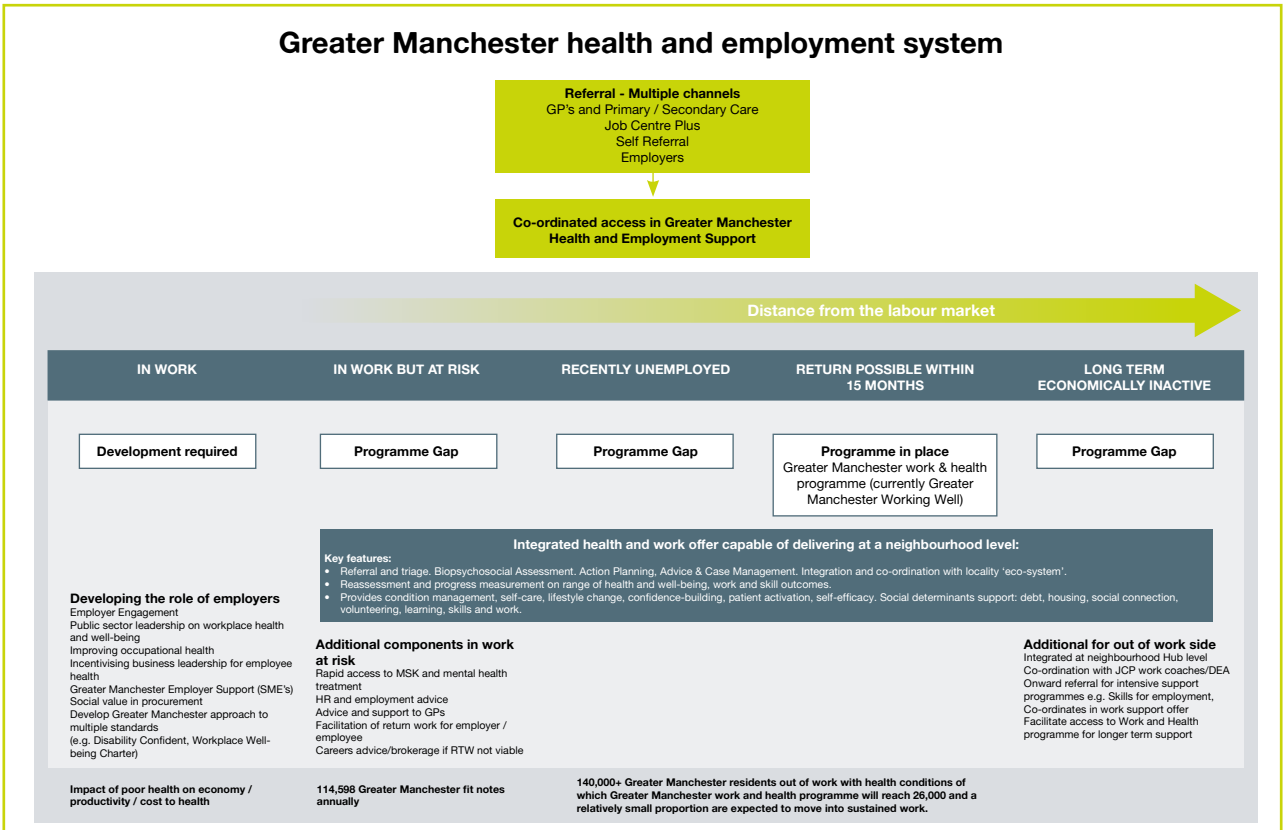


Figure 15: Health and employment

There is no coherent pathway for those with health conditions to access employment and skills support, condition management and other social determinants, at the scale required.

The 'Work, health and disability: Improving lives' Green Paper proposes steps to address earlier intervention for people making new claims for benefit/Universal Credit as a result of a health condition. This presents opportunities for collaboration between Greater Manchester and the Government to improve support across the spectrum of out-of-work claimants.

For both of these priorities, two of the key system interfaces at these critical risk points are Jobcentre Plus and NHS primary/secondary care services that hold responsibility for issuing fit notes and for treating those with long-term health conditions. In most cases, there is little clinicians can offer to support a return to work. Local examples from Salford, Bury and Manchester demonstrate that a trusted health and work pathway from primary care can be effective and well-used by GPs for those in or out of work with a health condition, and offer potential to enhance the proposals set out in the Green Paper.

Cost benefit analysis

Initial cost benefit analysis of the Manchester Fit for Work (in-work) and Healthy Manchester (out-of-work) models suggests that they offer good value for money. For a relatively low unit cost per client, significant fiscal benefits were delivered, including reduced worklessness and associated benefit payments (flowing to government), and reactive cost savings (flowing to local partners) associated with reduced mental health disorders, GP and physiotherapy appointments, and alcohol dependency. The gross five-year fiscal return on investment for the in-work service was an estimated 1.25,

and 1.35 for the out-of-work service; for both services, payback (when the benefits begin to outweigh the initial investment) should be achieved in four years. The wider public value delivered by the Manchester services incorporates increased economic output and reduced costs to employers, along with softer social benefits related to improved individual well-being – the public value return on investment was estimated at £5.74 for the In-work service and £2.36 for the Out-of-work.

When scaled up across further localities, the fiscal return on investment reported above is likely to increase, not least due to the economies of scale and potential efficiency savings that delivery on a Greater Manchester platform might generate

Opportunities still to be scoped
The significant efforts made at both Manchester and Greater Manchester level to move people back into employment will not achieve maximum gain if the work is not 'good work'. The role that employers can play is critical and significantly under-developed, both in terms of protecting health, supporting skills development and career progression, and promoting longer, healthier lives. There is an economic case for stronger leadership across public, private and third sector partners at Greater Manchester and locality levels.

Further work will take place over the next 12 months to scope the opportunities to support employers to provide 'good work', and employees to stay well in work.

4.1.4 Plan

The vision of this programme is to ensure that Greater Manchester has effective prevention and early intervention systems in place that support as many adults with health conditions as possible to return to, and remain in, good quality work. In order to do this, the programme is to build and test an approach to work and health that improves the integration and alignment of health, employment and other services, to ensure that the target group can access the support they require at an early stage and before falling into long-term unemployment. It also aims to give individuals the tools to manage health conditions in the longer term, build resilience and know where to go for other support when they need it.

The programme is set up to achieve the following core objectives.

Objective 1: Develop a work and health support model that addresses the needs of the identified cohorts, underpinned by data, evidence and cost benefit analysis, and secure endorsement by stakeholders across Greater Manchester.

Objective 2: Scope and determine the extent of current local work and health support delivered within Greater Manchester, tested against the work and health model described under Objective 1, scope procurement and delivery options and Greater Manchester/ locality approach.

Objective 3: Support a number of localities to implement the work and health model.

Objective 4: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion and mainstreaming of the programme across the whole of Greater Manchester, based on the evidence.

4.1.4.1 Approach to delivering objectives

Objective 1: Define the work and health support model that addresses the needs of the identified cohorts, underpinned by data, evidence and cost benefit analysis, and agree appropriate funding mechanisms.

The programme will seek to:

- undertake detailed cohort analysis and modelling
- define and agree the key features that need to be in place to deliver effective services to the cohort

- define the metrics through which to measure success
- develop a CBA model
- undertake a communication and engagement exercise with Greater Manchester stakeholders
- pursue and agree funding options, including:
  - The national Work and Health Innovation Fund
  - Greater Manchester Transformation Fund.

Objective 2: Scope and determine the extent of current local work and health support delivered within Greater Manchester to the defined cohort, tested against the defined work and health support model.

The programme will seek to:

- work with localities to identify the 'as is', taking into account local place-based delivery models
- hold discussions with localities where no offer is currently in place to understand appetite for implementing model and agree participation
- undertake an options appraisal of the appropriate procurement and funding models to progress implementation with participating localities.

Objective 3: Support a number of localities to build on existing services or implement new provision to address gaps in service for the cohort.

The project will seek to:

- secure and put in place agreements with a number of localities to implement the model and test locally
- undertake a procurement exercise or implement agreed funding arrangements
- provide programme management and delivery support to assist localities to develop
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 4: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the programme across the whole of Greater Manchester, based on the evidence.

The programme will seek to:

- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis
- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to expand the work and health support model to ensure coverage of remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide coverage.

4.1.4.2 Outcomes

The programme will work towards achieving four key outcomes.

- **Outcome 1:** A work and health support model that addresses the needs of the identified cohorts, has been developed, endorsed by stakeholders and is supported through an agreed investment approach.
- **Outcome 2:** The 'as is' support service landscape for the target group is understood and locality appetite to test an at scale new approach model has been explored.
- **Outcome 3:** A number of Greater Mchester boroughs are implementing and testing the model for agreed cohorts and participating in evaluation.

- **Outcome 4:** A business case and plan for refinement and extension of a Greater Manchester-wide roll-out of the model has been produced and agreed.

4.1.4.3 Programme of work – scope

Overall the programme will work to the following principles:

1. Early intervention when employees become ill and risk falling out of employment
2. Early intervention for those with a health condition who have become recently unemployed or are long-term economically inactive to support them to make a return to work
3. Support for employers to provide 'good work', and for employees to stay healthy and productive in work

There are significant gaps within the system offer for each of these areas. Prevention from leaving the labour market is key. NICE evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to employment, and after two years are more likely to die than return to employment.

Population in scope

We are looking to test and evaluate approaches that address the work and health needs of the following groups of working age adults:

- employed people who have been off sick for two weeks or more, and who require a biopsychosocial intervention to return to work as quickly as possible
- employed people who are at work but struggling with health conditions, and are at risk of going off sick and require a biopsychosocial intervention to remain effective and productive in work. This particularly includes those who are self-employed, or work for small and medium-sized enterprises (SMEs).
- people who have a health condition who are economically active and would benefit from integrated health and a wider support offer to move closer to the labour market.

4.2 New model of primary care for deprived communities

4.2.1 Background

We know that people experiencing multiple disadvantages are more likely to have poor health, alongside a range of other challenges including homelessness, worklessness, substance misuse, mental illness, poverty, violence and abuse.

Tackling these inequalities in health requires universally proportionate services to address the larger part of the inequalities gradient. There is also a need for tailored provision for the most disadvantaged communities, where multiple social determinants of ill health, clustering of risk behaviours, and early impact of multi-morbidities come together. These communities often experience (statistically) significant differences from the rest of the population.

Intervention through services can widen health gaps if attention is not focused on inequalities in access and outcomes. Often it is the most disadvantaged that make the least effective use of services and this can be exacerbated if they are offered poor levels of service (the 'inverse care law'). This mismatch of need and demand can be portrayed as those 'missing' from services.

People who face severe disadvantage need genuine opportunities to transform their lives; opportunities that help the individual overcome all aspects of the disadvantage so that they can reach their full potential in life.

Too often, people struggle to get the support they need and there is a strong chance that the disadvantages they face will become more severe. This means that when they do present to support agencies, the focus is on

managing problematic behaviours and the risks these present rather than addressing the person's underlying issues. This can escalate the severity of problems even further. Rather than responding to what the person is experiencing, a range of disconnected services are delivered, each tackling individual problems. This means that people who most need support find it difficult to navigate a complex structure of help, meaning they access services late or not at all.

4.2.2 Greater Manchester context

In spite of Greater Manchester's increasing economic prosperity, health inequalities persist, with 20% of our population (680,000 people) living in the 10% of most disadvantaged areas nationally.

Across Greater Manchester, we are developing models of place-based integration of services intended to identify early those people at risk of developing more complex issues that, over time, could place significant pressure on services and lead to poorer outcomes for individuals or families.

Each locality across Greater Manchester is in the process of implementing an approach to place-based integration. Based on the learning from these early adopter sites, district-wide roll-out plans will then be developed. By April 2017, plans will be in place for place-based integration across each part Greater Manchester.

Through Greater Manchester's place-based integration work, teams are being brought together from a wide range of organisations, bringing together the police, local authorities, health, housing and fire services, the voluntary sector, and others as needed. They are working with local residents in a new way. Rather than assessing and referring across the system, place-based teams are working together to agree how they can actively work with people to address the range of challenges they may face. They are sharing information, taking time to understand what may be the underlying factors contributing to the challenges faced by residents and agreeing what action to take through asset-based conversations with the residents they are working with.

This work is having a positive impact. Early analysis has highlighted that up to 70% of referrals across public services are generated by other parts of the public sector. Currently people are assessed and referred, passed around the system rather than being helped to directly address the challenges they are facing. By working in a new way, by intervening early and collaborating in our approach we can cut down that referral across the system and reduce the likelihood of issues escalating for the people we are working with.

Health and social care services are already engaged in this work. However, there is scope to increase that involvement, drawing in a wider range of health and social care services. Early work has identified the value of mental health professionals being full-time members of these teams. GP engagement in place-based integration models has been invaluable in those areas that have trialled work with GPs. The link into social care will be fundamental to the success of this new way of working. By aligning our population health strategy with Greater Manchester's approach to place-based integration we have the capacity to enrich our collective approach to new models of support.

Through place-based integration models there is significant opportunity to address issues that contribute to poor population health outcomes. Alongside this, there is also opportunity to build system-wide alignment with other elements of our health and care transformation work, such as social care.

Work is ongoing to support further integration and alignment of the health and social care programme with place-based integration by: developing a health and social care offer

in a broader place-based early intervention model; supporting localities to identify the specific health and social care services and interventions that could strengthen place-based integration in their locality; supporting the development of a cross-sector Early Help strategy in each locality; and ensuring this work is reflected in and informed by locality plans.

We will ensure the Greater Manchester place-based integration roll-out delivers on our Greater Manchester-wide reform ambitions, including the delivery of our health and social care strategy. Our goal is to ensure people will no longer need to navigate fragmented systems and services.

4.2.3 Opportunity

General practice has a pivotal role to play in supporting the most disadvantaged and in place-based integration of services. GPs are usually the first point of contact with NHS provision, although this is set against the context of the capacity challenge associated with serving populations who have a lower healthy life expectancy and experience more years of living with multi-morbidities.

Being able to provide preventative interventions and continuity of care are seen as the two key assets that GPs can deploy. GPs have repeated contact with their patients and are therefore ideally placed to understand the underlying causes of poor health, whether medical or social.

However, delivering effective primary care in the poorest communities is challenging. Some diseases are more prevalent in practices serving deprived populations, particularly mental health conditions, and there are higher levels of A&E attendances, emergency hospital admissions and primary care usage among these communities. Consultations in these practices are characterised by: higher demand, greater time constraints, greater psychological and physical morbidity, more multi-morbidity, less enablement reported by patients with complex problems, and greater GP stress. Furthermore, people's medical needs are intimately interwoven with emotional, psychological, financial and social problems.

Focused care is a model that has been developed in Greater Manchester from the work of Hope Citadel Healthcare CIC. It is a response to the frustration GPs feel when seeing patients experiencing multiple disadvantage, knowing they cannot do much in a 10-minute appointment but recognising great need. Often these patients are the most invisible to the normal workings of the NHS but they are often very expensive. They present late with significant conditions, and they turn up frequently and randomly at acute services.

Focused care is a systemised, standardised holistic approach now operating in eight GP practices in Greater Manchester. The model has been shown to change both patient and clinician behaviour and has led to improved outcomes and improved engagement and utilisation of services.

In essence, focused care is a holistic approach that:

- makes the invisible visible and keep them visible
- uses a clinical case discussion across disciplines and agencies, by people who know the patient
- keeps the responsibility for the patient at the GP surgery; the promotion of the value that these are our patients and we will do our best for them
- recognises the importance of relationships and that trust is a valuable commodity
- uses a focused care practitioner to enable households to be supported by mutually agreed plans
- fosters close working relationships with other agencies.

It has been likened to a Macmillan Cancer Support service for very deprived communities. Early cost benefit analysis suggests a 3:1 return on investment can be achieved.

4.2.4 Plan

The vision for this programme of work is to ensure that Greater Manchester has an effective system in place to meet the needs of the most disadvantaged in our communities. We have developed a unique collaboration with the Shared Health Foundation (SHF), an initiative of the Oglesby Charitable Trust (OCT), which is seeking to tackle health inequalities across Greater Manchester. We will develop new service responses that support general practice to work differently for people who face severe disadvantage by enabling genuine opportunities for people to transform their lives, opportunities that help the individual overcome all aspects of the disadvantage so that they can be and do the things they value in life.

The programme is set up to achieve the following core objectives:

- **Objective 1:** Provide proof of concept for the focused care approach by testing the model in 10 deprived practices in Greater Manchester
- **Objective 2:** Test the focused care approach to facilitate general practice involvement in place-based integration
- **Objective 3:** Develop a business case to support the future expansion and mainstreaming of the new care model, including exploration of sustainable funding mechanisms.

4.2.4.1 Approach to delivering objectives

Objective 1: Provide proof of concept for the focused care approach by testing the model in an agreed number of deprived practices in Greater Manchester.

The programme will seek to:

- identify an agreed number of suitable practices serving the most deprived areas and providing a good geographical spread across Greater Manchester
- work with SHF to develop an appropriate delivery vehicle for focused care
- work with SHF and New Economy Manchester to develop outcome framework and key success measures.

Objective 2: Test the focused care approach to facilitate general practice involvement in place-based integration.

The programme will seek to build on the testing of the model as described in Objective 1 by:

- documenting and developing the general practice contribution to the health and social care offer in a broader place-based early intervention model
- supporting the development of a cross-sector Early Help strategy in each locality
- ensuring this work is reflected in and informed by locality plans.

Objective 3: Develop a business case to support the future expansion and mainstreaming of the new care model, including exploration of sustainable funding mechanisms.

The programme will seek to:

- develop a cost benefit model
- pursue and agree funding options, including Social Impact Bonds, the Greater Manchester Transformation Fund and Life Chances Fund.

4.2.4.2 Outcomes

The programme will work towards achieving three key outcomes:

Outcome 1: A systemised, standardised holistic approach that supports behaviour

change in both patient and clinician, resulting in improved outcomes and improved engagement and utilisation of services.

Outcome 2: The focused care approach to facilitate general practice involvement in place-based integration and appetite to scale up has been explored and is understood in localities.

Outcome 3: Business case and plan for Greater Manchester roll-out procured and agreed.

4.2.4.3 Programme of work – scope

Overall the programme will work in the following way.

Focused care has no acceptance criteria. In an environment of social complexity and 'chaotic-ness', referral criteria are not helpful. There is no single clearly defined population group affected. For example, a single mother with four children might actually be thriving in life while a single man in his 50s may not be. Experience has shown that often patients on focused care don't meet criteria for other services, or have been rejected for other services. Patients in this cohort often end up being passed from pillar to post.

Population in scope

Focused care has a case load of 50 households per two days of focused care time. In previous analysis this represents about 2-4% of a deprived practice list per year. The equation used is two days of focused care per 2,500 patients on a list.

4.3 Incentivising and supporting healthy behaviours

4.3.1 Background

People's health behaviours are widely known to affect their health and risk of mortality. Close to half of the burden of illness in developed countries is associated with the four main unhealthy behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity.

As outlined in the NHS Five Year Forward View, the future health of the nation, the sustainability of the NHS and future economic prosperity all now depend on a radical upgrade in prevention and public health. Over a decade ago, the Wanless Review in 'Securing our future health: Taking a long-term view' warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and now we are facing a crisis in our health and social care services.

Despite improvements in population health, 70% of us still engage in two or more lifestyle risk factors. Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smokes. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two-thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities that can cascade down to generations. For example, smoking rates among routine and manual workers range from 15.8% in Bromley to 36.3% in Oldham.

The number of obese children doubles while children are at primary school. Fewer than one in 10 children is obese when they enter Reception. By the time they are in their final year, nearly one in five is obese.

As our population's health risk gets worse, the burden on our health and social care system increases. To take just one example from the Five Year Forward View – Diabetes UK estimates that the NHS is already spending approximately £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic.

Our current health challenges require widespread behaviour change. We need behaviour change at scale to respond to the rise in chronic disease. New types of approaches are needed that reduce unhealthy behaviours, such as smoking, and increase healthy behaviours, such as physical activity. In particular, we need to find effective ways to help people in lower socio-economic groups to reduce their multiple unhealthy behaviours, as evidence indicates that reductions in unhealthy behaviours achieved to date are mostly confined to the higher socio-economic groups, who respond better to social marketing campaigns.

4.3.2 Greater Manchester context

Evidence supports the need to upscale behaviour change support services across the conurbation. There are just under two million adults aged over 19 living in Greater Manchester. Among these it is estimated that:

- 730,000 adults regularly consume less than four portions of vegetables and/or fruit per day
- 270,000 adults smoke every day
- 560,000 adults binge drink (consume twice the daily recommended alcohol levels at least once a week or once a month among men and women, respectively)
- 677,600 adults are physically inactive (less than 30 minutes of physical activity per week).

Evidence from the King's Fund: Clustering of unhealthy behaviours overtime (2012) also estimates that approximately 1.4 million adults in Greater Manchester (circa 70%) will engage in two or more of these unhealthy behaviours. The same study also highlighted that over time inequalities regarding multiple lifestyle risks have increased, with those from the lowest socio-economic groups and with the least education being three to five times more likely to have all four risk behaviours than professionals.

We also know from the 'Taking Charge' engagement that 90% of people want to improve their lifestyles, with most people citing being more active, eating more healthily and tackling stress as their key areas of need.

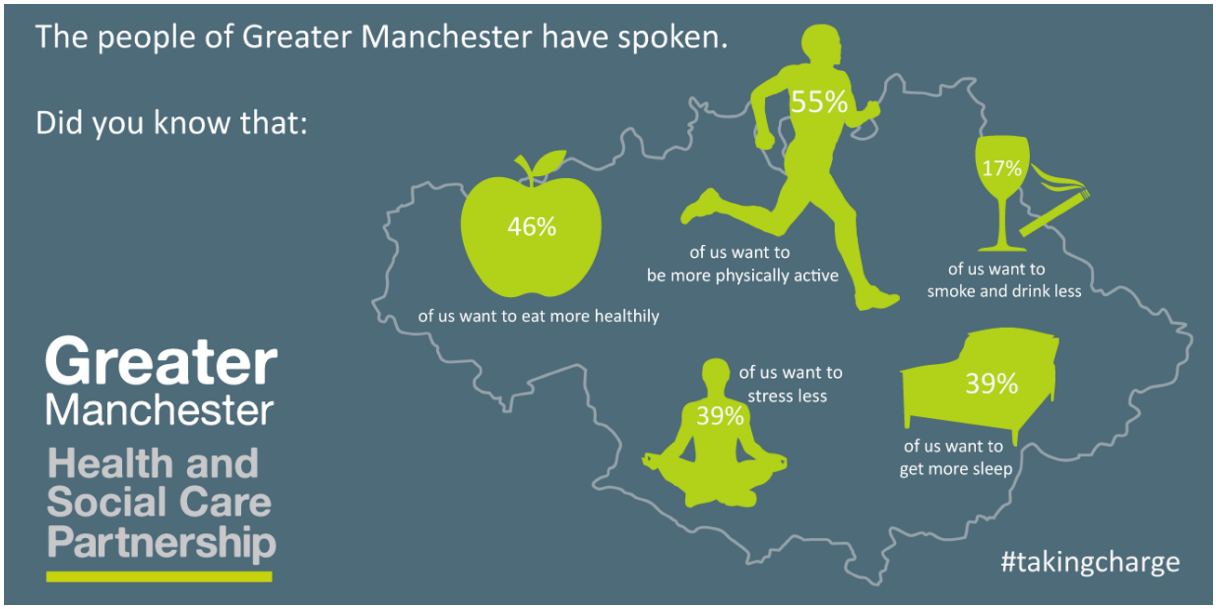


Figure 16: Greater Manchester population engagement responses to improving their lifestyle

This engagement process also generated new insights into the Greater Manchester population, which enabled us to group Greater Manchester people into one of six personas detailed below. However further ethnographic research is required to explore and refine these typologies further.

Figure 17: Greater Manchester population personas

4.3.3 Smoking

Despite good progress made in recent years, there are still over 423,000 adult smokers among the city-region's circa 2.8 million population. This is well above the England average (about 20% in Greater Manchester versus 17% nationally) and equates to around 63,500 more smokers than if at the England average.

Smoking is by far the biggest single cause of ill health as well as early death in Greater Manchester and in England. Figure 18 illustrates the scale and diversity of the deaths caused by smoking in England. Our Greater Manchester figures across localities for smoking-related cancers, respiratory and circulatory disease are higher than the England average, consistent with our higher than average smoking rates.

Smoking is also the biggest single contributor to health inequalities. More than half of the inequity in life expectancy between social classes is linked to higher smoking rates among poorer people. In Greater Manchester people in routine and manual (R&M) groups are far more likely on average to smoke than the general population, and R&M smoking rates in Greater Manchester are higher than the R&M England average.

Smoking prevalence remains lower than average in Black and minority ethnic groups, particularly in women, however, other tobacco use, such as oral and chewing tobacco and shisha use, is higher in some groups than in the general population and is a concern in some areas of Greater Manchester such as Oldham and Bolton and Manchester. The highest use of other tobacco products is in Manchester at 17.6% of the population and this extends to shisha use in the wider population.

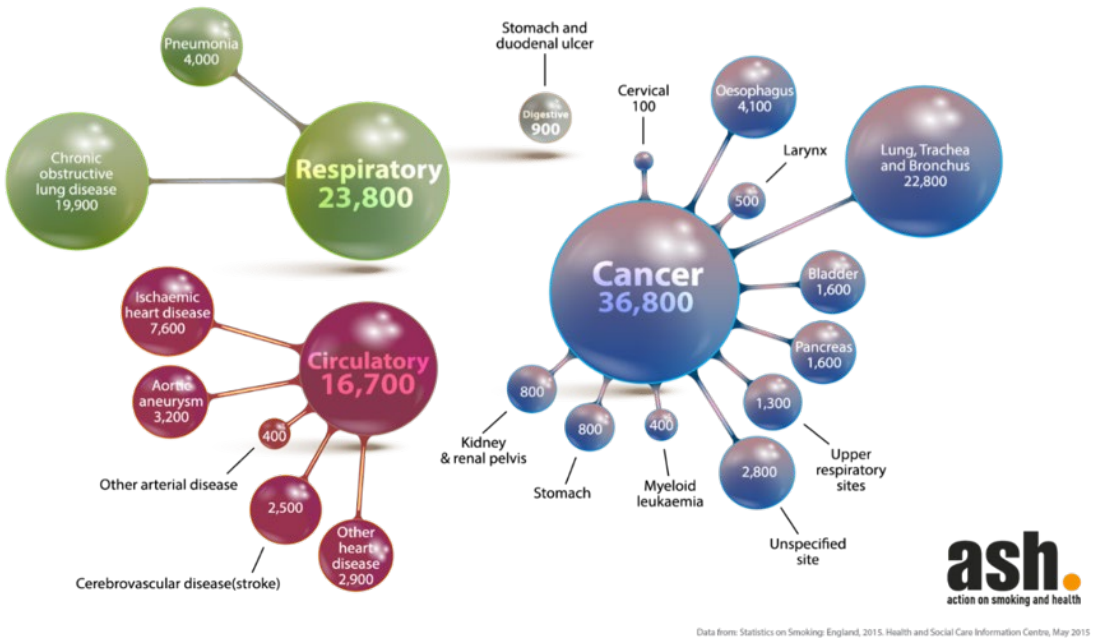


Figure 18: Variety of deaths caused by smoking

Figure 19 ('Smoking Still Kills', ASH 2015) illustrates the social divide in smoking rates in England that is reflected in Greater Manchester.

Smoking also has significant economic impacts in Greater Manchester at societal, systems, family and individual levels. The societal/systems costs of smoking are estimated to be £785 million a year (equating to £1,739 per smoker). This includes increased costs of health and social care, lost productivity, and house fires caused by cigarettes.

Research by ASH also shows that cutting smoking rates has the potential to lift some of Greater Manchester's poorest families out of poverty, as shown in Figure 20.

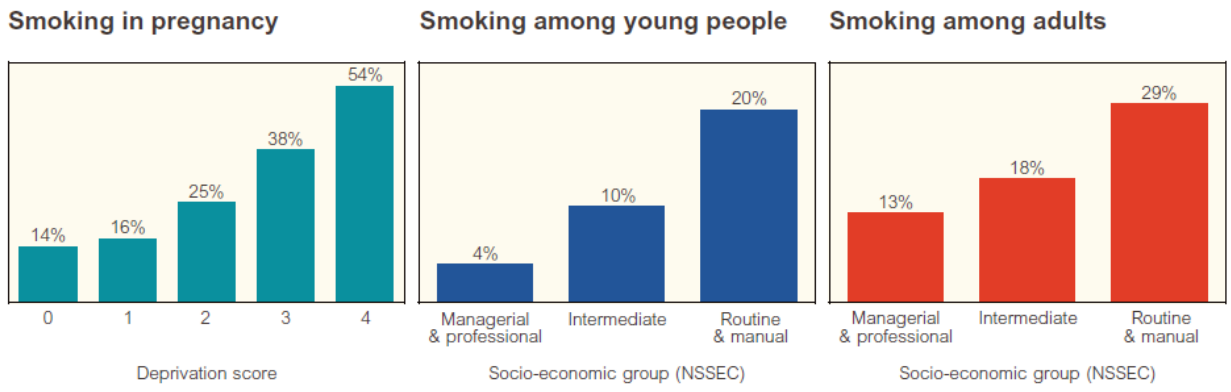


Figure 19: Data from Smoking Still Kills

Figure 20: Smoking and poverty

Sustained action is also needed to reduce the supply of, and demand for, illegal tobacco, which is cheap and unregulated. Its low price undermines high taxation that is key to encouraging 'cut-downs and quits' (the World Bank estimates a 10% price rise leads to circa 4% less consumption). The illegal trade also makes it easier for children to start and keep on smoking, and is linked to low-level and organised crime/terrorism. In Greater Manchester, illicit tobacco can be purchased for as little as £3 for a standard pack compared to the legitimate price of £7 for a standard retail pack of cigarettes.

While only 17% of respondents to the 'Taking Charge' engagement exercise wanted to smoke or drink less, we know from YouGov polling that actually the majority of those who smoke in Greater Manchester want to quit (only 10% of smokers don't want to quit) and two-thirds are supportive of efforts to tackle smoking.

4.3.4 Alcohol

Alcohol is inextricably linked with premature mortality – particularly through the causal link with at least seven types of cancer, including liver, bowel and breast cancer – and causes 80% of liver disease deaths.

Greater Manchester mortality rates are among the highest in the country in relation to alcohol-specific conditions (see figure 21).

Lower socio-economic status (SES) is associated with higher mortality for alcohol-attributable causes, despite lower socio-economic groups often reporting lower levels of consumption. People living in the most deprived decile are twice as likely to die from alcohol harm (16.1 per 100,000) than those living in the least deprived (8.3 per 100,000).

The demands placed on the NHS as a result of alcohol, both in terms of attendance at A&E departments at busy times and in terms of the impact on availability of beds, are significant. The rate of admissions for alcohol-related conditions has doubled nationally in a decade and is continuing to rise. Over 2014/15, there were over one million admissions in England, including 66,790 across Greater Manchester. The rate of admissions per 100,000 people is higher than the England average in all 10 Greater Manchester localities, and a disproportionate number relate to young people; there were 956 under-18s admitted to hospital due to alcohol, a rate of 52.1 per 100,000 compared with the England rate of 36.6 (see figure 22).

The combination of crime, worklessness and health and social care costs to Greater Manchester arising from alcohol-related harm are estimated at approximately £1.2 billion, equivalent to £436 for every man, woman and child living in Greater Manchester.

Alcohol-specific mortality (persons) 2012 to 2014

Directly standardised rate – per 100,000

Area	Value	Lower CI	Upper CI
England	11.6	11.4	11.8
Greater Manchester	-	-	-
Bolton	17.9	15.0	21.1
Bury	18.3	14.8	22.2
Manchester	24.1	21.1	27.3
Oldham	16.3	13.2	19.7
Rochdale	20.6	17.0	24.6
Salford	19.4	16.0	23.2
Stockport	17.3	14.6	20.3
Tameside	18.9	15.7	22.6
Trafford	17.9	14.7	21.4
Wigan	17.6	15.0	20.4

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

Figure 21: Alcohol mortality in the Greater Manchester region (CI=Confidence intervals)

Persons under 18 admitted to hospital for alcohol-specific conditions

Area	Value	Lower CI	Upper CI
England	36.6	36.0	37.3
Greater Manchester	52.1	48.9	55.5
Bolton	43.1	34.5	53.3
Bury	44.8	34.0	58.1
Manchester	47.9	40.8	55.9
Oldham	60.0	49.0	72.8
Rochdale	40.8	31.3	52.3
Salford	72.0	59.4	86.6
Stockport	59.5	48.8	71.8
Tameside	67.8	55.1	82.6
Trafford	32.1	23.9	42.2
Wigan	56.6	46.7	67.9

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

Figure 22: Alcohol-related under-18 hospital admissions in the Greater Manchester region

4.3.5 Physical inactivity and obesity

Doing less than 30 minutes of physical activity per week is one of the top 10 causes of early mortality. Greater Manchester has a high level of inactive population – around 677,600 residents (31% of the population versus the England average of 27.1%), with an estimated cost to health services in Greater Manchester of £26.7 million per year (2013/14 prices) related to the main chronic diseases (heart disease, diabetes, CVD and cancer) that could be prevented by exercise.

Levels of inactivity vary between localities, ranging from 22-33% across the 10 boroughs of Greater Manchester, and also across various under-represented groups.

- More than one in three females (35%) is inactive, compared to one in four males (26%).
- More than double the number of disabled people (56%) are inactive compared to non-disabled people (25%).
- Levels of inactivity range from 16% between the ages of 16-25 and 49% for those aged 65 and over.
- Between the upper National Statistics Socio-economic Classification (NS SEC) 1-4 and the lower NS SEC 5-8, levels of inactivity rise from 24% to 49%.

Physical activity programmes at work can reduce absenteeism by up to 20% and on average physically active workers take 27% fewer sick days. Nationally 131 million days were lost due to sickness absences in 2013, and 15 million days in the North West. A 20% reduction in the North West would reduce this by three million days. Furthermore, research suggests that participating in 3 x 30 minutes of activity per week could translate to an average increase in earnings of 7.5% due to improved productivity, social capital/networks and motivation to perform.

As well as being a risk factor for premature death in its own right, leading increasingly inactive and sedentary lifestyles – linked to time, work and more reliance on travelling by car – has also contributed to the steady rises seen in levels of obesity. While everyone would benefit from being more active every day, this is especially true in Greater Manchester, with 65% of adults and 28% of

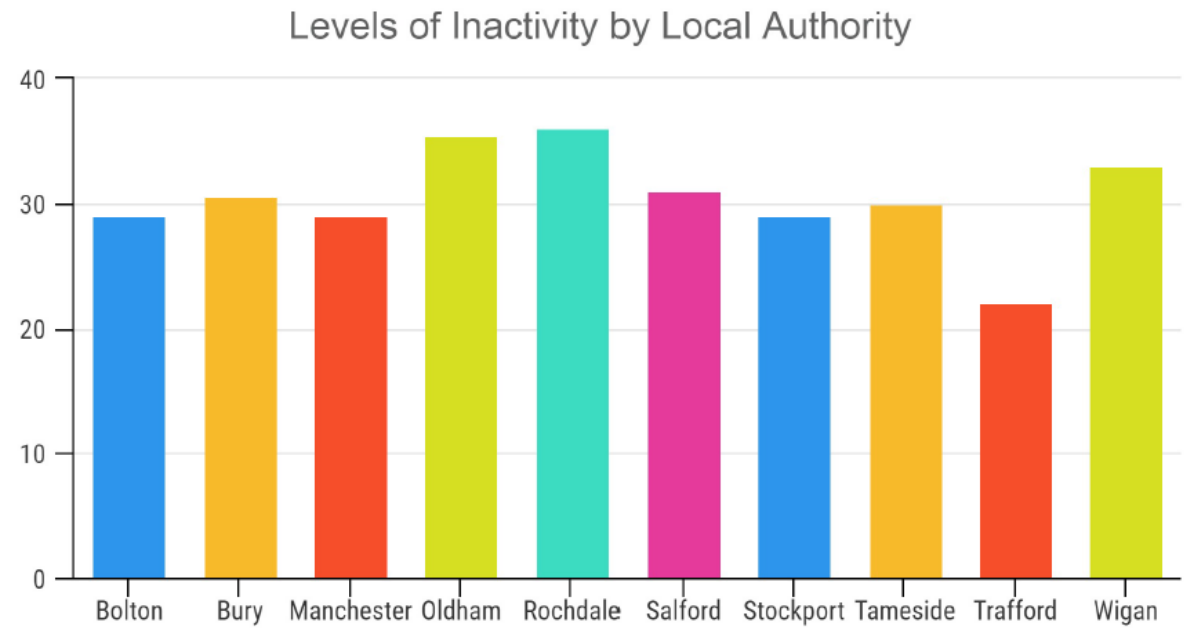


Figure 23: Levels of inactivity in the Greater Manchester region

Obesity prevalence and consumption of fruit and vegetables of children by Greater Manchester borough

Compared with benchmark Better | Similar | Worse | Lower | Similar | Higher | Not compared

Indicator	Period	England	Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Reception: Prevalence of overweight (including obese)	2014/15	21.9	22.0*	19.4	20.7	24.0	22.5	21.9	22.1	18.7	23.6	20.2	24.0
Year 6: Prevalence of overweight (including obese)	2014/15	33.2	34.7*	33.6	32.9	39.2	35.2	35.4	36.6	29.8	34.6	29.8	35.2
2.11v – Average number of portions of fruit consumed daily at age 15 (WAY survey)	2014/15	2.39	-	2.41	2.40	2.53	2.35	2.40	2.35	2.38	2.24	2.57	2.17
2.11vi – Average number of portions of vegetables consumed daily at age 15 (WAY survey)	2014/15	2.40	-	2.16	2.16	2.25	2.06	2.18	2.15	2.27	2.15	2.42	2.06

Source: Public Health Outcomes Framework http://www.phoutcomes.info/search/childhood%20obesity#page/0/gid/1/pat/103/par/E45000008/ati/102/are/E08000001

Figure 24: Obesity prevalence in the Greater Manchester region

children classified as overweight or obese, which is significantly worse than the UK average.

Bury, Oldham, Rochdale and Wigan have significantly higher levels, with between 67% and 69.5% of adults living with excess weight and obesity.

For children and young people, 22% of pupils in Greater Manchester are starting school in Reception with excess weight, which increases to over 35% when leaving primary school. These are much higher rates of childhood obesity than the rest of the country, according to the most recent National Child Measurement Programme (NCMP) data.

Obesity impairs lives. It raises the risk of serious physical health conditions such as diabetes, heart disease, stroke and cancer. Prevalence of obesity is higher among women of Black Caribbean, Black African and Pakistani ethnicities, compared to the other ethnic groups. It affects our mental health too and can stop us from fulfilling our potential and living a full and happy life.

Being overweight or obese is the main modifiable risk factor for type 2 diabetes, which is also on the increase and is a serious and incurable condition that has lifelong health implications. Currently 90% of adults with type 2 diabetes are overweight or obese. There are currently five million people in England at high risk of developing type 2 diabetes. In Greater Manchester, currently 164,000 people have type 2 diabetes and at least the same number of people are at risk of developing it.

If these trends persist, one in three people will be obese by 2034 and one in 10 will develop type 2 diabetes. However, evidence shows that many cases of type 2 diabetes are

preventable. There is also strong international evidence that demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

Obesity is widespread and appears to be increasing, but it can be very difficult to address at a whole-population level at the scale that is needed in Greater Manchester, and many approaches have already been tested. This plan presents an opportunity to think differently about how to address its root contributors – food and physical activity.

4.3.6 Opportunity

Devolution in Greater Manchester provides the opportunity to look at whole system innovative approaches to these major health risks, in order to fully harness the positive potential health impacts of the third sector, local government, employers and local communities themselves.

We will develop comprehensive, broad-based and hard-hitting Greater Manchester action at multiple levels and across sectors to address the major lifestyle risk factors, working in partnership with key national lead agencies such as Sport England and Public Health England.

A key principle behind the development of these new approaches will be building on the assets and skills we have in Greater Manchester, whether as individuals or communities, including forging stronger partnerships with charitable and voluntary sector organisations.

Work is already underway in the following areas.

The Greater Manchester Cancer Board has made reducing smoking a key focus within the emerging Greater Manchester Cancer Plan and is sponsoring work to develop a comprehensive Greater Manchester Tobacco Control Plan. The board believes that Greater Manchester should be a UK leader in becoming smoke free. Building on evidence from New York and other cities our approach will be:

- helping significantly more smokers to quit, working in partnership with smokers and a renewed commitment to meet their needs, to help them quit in whatever way works for them; greater investment in targeted year-round mass media and social marketing campaigns to educate and motivate quit attempts; and working across all sectors to exploit every opportunity to help smokers quit
- creating more smoke-free spaces. The mayor could lead the way for Greater Manchester by making the public places controlled by Greater Manchester authorities smoke free
- exploration of how further freedoms and flexibilities for Greater Manchester can reduce smoking prevalence through, for example, use of bye-laws for smoke-free spaces; consulting on raising the age of tobacco sales to 21; introduction of a Greater Manchester licensing scheme for tobacco retailers and wholesalers
- launching a fresh crackdown on the trafficking in, and selling of, illegal tobacco.

The GMCA's Greater Manchester Alcohol Strategy 2014–2017 continues to take forward a programme of activity across 11 strategic priorities, seeking to: support a focus on growth and reform; promote effective practice within Greater Manchester; and challenge the status quo on key national policy issues. Work taken forward through the strategy has contributed to a range of business areas, including the following.

Licensing, regulation and compliance – Greater Manchester authorities are promoting the effective and consistent use of licensing/ regulatory tools and powers, with a best-

practice toolkit devised, strong lobbying for change in respect of the 2003 Licensing Act, and a suite of devolution 'asks' tabled with government.

Alcohol campaigns and awareness raising – supporting the principle of local democratic leadership on public health, work through the strategy has maximised the impact of Greater Manchester campaign activity (with a particular focus on protecting young people from the harm of alcohol advertising). This has complemented local targeted campaigns to reach priority groups such as middle-aged drinkers and female drinkers, and specific programmes looking at the issue of drinking at home.

New solutions to addressing the key drivers of avoidable ill health – a Communities in Charge of Alcohol (CICA) programme is being developed, which recognises that the citizens of Greater Manchester will be active participants in supporting and enabling their own better health outcomes, and seeks to establish a new network of health champions. Parallel, asset-led work is also pursuing fresh collaboration opportunities with Greater Manchester universities and unions in respect of building a culture of responsible attitudes towards alcohol. At the locality level, Greater Manchester's recent status as a Home Office initiative: Wave 1 Local Alcohol Action Area has provided continued impetus to address alcohol health harm through effective, recovery-oriented treatment, with a greater focus on early intervention and prevention.

'Greater Manchester Moving: The Blueprint for Physical Activity and Sport' was established in 2015 as the foundation for a social movement to reduce inactivity and increase physical activity across Greater Manchester. Subsequently, in 2016 a memorandum of understanding (MoU) was signed between Sport England, the GMCA and the NHS in Greater Manchester. This provides an agreed framework to explore the delivery of both the Government's and Sport England's strategies for sport and physical activity at a Greater Manchester level, placing the customer first and central to all thinking and delivery while contributing to the strategic priorities of Greater Manchester, particularly regarding health, economic growth and social wellbeing.

The MoU will:

- have a framework that provides fundamentally different propositions to enable healthier, more resilient and empowered residents to take charge of their own wellbeing, including supporting inactive neighbourhoods and communities
- develop an insight-led, behaviour-change approach to sport and physical activity, starting with the individual and their communities and designing and delivering sport and physical activity according to their specific needs and wishes
- have shared metrics, performance measures and a robust cost benefit analysis for all joint areas of work, which will specifically include decreasing the number of inactive people, increasing participation of under-represented groups and increasing the number of people taking part in sport and physical activity more regularly
- demonstrate impact across government's five outcomes for sport and physical activity – physical health, mental wellbeing, individual development, social/ community development, and economic development.

We recognise that work needs to be developed at a Greater Manchester level to address the significant challenges related to obesity. We need to build on the best practice already underway such as the NHS Diabetes Prevention Programme (NHS DPP). The NHS DPP is a joint commitment from NHS England, Public Health England and Diabetes UK to deliver at-scale, evidence-based, behavioural interventions for individuals

identified as being at high risk of developing type 2 diabetes. Framing the problem posed by obesity in the context of diabetes is one important element of a wider programme to address obesity, but this needs to sit alongside collaborative approaches targeting the achievement of higher levels of physical activity in the general population as the 'norm', and innovative approaches towards food and nutrition. A focus on socio-economic and wider inequalities must form part of this.

From April 2017, all areas of Greater Manchester will start to offer behavioural interventions to people at risk of developing type 2 diabetes. This follows Salford leading as a demonstrator site, Bury, Oldham and Rochdale being early adopters and a successful bid led by the Greater Manchester Strategic Clinical Network to incorporate a further eight areas in to the NHS Diabetes Prevention Programme (NHS DPP). Those people identified and found to be applicable will be invited to attend an evidence-based course that either delays the possibility of developing type 2 diabetes or prevents it altogether.

Lifestyle and wellness services

The drive to more person-centred wellness and lifestyle services, which recognises that many of our Greater Manchester population have multiple unhealthy lifestyle risk factors and requires person-centred approaches that address the psychosocial and wider determinants of health, has been around for a number of years; however, progress has been slow. In addition, the reach of such services into the populations most at need is limited and more work needs to be done to extend such service offers into the C2DE cohort (the three lower socio-economic groups) with particular focus on 40 to 60-year-olds. Devolution offers us an opportunity to deliver a radical upgrade in lifestyle behaviour change support that delivers innovative approaches at scale to drive long-term behaviour changes and reduces current and future demand on health services from lifestyle-related long-term conditions.

Our role as public sector employers

We also want to ensure that, as a public sector and major employer accounting for over 18% of all jobs in the region, we are a positive role model for workplace health, innovating and implementing best practice to support our 219,400 staff to stay healthy and serve as health champions in their local communities.

4.3.7 Plan

4.3.7.1 Objectives

The objectives of this programme are to develop Greater Manchester-wide approaches to tackle the main lifestyle risk factors, i.e. smoking, physical inactivity, alcohol, poor diet and obesity, including developing innovative approaches that can be tested at scale.

Objective 1: To develop a comprehensive Greater Manchester Tobacco Control Plan that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

Objective 2: To support the development and implementation of a refreshed and integrated GMCA Substance Misuse Strategy.

Objective 3: To develop a comprehensive plan to reduce inactivity and increase participation in physical activity and sport that is aligned to the Population Health Plan priority themes and wider reform agenda.

Objective 4: To develop a comprehensive plan for better nutrition and healthy weight that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

Objective 5: To develop a whole systems approach to lifestyle and wellness services, including testing innovative service delivery models for incentivising and supporting lifestyle behaviour change, and to:

- work with a pathfinder local provider to test out and develop an effective delivery model aimed at promoting a radical upgrade in self-care and lifestyle prevention, which can be tested at scale in parts of Greater Manchester
- develop and test an innovative incentives-based digital platform to support lifestyle behaviour change at scale aimed at Greater Manchester's public sector workforce
- develop standards and a performance framework for Greater Manchester integrated wellness services to ensure a more standardised offer for Greater Manchester residents
- develop the role of wider primary care in supporting lifestyle behaviour change

4.3.7.2 Approach to delivering objectives

Objective 1: To develop a comprehensive Greater Manchester Tobacco Control Plan that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

The project will seek to:

- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- utilise best evidence and modelling analysis for Greater Manchester to identify the key components of a comprehensive plan
- engage with all key sectors, organisations and localities to identify their contribution to a Greater Manchester plan
- produce a detailed plan and implementation timeline
- work with New Economy Manchester to carry out cost benefit analysis to support bid to Transformation Fund and development of evaluation framework for plan
- develop and secure transformation funding to resource key elements of plan.

Objective 2: To support the development and implementation of a refreshed and integrated GMCA Substance Misuse Strategy.

The project will seek to:

- secure full support of the Greater Manchester health and social care system to the process of refreshing the strategy and defining an integrated suite of shared priorities
- leverage support for all relevant workstreams within the Greater Manchester Substance Misuse Review – with the ultimate aim to ensure that substance misuse service delivery for drugs, alcohol and new psychoactive substances is better co-ordinated and delivering the best possible outcomes across Greater Manchester
- embed strategic dialogue on alcohol harm in the wider context of devolution, and promote collaborative commissioning through a recognition of alcohol as a cross-cutting priority in other Population Health Plan theme areas.

Objective 3: To develop a comprehensive plan to reduce inactivity and increase participation in physical activity and sport that is aligned to the Population Health Plan priority themes and wider reform agenda.

The project will seek to:

- engage with all key sectors, organisations and localities to identify their contribution to a Greater Manchester plan
- develop an insight-led, behaviour-change approach to sport and physical activity, starting with the individual and their communities
- produce a detailed plan and implementation timeline to drive the outcomes of the MoU

- develop opportunities to secure Greater Manchester and national resource to enable delivery of key elements of plan, which would include having shared metrics, performance measures and a robust cost benefit analysis for all joint areas of work.

Objective 4: To develop a comprehensive plan for better nutrition and healthy weight that is fully aligned to the Population Health Plan priority themes and wider reform agenda.

The project will seek to:

- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- utilise best evidence and modelling analysis for Greater Manchester to identify the key components of a comprehensive plan
- engage with all key sectors, organisations and localities to identify their contribution to a Greater Manchester plan
- produce a detailed plan and implementation timeline
- work with New Economy Manchester to carry out cost benefit analysis to support bid to Transformation Fund and development of evaluation framework for plan
- develop and secure transformation funding to resource key elements of plan.

Objective 5: To develop a whole systems approach to lifestyle and wellness services, including testing innovative service delivery models for incentivising and supporting lifestyle behaviour change.

Objective 5.1: Work with a pathfinder local provider to test out and develop an effective delivery model aimed at promoting a radical upgrade in self-care and lifestyle prevention, which can be tested at scale in parts of Greater Manchester.

This project will seek to:

- use national exemplars and local good practice to document a replicable and scalable model that can be tested at scale in parts of Greater Manchester
- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- secure local provider partners to be part of the trial
- work with New Economy Manchester to develop an initial cost benefit analysis based on work to date and to support development of transformation bid
- develop a business case to support the adoption and testing of the new model across two or three localities and secure monies from Greater Manchester Transformation Fund
- support a number of localities to collaborate to implement the described model, recognising the local variations that may be required
- develop a business case that builds on the evaluation of testing the model to support expansion of the project across other parts of Greater Manchester.

4.3.7.3 Programme of work – scope

The proposal is to develop a three-tiered behaviour-change support offer across Greater Manchester (see figure 25). This is in effect a hub and spoke model. The first two tiers, including a web portal and virtual telephone support, can be provided at a sector level and will integrate with the third tier, which is the locality-based lifestyle and wellness service offer.

A key principle is that of proportionate universalism, where the service response will be according to need.

The primary audience for the service will be the target demographic for the Public

Health England One You lifestyle campaign. This is C2DE aged 40-60, because evidence suggests a strong link between unhealthy behaviours and social class and NICE identifies the 40-60 age group as a key window of opportunity to engage adults in their own health to prevent disease in later life. This enables Greater Manchester to capitalise on the current national campaign of focus (One You) and prioritise digital content to support its delivery.

Objective 5.2: Develop and test an innovative incentives-based digital platform to support lifestyle behaviour change at scale aimed at Greater Manchester's public sector workforce.

The project will seek to:

- secure an existing developer to develop a bespoke incentivised digital health platform to support at scale self-care, and pilot the programme with Greater Manchester public sector staff
- undertake consumer research to ensure that the incentives package is attractive to the target audience
- work with developer and New Economy to carry out cost benefit analysis to support bid to Transformation Fund
- develop a costings model that includes staffing costs and non-pay budget to secure services of an expert reference group
- develop and secure transformation funding to resource the development, commissioning and evaluation of a pilot programme for Greater Manchester public sector staff
- evaluate service model to inform further roll-out.

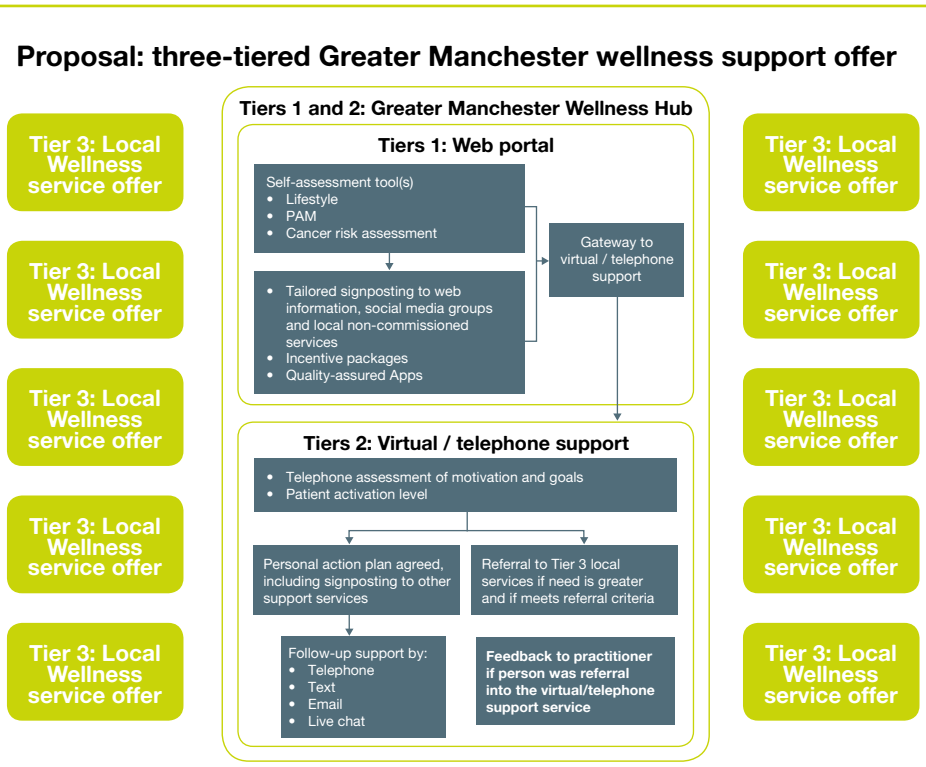


Figure 25: Three-tiered Greater Manchester wellness support offer

4.3.7.4 Programme of work – scope

This is a more basic service delivery model in comparison with the lifestyle and wellness hub described above.

Its central feature is the provision of an online incentives package that rewards participants for undertaking health promoting behaviours such as screening or quitting smoking.

It would take the form of a digital platform, with an interactive directory and incentivised health platform (see figure 26).

Such a platform could also support other digital offers, such as Orcha, a Wakelet page for community champions to collect and share content, and access to managed social media options.

Objective 5.3: Develop standards and a performance framework for Greater Manchester integrated wellness services to ensure a more standardised offer for Greater Manchester residents.

The project will seek to:

- define key standards and performance metrics that describe a consistency of approach and quality against which services can be commissioned, monitored and evaluated
- gain agreement from the system to adopt and implement the standards and performance framework
- launch the framework to cement support across the system for this way of working.

Objective 5.4: Develop the role of wider primary care in supporting lifestyle behaviour change.

The project will seek to:

- develop the role of the primary dental care setting in delivering brief interventions, particularly focusing on smoking cessation and reduction of harmful drinking (both significant risk factors for mouth cancer as well as other health conditions)

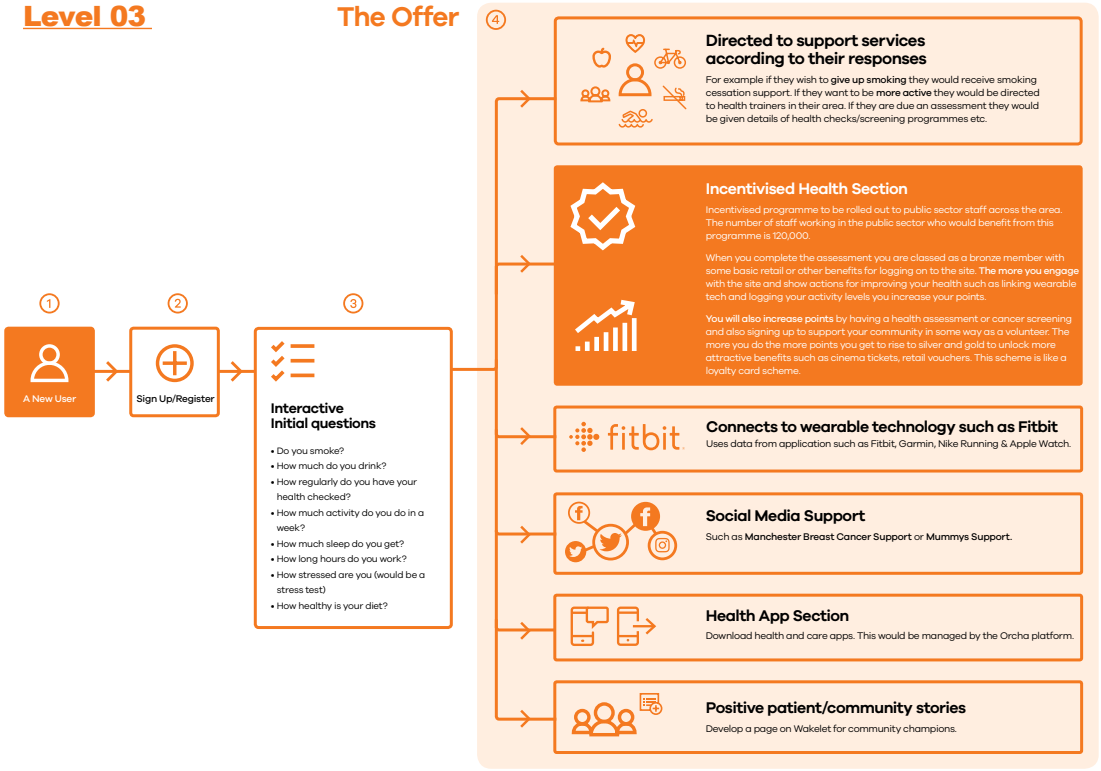


Figure 26: Infographic for incentives based digital platform

- facilitate the roll-out of the Healthy Living Framework to all pharmacy, optometry, dental and general practice providers.

4.3.7.5 Target outcomes for 2016/17 and 2017/18

Outcome 1: Comprehensive Greater Manchester Tobacco Control Plan produced that is fully aligned to the Greater Manchester Population Health Plan priority themes and wider reform agenda

Outcome 2: Refreshed and integrated GMCA Substance Misuse Strategy developed and implemented

Outcome 3: Comprehensive physical activity plan produced aimed at reducing inactivity and increasing participation in sport and physical activity, and fully aligned to the Greater Manchester Population Health Plan and wider reform agenda

Outcome 4: Comprehensive plan for better nutrition and healthy weight produced, linked to the Population Health Plan priority themes and wider reform agenda

Outcome 5a: New delivery model tested and evaluated with pathfinder local provider, aimed at promoting a radical upgrade in lifestyle prevention and self-care

Outcome 5b: Innovative incentives package to support lifestyle behaviour change for public sector workforce tested and evaluated

Outcome 5c: Greater Manchester will have a standards and performance framework for lifestyle services agreed by all commissioners to support localities

4.4 Cancer prevention and early detection

4.4.1 Background

Cancer survival rates are at their highest, with more than half of those diagnosed living for at least 10 years. However, it is estimated that by 2020 more than one in two people will be affected by cancer at some point in their lives, which is particularly alarming given evidence suggesting that 42% of the country's most common cancer cases could be preventable. In the last five years, almost 600,000 cancer cases in the UK could have been prevented by modifications to lifestyle factors.

The NHS Five Year Forward View signalled a continued focus on improving care, treatment and support for everyone diagnosed with cancer. It set an ambition to improve outcomes across the whole pathway, including:

- better prevention
- swifter diagnosis
- better treatment, care and aftercare.

In 2015, following the publication of the NHS Five Year Forward View, NHS England established the Independent Cancer Taskforce to look at how cancer services are currently provided and to set out a vision for what cancer patients should expect from the health service. The taskforce produced a report, 'Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020', which included 96 recommendations to help transform the care that the NHS delivers for all those affected by cancer.

A plan has now been launched to deliver these changes. It is designed to increase cancer prevention, speed up diagnosis, invest in technology, improve patient experience and help people living with and beyond cancer.

As part of this plan, new models of care piloted by the National Cancer Vanguard will aim to radically improve patient outcomes and save thousands of lives every year by developing new models of care that are ambitious and transformational, and provide replicable models for cancer care nationally that will act as blueprints for the NHS. Its key objectives are to:

- improve rates of earlier diagnosis and detection

- improve patient outcomes
- reduce variation
- improve patient experience

The National Cancer Vanguard is led by The Christie, The Royal Marsden and University College London Hospitals. The three organisations will lead a local delivery system – Greater Manchester Cancer, Royal Marsden Partners and University College London Hospitals Cancer Collaborative – which comprises health organisations in their area, including clinical commissioning groups, NHS acute trusts, community services and hospices, that will develop and trial new models to improve cancer care along the patient pathway.

4.4.2 Greater Manchester context

A key commitment in 'Taking Charge' is to deliver improvements in our cancer services and outcomes, with a particular focus on reducing premature mortality from cancer by 1,300 fewer deaths by 2021. This is based on the transformation of our health and social care system towards prevention and earlier intervention.

Half of people born since 1960 will be diagnosed with cancer in their lifetime, and every 30 minutes someone in Greater Manchester is told they have cancer. The incidence of cancer is growing at a rate of about 2% per annum; in 2013, 14,500 people were diagnosed with cancer in Greater Manchester. This means the burden of cancer on our health and social care system is growing. There were 89,200 GP referrals for suspected cancer to Greater Manchester hospitals in 2014/15, up from 77,800 the year before. The National Audit Office estimates cancer-related costs for the NHS in England – extrapolating from these costs for Greater Manchester gives approximate costs of £335m in 2012/13, rising to £650m by 2020/21 (acknowledging that these do not capture all costs, such as those incurred by primary care).

Clearly we will not be able to sustain comprehensive health and social care coverage unless we take more concerted action on prevention. Rising numbers of cancer cases that could be prevented should be seen as unacceptable. It is within our control to prevent many cases of cancer and we should seize this opportunity. More than four in 10 cases of cancer are caused by aspects of our lifestyles that we have the ability to change. Tobacco remains the main risk factor, followed by obesity, alcohol consumption and physical inactivity.

Earlier diagnosis of the disease is also essential if we are to take meaningful steps in improving survival for our patients. The key here is a strong focus on improving the uptake of the three national cancer screening programmes. Screening contributes to reducing incidence and improving outcomes for those patients whose cancers can be treated at an earlier stage. England's existing cancer screening programmes already save thousands of lives each year. However, there is potential to do better, to reduce the considerable variation in uptake of these programmes and further develop the programmes by introducing new tests.

With increasing numbers of people surviving their primary cancer, we also need a stronger focus on preventing secondary cancers.

4.4.3 Opportunity

In 2015 Greater Manchester was designated as part of the National Cancer Vanguard. The two-year vanguard programme will allow the testing of clinical innovations and a new approach to the commissioning of cancer and delivery for the Greater Manchester population. It began delivery in April 2016. Central to the Greater Manchester programme is a prevention workstream, which incorporates primary and secondary prevention projects as well as a focus on screening.

In summer 2016 a new Greater Manchester Cancer Board was established to oversee all cancer activity in the area, and it will develop a five-year cancer plan to transform services and re-orientate the system towards prevention and early detection. This is an opportunity for Greater Manchester to strengthen and build on the work of the National Cancer Vanguard and other innovations such as the Macmillan Cancer Improvement Partnership (MCIP), led by the three CCGs in Manchester.

As identified above we want to reduce premature mortality from cancer by 1,300 fewer deaths by 2021. On average, over a three-year period from 2012-14, cancer was responsible for 7,571 deaths in Greater Manchester and half of those were preventable. The main driver of premature mortality and health inequalities in Greater Manchester is related to tobacco. Despite significant improvements made in recent years to reduce smoking, smoking rates in Greater Manchester are significantly higher than in the rest of England and 21% or about 450,000 adults still smoke. This equates to around 70,000 more smokers than if Greater Manchester was at the England average. Smoking also significantly contributes to health inequalities, as smoking rates among our poorest families are twice the Greater Manchester average. Therefore a key focus of work for the Greater Manchester Cancer Board will be tobacco control.

4.4.4 Plan

4.4.4.1 Objectives

The overall objectives of the programme are to effectively deliver the cancer prevention workstream of the National Cancer Vanguard by April 2018, testing and evaluating innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle-based secondary prevention. This includes four key objectives.

- **Objective 1:** To develop new Greater Manchester-wide social marketing strategies for cancer to scale up prevention and earlier detection
- **Objective 2:** To apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, as part of the national pilot programme Health as a Social Movement
- **Objective 3:** To improve access to, and uptake of, three national cancer screening programmes (bowel, breast, and cervical) among the eligible population of Greater Manchester residents
- **Objective 4:** To develop a Greater Manchester-wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis)

Furthermore, through the MCIP work the three Clinical Commissioning Groups in Manchester are pilot testing an innovative service that aims to detect lung cancer earlier. The pilot service offers people at high risk of lung disease an opportunity to attend a lung health check. If the pilot of the MCIP lung health check is shown to be successful we will roll it out across Greater Manchester to transform our lung cancer outcomes.

4.4.4.2 Approach to delivering objectives

Objective 1: To develop new Greater Manchester-wide social marketing strategies for cancer to scale up prevention and earlier detection.

In Year 1 the project will seek to:

- work in partnership with PHE/Cancer Research UK (CRUK) to test out, deliver and evaluate a major bowel screening campaign to improve uptake, featuring mass media (TV, outdoor media etc) and direct mail

- commission additional behavioural insights research into Greater Manchester to gain a deeper understanding of the core behavioural attitudinal barriers and motivators for our population
- use the insights gained to amplify the CRUK/PHE campaign activity to nudge further Greater Manchester audiences into participation
- undertake evaluation to inform future national and local campaign activity.

In Year 2 the programme will:

- commission primary and secondary qualitative and quantitative research to segment, profile and prioritise our smoking population
- using the above audience profiling and behavioural insights, design a social marketing programme
- co-ordinate delivery and evaluation of Greater Manchester social marketing programme
- undertake evaluation to inform future campaign activity.

Objective 2: To apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, as part of the national programme to pilot Health as a Social Movement.

The project will seek to:

- work in partnership with the third sector to develop an exemplar social movement –focused on cancer prevention
- apply at scale a multi-faceted approach to nurture a citizen-led social movement across the entire cancer prevention spectrum
- develop a network of 20,000 cancer champions and expert patients to provide a 'more than medicine' approach
- demonstrate 'what works' using rigorous evaluation approaches
- support spread – in Year 3, identifying approaches that could be scaled or adapted and adopted in other communities
- explore the digital opportunities that would support mass involvement, such as social media approaches.

Objective 3: To improve access to, and uptake of, three national cancer screening programmes (bowel, breast, and cervical) among Greater Manchester's eligible population.

The project will seek to:

- increase the effectiveness of the initial invites letters through the application of innovative behavioural insight techniques. This will involve running randomised control trials over a six-month period to test out the different approaches
- commission health equity assessments (HEAs) for all providers of cancer screening services to identify inequities in service usage and test out service changes based on findings of HEAs
- design and test out innovative patient engagement approaches to improve people's experience of screening and to increase uptake of screening and self-care
- evaluate different approaches to inform local and national roll-out.

Objective 4: To develop a Greater Manchester-wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis).

The project will seek to:

- develop and test out an effective delivery model of lifestyle-based secondary prevention as part of the vanguard's new aftercare pathways for breast, urology and colorectal cancer

- develop and roll out a locality-based, lifestyle behaviour change support offer with a focus on Greater Manchester-wide access to exercise referral programmes for cancer survivors, providing increased access to tailored physical activity programmes
- develop and test a digital platform (tech bundle) to enable cancer patients to access professionally approved secondary prevention self-management content, mobile applications, managed social support networks and links to locality-based prevention services
- evaluate different approaches to inform further roll-out.

4.4.4.3 Outcomes

The overall objective is to make a significant contribution to reducing the number of premature deaths due to cancer by 1,300 fewer deaths by 2021, through improved prevention and earlier diagnosis. More specific outcomes include:

- **Outcome 1:** Increased uptake of bowel screening (+10% in first timers and +3% in non-responders)
- **Outcome 2: I**ncrease in smoking quitters
- **Outcome 3:** The development of a mass social movement across the entire cancer prevention spectrum that is ultimately self-sustaining, and spread of effective approaches to other communities/areas
- **Objective 4:** Improved uptake to the three national cancer screening programmes (bowel, breast, and cervical) among the eligible population of Greater Manchester residents
- **Objective 5:** The development of lifestyle support offer for cancer survivors in Greater Manchester with a focus on secondary prevention of cancer

4.5 Scaling up our response to HIV eradication

4.5.1 Background

A 2015 report by Public Health England (PHE) estimated that 103,700 people were living with HIV in the UK in the year 2014. Once people are diagnosed they are able to receive very effective treatment. However, nationally 17% of people living with HIV are unaware of their status. Furthermore, 40% of adults newly diagnosed with HIV were diagnosed late, after they should have started treatment (PHE, 2014).

Late diagnosis reduces health outcomes for HIV-positive people, as well as increasing the likelihood of onward transmission of HIV. In addition to the negative effects of late HIV diagnosis on an individual's and population's health, it also makes an impact upon the public purse; the lifetime treatment cost of living with HIV is estimated to be around £360,000. Late diagnosis increases further the cost of HIV treatment by 50%.

It is well recognised that HIV symptoms are frequently missed. As a consequence, many people that have been diagnosed with HIV have previously presented at a healthcare setting but HIV diagnosis had been missed. Furthermore, while HIV is a condition that can affect all population groups, some communities are more disproportionately affected by HIV.

- Gay, bisexual and other men who have sex with men (MSM): Across the UK, one in 20 gay men is living with HIV. In large cities like Manchester, the figure is more likely to be one in 10. A total of 44,980 gay, bisexual and other men who have sex with men are living with HIV (prevalence of 4.8%).
- People from Black and minority ethnic groups (BME) made up 40% of HIV-positive individuals accessing treatment and care in Greater Manchester in 2015, a substantial over-representation compared

to the proportion of BME groups in the Greater Manchester population as a whole (16%).

- Transgender population: One worldwide meta-analysis of 39 studies from 15 countries found that transgender women had an HIV prevalence rate of 19% – 49 times higher than that of the general population. In high-income countries the prevalence was 22%, with the highest rate among transgender women of colour (aidsmap, 2016).

Late diagnosis of HIV is a key public health issue as identified within the Public Health Outcomes Framework. If someone has a late HIV diagnosis, they are 10 times more likely to die within the first year of diagnosis compared to people diagnosed promptly (PHE, 2014).

It has also been recognised that further progress needs to be made in improving early diagnosis of HIV; nationally, there is a need to increase and target HIV testing in order to improve early diagnosis and to reduce onward transmission by getting people onto treatment. Early diagnosis results in earlier treatment (National Institute for Health and Care Excellence, 2016).

We have an opportunity in Greater Manchester to strengthen a city-region approach to eradicating HIV within a generation, by adopting a similar approach to the Fast-Track Cities Initiative.

The Fast-Track Cities Initiative aims to build upon, strengthen and leverage existing HIV programmes and resources in 'high HIV burden' city-regions to strengthen local AIDS responses, including attaining the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets:

- 90% of all people living with HIV (PLHIV) will know their status
- 90% of all PLHIV will receive sustained antiretroviral therapy (ART)
- 90% of all PLHIV on ART will have durable viral suppression.

4.5.2 Greater Manchester context

There is clear synergy with a city-region approach to eradicating HIV within a generation and the vision of transforming population health in Greater Manchester; to deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester.

In particular, a city-region approach fits with the Greater Manchester objective to transform our health and social care system to help more people stay independent and well and take better care of those who are ill. It does this by preventing onwards transmission of HIV, both through earlier diagnosis and identification of undiagnosed people living with HIV; across Greater Manchester there are estimated to be 984 people living with undiagnosed HIV. These individuals are very much a part of the 'missing thousands' (i.e. those that are unknown to the system, but live and work in the community) identified within Greater Manchester priorities. An innovative, ambitious programme of upscaling of HIV testing and associated interventions, particularly targeted at and with those communities most at risk of acquiring HIV, is an opportunity for Greater Manchester.

The Fast-Track Cities Initiative complements and adds value to the Greater Manchester focus on Health as a Social Movement through utilising the assets of communities, supporting people to talk about the importance of HIV testing and sharing people's stories of how they maintain their wellbeing. This is focused upon communities taking charge of their own health.

Reducing late diagnosis of HIV is a key Public Health Outcomes Framework indicator. Upscaling targeted HIV testing is a key mechanism to achieve this. A combination approach to prevention is a key part of the Fast-Track Cities Initiative, which includes not

only testing but also pre-exposure prophylaxis (PrEP), prompt access to treatment and support with adherence.

- 4,922 HIV-positive Greater Manchester residents accessed treatment and care in 2014, a 5% increase on the number reported in 2013 (4,682 individuals).
- It is estimated that one in six people living with HIV in the UK is yet to be diagnosed.
- This means there could be approximately a further 984 people living undiagnosed with HIV in Greater Manchester.
- Overall prevalence of HIV in Greater Manchester is 2.78 per 1,000 population, (significantly higher than the England rate of to 2.1 per 1,000).
- Two local authorities in Greater Manchester, Manchester (5.83 per 1,000 population aged 15-59) and Salford (4.8) have an adult prevalence of over two per 1,000 population, the threshold at which the British HIV Association recommends routine testing for all medical admissions and new GP registrants.
- The dominant mode of HIV exposure is men who have sex with men (MSM) at 57% of new cases, followed by heterosexual sex, representing 37% of new cases.
- The predominant route of infection for new cases in 2014 was MSM (57%) but this varied across local authorities, with the majority of new cases in Stockport, Bury and Trafford being among MSM (71%, 62%, and 62% respectively) while in Wigan a higher proportion of new cases were acquired heterosexually (56%).
- People from BME groups made up 40% of HIV-positive individuals accessing treatment and care in Greater Manchester in 2015, a substantial over-representation compared to the proportion of BME groups in the Greater Manchester population as a whole (16%).
- Compared to other people living with HIV, people who died of an AIDS-related cause in 2014 had the highest mean number of outpatient visits (5.8) and spent the greatest mean number of days as inpatients (19.6 days).

4.5.3 Opportunity

There is opportunity to develop a city-region approach to eradicating HIV within a generation. Greater Manchester devolution and closer integration and collaborative approaches present opportunities for cross-sector partnership working to eradicate HIV within a generation, with public, voluntary and private sectors developing an ambitious programme to identify the missing 984 people living with HIV.

Deeper exploration of the barriers and enablers of reducing late and undiagnosed HIV across Greater Manchester will help formulate a Greater Manchester strategy to eradicate HIV within a generation. Shared Greater Manchester system leadership will provide opportunities for analysis of how both more frequent and earlier HIV testing, at scale and targeted at those communities most at risk, could be implemented.

This Greater Manchester-wide city-region approach will also encompass transferable learning for addressing other health priorities and inequalities. This would include the similar challenges with early diagnosis of hepatitis B and hepatitis C, which this Greater Manchester approach can also help to tackle.

There are pockets of existing or recent best practice in individual Greater Manchester boroughs, which could be more fully explored to identify areas that could be scaled up via a Greater Manchester approach. Regarding community-based HIV testing, LGBT Foundation is working in partnership with health equalities charity BHA, local PHE teams and sexual health commissioners to provide point-of-care HIV testing in community settings, churches etc. This approach is

particularly targeting those most at risk of acquiring HIV infection; gay, bisexual and other MSM and Black African communities. The project is currently in its delivery phase but it is proving to be successful and there are opportunities to explore scaling up provision and replicability in its community-led and focused approaches.

A city-region approach and Greater Manchester strategy also provides opportunities to explore associated enablers for eradicating HIV within a generation. These could include evaluation of access to post-exposure prophylaxis (PEP) and exploration of how partner notification is currently working in Greater Manchester.

4.5.4 Plan

4.5.4.1 Objectives

The objectives of this programme of work are to help develop a Greater Manchester city-region approach to eradicating HIV within a generation. It would facilitate the roll-out, testing and evaluation of an approach to tackling issues around undiagnosed and late diagnosis of HIV. The project would be informed by existing good local practice, including the current PHE community-based point of care test project, access to HIV testing within healthcare settings and PEP. The project is set up to achieve the following core objectives.

- **Objective 1:** Review and map out current HIV testing approaches and related interventions across Greater Manchester, to inform the ambition of eradicating HIV within a generation.
- **Objective 2:** Develop a business case that builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a Greater Manchester city-region approach to eradicating HIV within a generation. To then pilot and evaluate a Greater Manchester city-region approach to eradicating HIV within a generation.

4.5.4.2 Approach to delivering objectives

Objective 1: Review and map out current HIV testing approaches across Greater Manchester, to inform the ambition of eradicating HIV within a generation.

The project will seek to:

- describe a Greater Manchester vision around reducing undiagnosed and late HIV diagnosis
- work with the Greater Manchester Sexual Health Network, mapping out current HIV testing methods and associated interventions
- utilise data within the public health domain to inform future HIV testing approaches
- develop a costings model for the possible expansion of HIV testing services, targeted at Black African and gay, bisexual and other MSM communities, across Greater Manchester
- develop and secure transformation funding to fund roll-out to adopt and test the model.

Objective 2: Develop a business case that builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a Greater Manchester city-region approach to eradicating HIV within a generation. To then pilot and evaluate a Greater Manchester city-region approach to eradicating HIV within a generation.

The project will seek to:

- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model
- collate HIV data from a range of sources for analysis across Greater Manchester

- develop cost benefit analysis for a city-region approach to eradicating HIV within a generation, particularly the upscaling of HIV testing
- collate lessons learned in targeting HIV testing for Black African and gay, bisexual and MSM communities in order to inform future development of HIV testing models across Greater Manchester
- explore different sustainability and investment models.

4.5.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes.

- **Outcome 1:** Through partnership working across Greater Manchester and mapping of current practice, a Greater Manchester-wide HIV strategy for eradicating HIV within a generation, has been developed.
- **Outcome 2:** A model to increase HIV testing and associated interventions has been developed.
- **Outcome 3:** A business case and plan for the Greater Manchester-wide roll-out of the model has been produced and agreed and a Greater Manchester pilot implemented.

4.5.4.4 Programme of work – scope

Greater Manchester residents who are currently living with undiagnosed HIV are the primary target cohort who would benefit from this intervention. It is estimated that 984 people are currently living with undiagnosed HIV across Greater Manchester. Thus, the programme would seek to target, reach and work alongside this key population group, through a community-led, assets-based approach.

The specific sub-groups within this proposal, who are intended to benefit most from this programme, are those communities that shoulder a disproportionate burden of HIV; gay, bisexual and other MSM, Black African and trans communities.

The new delivery model would be a city-region approach to eradicating HIV within a generation. It would be a cross-sectoral collaboration, with the key driver being evidence-led interventions. This city-region approach would also capture wider benefits and learning for other health issues, and how these can be tackled Greater Manchester wide.

Central to the new approach is an evidence-led delivery model. System leadership and the development of a shared response to eradicating HIV within a generation will enable greater analysis and exploration of the barriers and enablers to reducing late diagnosis.

5. Age Well

Greater Manchester is leading the way in its efforts to promote healthy ageing, creating a vision for a society where older age is seen positively and people in later life are empowered to secure a healthy future and good quality of life for themselves. There is a wide range of activity already underway that complements and enhances the projects in the Greater Manchester Population Health Plan.

They include the following.

- In September 2016 Greater Manchester achieved European Innovation Partnership on Active and Healthy Ageing reference site status.
- The Greater Manchester Ageing Hub and the national Centre for Ageing Better have agreed funding that will support the work of the hub to work to achieve a world-class age-friendly city-region.
- The collaboration between Salford Royal NHS Foundation Trust and the Haelo innovation and improvement science centre, through Dementia United, aims to make Greater Manchester the best place in the world to live for people with dementia and improve the lived experience of people with dementia and their carers.
- Greater Manchester Centre for Voluntary Organisation (GMCVO) has established and continues to lead the Big Lottery funded Ambition for Ageing programme, which aims to tackle at a community level the risks to health and wellbeing presented by social isolation and loneliness in older age.
- The developing Greater Manchester adult social care strategic proposals identify 'support for carers' as one of eight priorities, recognising that many carers are in later life themselves and can experience poor wellbeing due to health, economic and wider factors.

The aim of the Age Well theme in this plan is to promote active ageing and implement preventative and early intervention services to enable people to stay well and healthy in their own homes. We have focused on supporting people currently in early older age (65-75+) to maintain good health, social and emotional wellbeing, independence and quality of life for as long as possible, while also managing the current pressures associated with people who are very old (80-85+) where the challenge is to identify appropriate support and positive risk management to restore daily functioning and independence as far as possible or desirable. Our focus is on age-associated issues within the health, social care and housing sectors that are 'modifiable', based on evidence and effective interventions, and which will enable more people to stay well and live independently at home for as long as possible as they age.

The individual programmes of work within Age Well highlight common issues affecting health and wellbeing in older age that cross all ethnic and social groups. But each one will recognise the cumulative effect, over a lifetime, of social or economic disadvantage and how this can manifest in the earlier onset of physical and emotional ill health. These inequalities will be taken into account by effectively targeting all three projects towards the people who need support the most, which will include disadvantaged individuals and communities.

The three programmes of work have a good fit with the creation of locality care organisations (LCOs) and can be incorporated on a longer-term basis into the usual practices adopted and support offered through integrated health and social care teams. Current cost benefit analysis modelling suggests that there is a good case for each proposal to release savings back into the local health and social care system and for this reason we are suggesting that a central bid to the Transformation Fund is made for each project, to pump-prime the roll-out the proposals across Greater Manchester, with a view to them being locally financially sustainable after a given number of years.

5.1 Housing

5.1.1 Background

Poor housing is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing or precarious housing circumstances or lack accommodation altogether. Generally speaking, the health of older people, children, disabled people and people with long-term illnesses is at a greater risk from poor housing conditions.

Direct effects of cold homes on a person's health can include: heart attacks, stroke, respiratory disease, flu, falls and injuries, and hypothermia. The indirect effects are poor mental health and risk of carbon monoxide poisoning. This in turn can lead to greater demand for health and emergency services. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. Poor housing is estimated to cost the NHS at least £600 million per year.

In England and Wales trends in excess winter deaths have decreased by about 30% since 2008/09, when there were 36,450 deaths attributable to all causes. In 2010/11 there were 25,700 excess winter deaths. The majority of these occurred among those aged 75 and over.

From estimates of the Excess Winter Mortality Index (EWM Index) by the Office for National Statistics, circulatory diseases caused 37% of excess winter deaths in 2009/10. Respiratory diseases came in second and accounted for 32%. Cold homes are one contributor to this, and increase the risk of cardiovascular, respiratory and rheumatoid diseases as well as hypothermia and poorer mental health. Older, retired people are particularly at risk.

Around 1.8 million homes had damp problems in 2009. Privately rented homes were most likely to experience damp problems: 15% compared to 8% of owner-occupied homes and 10% of social housing. Twelve per cent of poor households lived with damp problems compared with 7% of other households.

There is evidence that interventions to improve the quality and suitability of the home environment can be effective in preventing, delaying and reducing demand for social care and health care; can enable people to manage their health and care needs; and can allow people to remain in their own homes for as long as they choose. There are substantial health benefits associated with improvements to housing conditions; for example, cavity wall insulation can deliver improvements equating to a health saving of £969.

One in three people aged over 65 and half of those aged over 80 fall at least once a year.

Falls are the commonest cause of death from injury in the over-65s, and many falls result in fractures and/or head injuries. Falls cost the NHS more than £2 billion per year and also have a knock-on effect on productivity costs in terms of carer time and absence from work.

Unsuitability of housing and the need for suitably adapted property can also prevent a timely transfer of care for patients back to their home from hospital. In a six-month period in 2015, 916 days were reported as delayed waiting for adaptations; a potential cost of £732,800 per year, assuming the cost of an acute bed to be £400 per day.

Housing plays a critical role in helping older people and adults with disabilities or mental health problems to live as independently as possible, and in helping carers and the wider health and social care system offer support more effectively. Evidence shows that Government investment in specialised housing for these groups is cost effective, with a positive impact on health and social care spend through for example, the prevention of falls, or a reduction in the levels of readmittance to hospital. Poor or inappropriate housing has been shown to put the health and wellbeing of people at risk. Evidence also demonstrates that a wide variety of outcomes are better for those living in specialised housing compared to regular housing.

The lack of an adequate supply of specialised housing means people are not able to make suitable housing choices, and are forced to stay in less suitable accommodation when, given the opportunity, they may wish to move. Furthermore, there is a lack of public awareness of the wider variety of housing models or solutions available.

In terms of the national policy context, the recent 'Memorandum of Understanding to support joint action on improving health through the home' (2014), recognises that the home environment is essential to health and wellbeing. Ensuring homes are safe, warm and dry can:

- delay and reduce the need for primary care and social care interventions, including admission to long-term care settings
- prevent hospital admissions
- enable timely discharge from hospital and prevent readmissions to hospital
- enable rapid recovery from periods of ill health or planned admissions.

The 'home' becomes a vital component in developing successful integrated services. The role that the housing sector can play in assisting people to live independently for longer is often underestimated and unrecognised by commissioning bodies.

The provision of adaptations to the home through Disabled Facilities Grants (DFGs) is a statutory requirement for local authorities. The funding stream recently became part of the Better Care Fund. The Care Act 2014 placed a responsibility on local authorities to ensure suitability of the living environment and recognised that preventative services such as 'handyperson' schemes can play a key role in ensuring people are able to live independently for longer.

5.1.2 Greater Manchester context

Housing growth is a priority for Greater Manchester and having the right type of homes to meet the needs of the population is fundamental to this. The emerging Greater Manchester Spatial Framework highlights the increasing ageing population and provisions that will need to be put in place to accommodate the changing demographic.

The Greater Manchester Low Carbon Hub has a priority to reduce fuel poverty through retrofitting existing homes with energy-efficient measures and behaviour change. More generally, local authority housing

officers and registered providers recognise the contribution that providing good-quality housing can have on an individual and their ability to live independently. However, this also has an impact on the health and social care system by reducing demand for health and social care through the integration of housing interventions.

By aligning our housing priorities with the vision for health at a Greater Manchester strategic level, we will be able to achieve:

- a better quality of life for our residents by 2020 and assist with closing the health inequalities gap
- a clear focus on prevention and re-enablement
- promote self-care at home and improve community resilience
- support effective discharge from hospital.

Greater Manchester-wide schemes focused on fuel poverty and energy efficiency have been successful in the past, ensuring the delivery of a baseline offer of insulation, boiler replacements, energy switching and behaviour-change advice to residents in Greater Manchester. However, these programmes have been reliant on Government funding, which has ceased, and now the emphasis is to work with private sector energy companies, which have an obligation to assist vulnerable households. However, this tends to be restrictive and cannot deliver at the same scale as when Government funding was available.

5.1.3 Opportunity

The next decade will see dramatic growth in the number of older people seeking help to remain at home as long as possible, while local authorities and health and social care conversely face continuing pressure to reduce costs and seek efficiencies. Home improvement agencies (HIAs) carry out small handyperson jobs and project-manage larger repairs and adaptations, as well as providing housing information and advice, for older and disabled customers. One main source of grant funding for the sector's activities, the Disabled Facilities Grant (DFG), is now part of the Better Care Fund (BCF), and the HIA sector has a central role in the Government's ambition for an integrated health and care system that promotes wellbeing at home and can provide a preventative response to reduce, delay or remove the need for costly institutional alternatives.

Integrating a home improvement agency model into a much larger jigsaw will ensure a greater range of resources, products and services can be deployed to keep a person living healthily at home. For health trusts and clinical commissioning groups, HIAs provide 'home-readying' services to ease hospital discharges, prevent readmission and provide the means to better self-manage health conditions.

Across Greater Manchester, different approaches have been taken to understanding the extent of poor-quality housing and also the level of interventions available. About half of the local authorities run a home improvement agency; however, some are more comprehensive than others. A number of local authorities use Age UK's handyperson service. There are best practice examples within Greater Manchester including Manchester Care and Repair, Bolton Care and Repair and St Vincent's Homecare and Repair.

Discussions have been undertaken with health, strategic housing, registered providers and the Low Carbon Hub on the concept of a Greater Manchester HIA model, and there is broad support.

The establishment of a Greater Manchester home improvement agency model, which builds on existing models in operation, would ensure that all districts are able to provide a basic offer to older and disabled residents, while also providing a single access point for health and social care professionals to

refer into. Procurement of adaptations and a handyperson service for Greater Manchester is also likely to lead to efficiencies. There is also scope to link Greater Manchester Fire Service Safe and Well checks into the model.

Targeting of customers most likely to be living in unsuitable housing, suffering from respiratory diseases, at risk of falls etc, and in receipt of homecare packages, would ensure resources are spent where most needed.

5.1.4 Plan

5.1.4.1 Objectives

The objective of this programme of work is to help facilitate the roll-out, testing and evaluation of an approach to tackling issues around poor-quality housing based on the work already taking place across Greater Manchester, in line with the other Population Health Plan proposals aimed at promoting an effective response to population ageing. The project is set up to achieve the following core objectives.

- **Objective 1:** Develop and document a replicable and scalable model, which can be tested at scale in a cluster of districts in Greater Manchester
- **Objective 2:** Support a number of localities in implementing the described model, recognising the local variations that may be required
- **Objective 3:** Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence

5.1.4.2 Approach to delivering objectives

Objective 1: Develop and document a replicable and scalable model, which can be tested at scale in a cluster of districts in Greater Manchester.

The project will seek to:

- describe a Greater Manchester vision around tackling issues of poor quality housing and a Greater Manchester HIA
- work with Greater Manchester districts that already have an HIA in operation to carry out an initial cost benefit analysis based on the findings to date and agree metrics for evaluation of future Greater Manchester implementation sites
- develop a costings model that includes staffing costs, service provision and interventions, and identify sources of funding
- develop and secure transformation funding to fund roll-out in totality for all agreed localities to adopt and test the model.

Objective 2: Support a number of localities in implementing the described model.

The project will seek to:

- secure and put in place agreements with a number of localities to implement the model and test locally
- provide programme management and delivery support to the initial and roll-out model across each of the boroughs (this could be shared across more than one borough)
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence.

The project will seek to:

- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis developed for the model

- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to fully roll the model out to the remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide roll-out.

5.1.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes:

- **Outcome 1:** Partnership working with existing HIAs and New Economy Manchester has developed a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester using transformation funding
- **Outcome 2:** A number of Greater Manchester boroughs have implemented the model
- **Outcome 3:** A business case and plan for the Greater Manchester-wide roll-out of the model produced and agreed

5.1.4.4 Programme of work – scope

The Greater Manchester HIA model would be available to all older people aged 60-plus and disabled people across Greater Manchester. It is envisaged that there would be a core service and a menu of options that localities can adopt/commission.

Within the scope of the service, the intention is to include:

- delivery of Disabled Facilities Grants (DFGs)
- handyperson service
- fuel poverty/energy efficiency measures
- home improvements
- project management/'handholding' service
- advice and assistance – fuel poverty, housing options, benefits
- referral mechanisms
- home safety checks e.g. Safe and Well checks.

There is also scope to include:

- home from hospital/hospital discharge services
- hoarding service
- community equipment
- community alarm and assistive technology services
- falls prevention.

It will be important that referrals are enabled into and out of the service by housing, health and social care workers. Self-referral and self-funding will also be integral to the model.

Funding sources are likely to be varied, with a management fee taken from DFG funding being the core and sustainable contributor. Other sources of funding could include bidding for grants, private sector and fee generation. Transformation funding is likely to be required to develop the scalable model and kick-start delivery.

5.2 Nutrition and hydration

5.2.1 Background

There is a good evidence base, drawing on the literature and operational experience, relating to the role of nutrition and hydration in supporting good overall health, independence and avoidable deterioration in older age. The risk and prevalence of malnutrition increases with age so we should expect the rate of malnutrition to rise as the population ages (NICE). Some experts place the potential prevalence of malnutrition at as much as 40% of the 65+ population. NICE guidance for commissioners (2012) estimates the following prevalence in different settings: 30% of hospital admissions, 35% of care home residents, 10-14% of people living in sheltered housing.

However, the King's Fund: Making our health and care systems fit for an ageing population report, observed in its 2014 report on the readiness of the health and care system to respond to an ageing population that malnutrition is often regarded as a 'minor' factor in maintaining independence and wellbeing, alongside issues like foot health, visual and hearing impairment, incontinence and oral health (King's Fund, 2014).

What is perhaps different about malnutrition and dehydration is that it can go unnoticed and therefore untreated – the majority (93%) of people at risk of malnutrition live in the community, it often develops over the medium to long-term and there is rarely a specific, treatable 'symptom' associated with it until it becomes very severe. Yet it can undermine mobility, steadiness (leading to falls), healing and recovery, mental alertness and energy levels. Outcomes are therefore much worse for older people who are malnourished and the same is true of dehydration.

In terms of the national policy context, the Malnutrition Prevention Programme overseen by the Malnutrition Task Force (MTF) is a Department of Health funded scheme to help the one million older people in England suffering from or at risk of malnutrition. The pilot programme was part of the Government's response to the Francis Report into the failings at the Mid Staffordshire Foundation Trust (see 'Recommendation 241' on the Department of Health website). The report revealed that patients, many of them older, had been unable to eat or drink properly and that nutrition and hydration was not treated as a priority. The programme aimed to engage whole communities – local NHS trusts, local authorities, GP practices, care homes and the third sector to come together to tackle malnutrition. The aim is to significantly reduce the number of people aged 65 and over in these areas who are malnourished. The pilot areas were Gateshead, Salford, Purbeck in Dorset, Kent and Lambeth and Southwark.

5.2.2 Greater Manchester context

In Greater Manchester, the effects of malnutrition and dehydration do seem to be recognised in parts of the health and social care system. It is seen or identified at point of hospital admission, often as a complicating factor alongside a wider set of clinical issues, and the Greater Manchester Directors of Adult Social Services Group also recognise it as in issue for people with eligible social care needs, in particular those people living in long-term residential care.

There are pockets of relatively recent work focusing on food and nutrition in individual Greater Manchester boroughs (certainly work in Salford as part of the MTF national pilot and in Manchester relating to care homes), but it would seem that this issue does not have a high or consistent profile across Greater Manchester. Given the impact it can have on individuals and the care system, this is a potentially missed opportunity that could provide a strong focus for collaboration at a Greater Manchester level.

The analyses below by the Salford public health team in 2015 show hospital admissions across Greater Manchester where malnutrition has been coded in the hospital admission record, with a breakdown by gender. The overall trend between 2010 and 2015 appears to be rising, which could be a reflection of the ageing population, or an independent increase in the rate of malnutrition, or a combination of both. The analyses give us an insight into hospital admissions where malnutrition has been explicitly recognised, but it is important to appreciate that this cannot be used to gauge overall prevalence, which is estimated to be much higher (see previous sections).

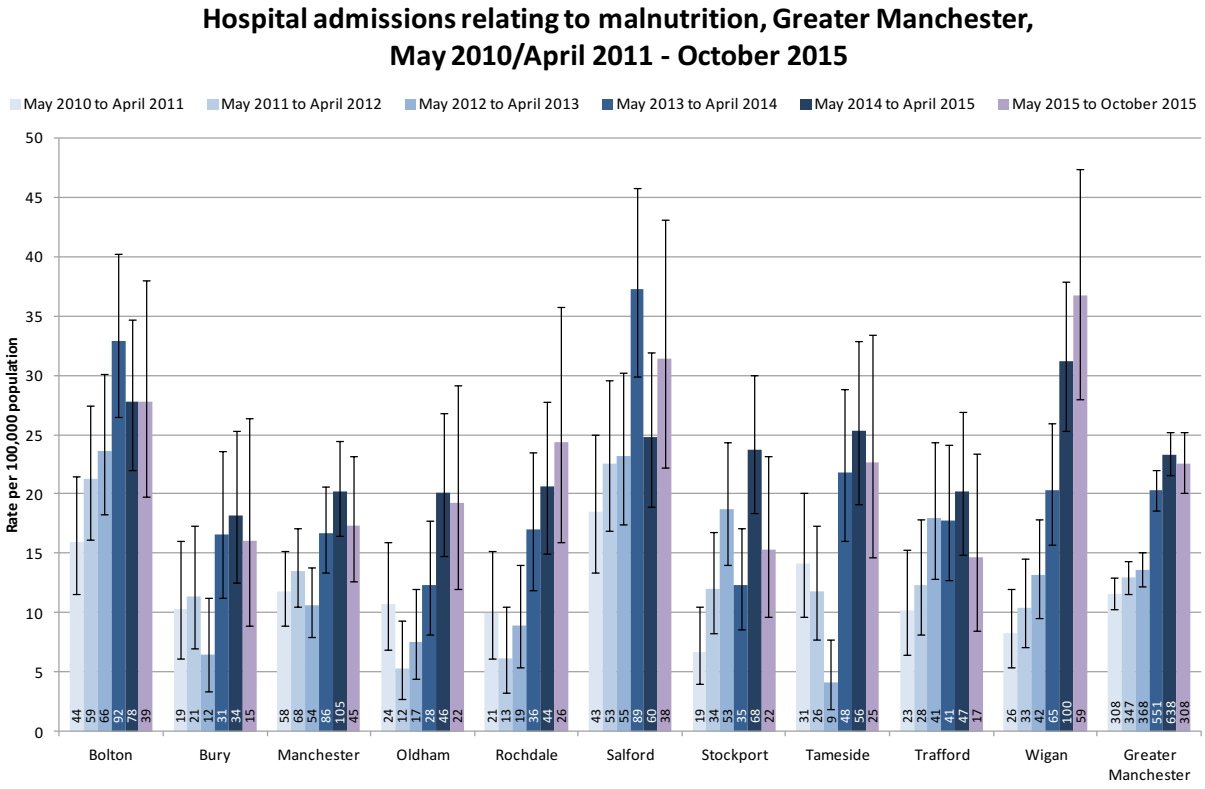


Figure 27: Hospital admissions relating to malnutrition

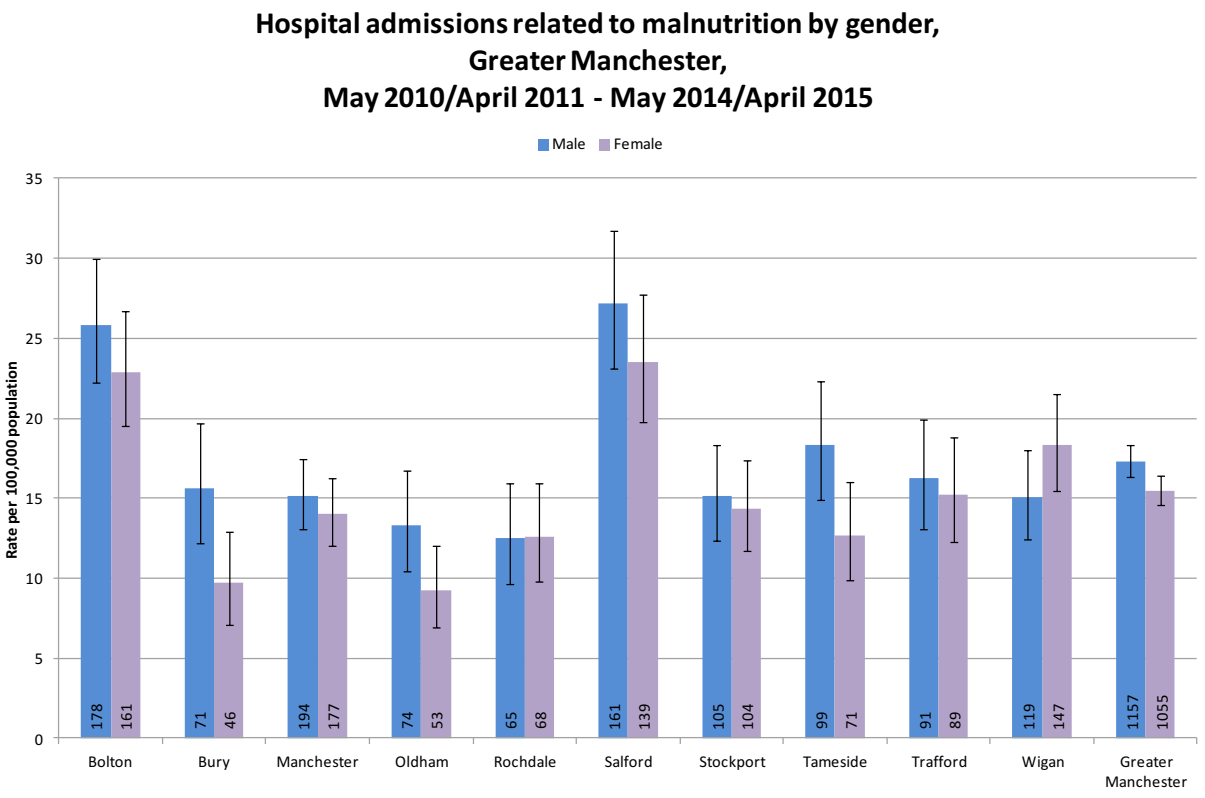


Figure 28: : Hospital admissions relating to malnutrition by gender

5.2.3 Opportunity

A number of reports and guidance sourced around food, hydration and nutrition refer to the very good availability of nutritional guidelines, yet there clearly remains a gap between knowledge and application, which is confounded by the wide range of individual and environmental factors that can contribute to the development of malnutrition, usually over a long period of time.

In the community, the potential solution is to raise individual, family, carer and practitioner awareness and promote a stronger understanding of the particular groups of older people that may be especially at risk of malnutrition and hydration – they might typically include men, people living on their own, those who are recently bereaved and people with a psychological or cognitive impairment. NICE,2012: 'Nutrition support in adults QS24, suggests that nutritional support is an ongoing process involving the following steps:

1. Raising awareness
2. Screening
3. Recognising malnutrition or the risk of malnutrition
4. Documenting nutritional support goals in a management care plan
5. Treatment
6. Reviewing nutritional care to identify and respond to changes in nutritional status.

Steps 1-3 are equally applicable to the identification of dehydration. In care home settings, and domiciliary care arrangements such as home care or extra care, although the same issue of promotion and awareness-raising is important, because the groups of older people being supported by these arrangements are likely to be much more vulnerable – needing more support with food and drink at mealtimes, alongside very specific dietary needs – the issues may need to be approached in different ways. The higher numbers of hospital admissions from these settings, care homes in particular, and the more rapid physiological effects of dehydration generally and on more frail older people specifically, may point towards a stronger emphasis on hydration in these settings.

Salford has emerged as already leading and developing local good practice in the area of malnutrition in particular and, as referred to above, is a pilot site for a whole community approach to prevention under the national Malnutrition Prevention Programme. The site has developed the Salford Together Nutrition Armband, which is gaining traction nationally and has been rebranded as PaperWeight Armband©. The Salford team have been nominated by Barbara Keeley MP for a public health excellence award due to their work. The armband is a simple and non-intrusive way of gauging potential malnutrition by measuring the non-dominant upper arm. Importantly, this has proved to be a way of opening up a conversation, through a wide range of community contacts with older people, about food and nutrition in a non-threatening way and providing access to high-quality, tailored information about relevant local services, support and advice on the topics.

Kirstine Farrer, one of few consultant dieticians nationally who is based at Salford Royal, and partners in Salford (including Age UK Salford and local integrated care programme colleagues) have already done much of the thinking on ways to open up conversation on malnutrition, having developed their own local scheme during the past three years. They are now continuing to pilot work in care homes and have developed an e-learning package designed to improve understanding of nutrition and hydration among practitioners and care staff working in the community and also relevant hospital staff.

The approach is relatively simple and likely to be replicable across other boroughs

– delivered through effective project management at a Greater Manchester level; supported by local buy-in to ensure that it fits and reflects existing local provision; and with expertise and learning from colleagues at Salford.

New Economy has undertaken initial indicative analysis of the Salford Malnutrition Pilot to understand the financial case for the initiative. This analysis suggests that the gross fiscal return on investment over a five-year period is 3.20 and the net present budget impact is around £800,000. The long-term cashable fiscal return on investment is estimated at 2.69.

The costs comprise staff input (predominantly GP capacity in screening elderly patients), resource and distribution of materials, and project management costs including initial outlay on programme design. The benefits are driven by the significant reactive cost savings from a reduction in falls associated with addressing malnutrition and dehydration – this includes savings from non-elective admissions, residential care admissions and a reduced need for intermediate care, re-enablement and home care. Considerable benefit is also anticipated from reduced GP appointments and a reduction in the use of enteral feeds and nutritional supplements.

Further work will need to be undertaken to test these emerging findings with partners and to replace national level assumptions with additional local evidence. As they stand, the cost benefit analysis (CBA) outputs should be considered as indicative and subject to change. To reflect plans for scaling up more widely across Greater Manchester, the CBA can be re-run on a multi-locality footprint. It is likely that this will increase the return on investment through cost efficiencies related to procurement and savings in the project design phase.

5.2.4 Plan

5.2.4.1 Objectives

The objectives of this programme of work are to help facilitate the roll-out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford, in line with the other Theme 1 proposals aimed at promoting an effective response to population ageing. The project is set up to achieve the following core objectives.

- **Objective 1:** Using the Salford approach, develop and document a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester
- **Objective 2:** Support a number of localities in implementing the described model, recognising the local variations that may be required
- **Objective 3:** Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence

5.2.4.2 Approach to delivering objectives

Objective 1: Using the Salford approach, develop a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester.

The project will seek to:

- describe a Greater Manchester vision around tackling issues of malnutrition and dehydration
- work with Salford to carry out an initial cost benefit analysis (CBA) based on the findings to date and agree metrics for evaluation of future Greater Manchester implementation sites

- develop a costings model that includes staffing costs, plus all the materials, a working budget and funds to secure the services of an expert reference group
- develop and secure transformation funding to resource two to three localities to adopt and test the model.

Objective 2: Support a number of localities in implementing the described model.

The project will seek to:

- secure and put in place agreements with a number of localities to implement the model and test locally
- provide programme management and delivery support to roll out the model across each of the boroughs (this could be shared across more than one borough)
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence.

The project will seek to:

- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis developed for the Salford model
- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to fully roll the model out to the remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide roll-out
- ultimately embed the use of the PaperWeight Armband into routine contact with older people; improve awareness and vigilance of malnutrition and dehydration in the community; and reduce the impact of malnutrition and dehydration on the quality of life, health and care outcomes of older people
- implement a financially sustainable approach, using transition funding to mainstream good preventative practice, which can then continue to be overseen and developed in the medium to longer-term by a local multi-disciplinary expert reference group.

5.2.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes.

- **Outcome 1:** The partnership working with Salford and New Economy Manchester has developed a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester using transformation funding
- **Outcome 2:** A number of Greater Manchester boroughs have implemented the model
- **Outcome 3:** A business case and plan for the Greater Manchester-wide roll-out of the model produced and agreed

5.2.4.4 Programme of work – scope

This proposal is intended to be implemented across community and allied healthcare, social care (public and independent sector) and voluntary sector services delivered within a locality, which are already in contact with older people in the normal course of delivering their services or support.

The proposal and model for delivery

- The model is designed explicitly to be a community-level preventative approach that can be applied in a wide range of care and health scenarios with older people. It does not require clinical expertise

to use the armband, so it has wide application across the social care and health workforce based in the community. Although the armband and its associated resources could be used in secondary care settings, that is not the focus of this proposal as it is expected that secondary care practitioners are likely to have more direct experience of malnutrition and dehydration and more tools at their fingertips to identify and assess it clinically.

- The target group to be identified, prompted and supported to benefit from the intervention will largely be an older cohort of adults living in their own homes in the community, some of whom may be experiencing signs of mild frailty, and many are also likely to have co-morbidities that they are managing medically. A key sub-group will be older people living in a care home setting, where the emphasis of the intervention may be more tailored to that environment e.g. training for residential care staff.
- The chief purpose of the model is to embed better awareness and understanding of malnutrition and dehydration in older age and introduce a simple tool, which doesn't require any specialist or clinical knowledge to apply (the PaperWeight Armband), to prompt its identification. The Salford model was overseen and implemented by a cross-sector team who also collectively designed and produced the materials used. A multi-disciplinary team, which is jointly committed to the implementation of the project, creates shared ownership and disperses leadership, both of which strengthen the model.
- In practice, a local project co-ordinator takes lead responsibility for introducing the PaperWeight Armband, and its associated support materials, to a wide range of practitioners who regularly come into contact with older people in the community, including family carers. It can also be used/promoted at one-off community events or alongside preventative interventions targeting older people e.g. 65+ flu clinics.

5.3 Falls

5.3.1 Background

Falls, osteoporosis and fragility fractures are three sides of the same problem. Falls can happen to anyone at any time, but they are more common among older age groups and strongly associated with chronic conditions. Falls are a major cause of disability and the leading cause of mortality due to injury in people aged over 75 in the UK. Annually, around 35% of people aged 65 and over will experience one or more fall and this rate doubles for those living in care homes. Falls are implicated in the majority of fractures in older people. Most of these are fragility fractures affecting the pelvis, wrist, upper arm or hip. Around half of all women and one in six men will experience a fragility fracture in later life. Fragility fracture is often the first indicator of undiagnosed osteoporosis.

Falls-related injuries range from minimal to serious, including loss of confidence. Falls can increase isolation and reduce independence, with around one in 10 older people who fall becoming afraid to leave their homes in case they fall again. Falls trigger over 40% of admissions into nursing and residential care and are the commonest reason for referrals into intermediate care.

Hip fracture is the most serious consequence of a fall, the commonest reason for older people to need emergency surgery, and the most common cause of accident-related death in older people. Around 30% of over-65s experiencing a hip fracture will die within a year, and a quarter will need long-term care. Hip fracture patients take up 1.5 million hospital bed days each year and cost the NHS and social care £1 billion. This one injury carries a total cost equivalent to about 1% of the whole NHS budget.

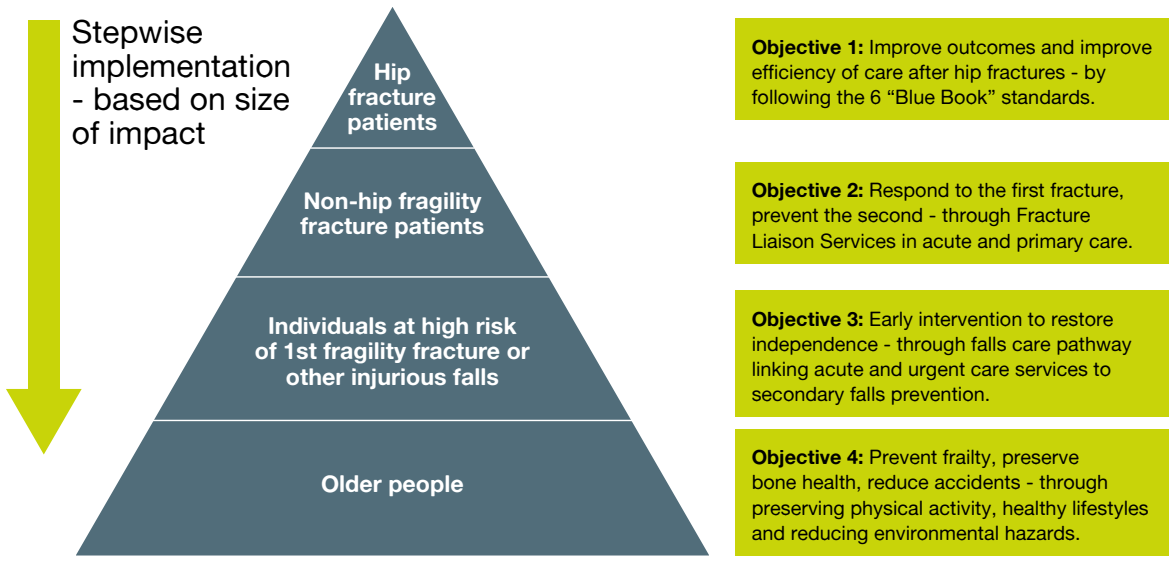
5.3.2 Greater Manchester context

'Taking Charge' sets out our ambition to reduce falls-related injurious falls admissions in older people to the England average, resulting in 2,750 fewer serious falls. All locality plans across Greater Manchester have identified falls as a priority issue and/or an area for development. An understanding of key deliverables right across Greater Manchester will be vital to ensure we are maximising all our potential to reduce injurious falls and we collaborate where possible. Ensuring falls pathways are in place that link acute and urgent care services to secondary falls prevention will be key to intervening early and restoring independence. Work with care homes, where falls prevalence is much higher than in the general 65+ population, will also be needed and exploring how we can scale up relevant physical activity interventions will also be key. There is much to learn and share from existing practices across Greater Manchester and beyond, and we will seek to facilitate that and collaborative approaches where possible.

5.3.3 Opportunity

Given the ambition set out in 'Taking Charge' there is now an opportunity in Greater Manchester to support the development of integrated systems geared to falls and fragility fracture prevention, informed by the available evidence. A Greater Manchester falls programme could utilise the Department of Health (DH) model for a systematic approach to falls and fracture prevention as set out in Figure 29. Falls and osteoporosis are essentially long-term conditions and this needs to inform preventative approaches in parallel with other long-term conditions.

A systematic approach to falls and fracture prevention - four key objectives



Source: Falls and fractures: Effective interventions in Health and Social Care, 2009, DH.

Figure 29: Falls and fractures

A Greater Manchester approach around falls could aim to:

- reduce the incidence of falls
- reduce the severity of injuries
- ensure effective treatment and rehabilitation for those who have fallen.

Two high-impact changes have been identified for Years 1 and 2, in keeping with the stepwise implementation suggested in the model above. These centre around reducing variation in, and improving the quality of, hip fracture care outcomes (to be delivered through Theme 3) and testing the potential of fracture liaison services integrated with local falls prevention services across Greater Manchester through the delivery of this plan. These two areas are now described below:

5.3.3.1 Hip fracture care

Quality in hip fracture care is incentivised through a best practice tariff (BPT). The National Hip Fracture Database (NHFD) captures a range of clinical audit data in relation to hip fracture care by provider site. Comparative data for achievement of BPT shows some sub-optimal care and variations across Greater Manchester. This component of the programme will drive up improvements in hip fracture outcomes, implementing relevant recommendations from the 'NHFD Annual Report 2016', and seek to:

- support quality improvement
- implement relevant NICE guidance and quality standards
- review and revise the whole hip fracture pathway beyond acute care, and bring into scope rehabilitation, intermediate care and community care.

This element of the Greater Manchester Falls Programme will be taken forward by the Greater Manchester MSK and Orthopaedics Programme within Theme 3.

5.3.3.2 Fracture liaison service (FLS)

Sustaining a fragility fracture at least doubles the risk of a future fracture. A study of the Glasgow FLS established that 80% of re-fractures that occur over a three-year follow-up period happen during the first year after the initial (post-index) fracture, with 50% of re-fractures having occurred during the first 6-8 months. A significant proportion of fragility fractures are recurring fractures that could have been prevented if steps had been taken to diagnose and treat osteoporosis after the initial or index fracture and to address any falls risk. This leads to a situation where "hip fracture is all too often the final destination of a 30-year journey fuelled by decreasing bone strength and increasing falls risk".

An FLS will systematically identify, treat and refer to appropriate services all eligible patients over 50 years old within a local population who have suffered fragility fractures. An FLS is regarded as clinically and economically efficient. An FLS in an acute setting can intervene in 50% of future hip fracture cases and, in a primary care setting, increase compliance with NICE guidance on secondary prevention of osteoporotic fracture by up to 64%. These reductions are realised quickly and certainly within three years of the commencement of relevant drug treatment. It is generally recognised that, in the absence of follow-up (which an FLS can provide), compliance with treatment is generally very poor.

Interventions to reduce future fracture risk in patients who have already broken a bone takes priority over primary fracture prevention due to:

- the 2-3 fold greater risk of fracture (any skeletal site) following index fracture
- 50% of hip fractures occurring in patients who have previously sustained a fracture
- achieving the same reduction in fracture incidence through primary prevention would necessitate identification and assessment of 5-6 times more patients.

A secondary fracture prevention strategy will achieve substantially greater fracture risk reduction for any investment of resources than can be achieved through primary fracture prevention.

Fracture liaison services originated in acute settings. However, more models are emerging within community-based settings, which support the drive for care closer to home. A community model can be more easily facilitated with a 'reporting radiographer' approach rather than case finding in acute fracture care, which some earlier models adopted. This also maximises opportunities to identify vertebral fractures. Wigan, for example, currently has a community-based FLS+ that has an extended role into primary care. Wigan's FLS is also integrated with its falls prevention service on the basis of the inter-relationship between falls, osteoporosis and fragility fractures.

High-level predictive CBA undertaken by New Economy suggests an overall gross fiscal return on investment of 2.26 with a net present budget impact of £11.2 million over five years. While there is a significant increase in benefits as the target cohort increases over time, it is anticipated that the investment in FLS across Greater Manchester will have been 'paid back' during the first year of activity.

The largest benefits created by the FLS are those pertaining to prevented hip fractures. These benefits include savings as a result of both a reduction in acute care presentations and the circumvented need for residential care. The most significant costs of the FLS are those associated with staffing. However, there are also costs linked to the increased number of patients prescribed medication, and to a lesser extent, those likely to undergo bone scans.

Findings reflect indicative reactive savings that could be made through the provision of fracture liaison services based in an acute setting within each of Greater Manchester's hospital sites, and are subject to decision-making around service configuration. Findings are presented here in isolation from other strands of the Age Well workstream, but in future will be considered as part of a wider portfolio of work.

Opportunities still to be scoped

Work is still needed to develop and agree further opportunities at Greater Manchester to complement the work at a locality level to reduce injurious falls in older people. Work will take place over the next 12 months to further define these pieces of work in collaboration with localities. Initial areas for consideration are described in the sections below.

5.3.3.3 Falls care pathway

Ensuring falls pathways are in place that link acute and urgent care services to secondary falls prevention is key to intervening early and restoring independence.

All locality plans have identified falls as an issue or area for development. An understanding of key deliverables right across Greater Manchester will be vital to ensure we are maximising all our potential to reduce injurious falls and we collaborate where possible. There is much to learn and share from existing practice across Greater Manchester and beyond in relation to multi-factorial risk assessments, falls pathways and falls prevention practice. For example, Stockport has developed a falls pathway that supports the implementation of relevant NICE guidance.

The rate of falls in care homes is almost three times that of older people living in the community and 30% of hip fracture hospital admissions are from a care home. Scotland and Derbyshire have developed good practice toolkits.

Work could include steps to:

- identify and share examples of practice from across Greater Manchester

- stimulate collaborative approaches to implementing relevant NICE guidance on falls prevention
- work with localities to identify toolkits and best practice around falls prevention in care homes, and share for implementation.

Evidence-based physical activity programme for falls prevention

Poor gait and balance is the most significant intrinsic risk factor for a fall. The most effective component of multi-factorial interventions is therapeutic exercise. Any therapeutic exercise should be individually prescribed, focus on building strength and balance, be progressive, and meet the right dosage criteria to sufficiently reduce falls risk. FaME, Otago, and LiFE are all evidence-based therapeutic exercise programmes, which variously reduce falls risks by at least 35% and up to 54%. Compliance, however, is known to be problematic and, ideally, activity needs to be sustained beyond the initial therapeutic phase.

Delivery requires instructor training in one of the evidence-based programmes, with relevant prerequisites. Instructors can come from a number of backgrounds, including physiotherapists, occupational therapists, sports scientists, and registered exercise professionals. There are varied approaches to, and provision of, falls prevention physical activity programmes and we need to understand, learn and share from all Greater Manchester districts.

Work could include steps to:

- identify and share delivery models
- facilitate an asset-based approach to build capacity for physical activity interventions for falls prevention
- work with localities to identify options to scale up therapeutic physical activity programmes for falls prevention.

5.3.4 Plan

5.3.4.1 Objectives

The objectives of this programme of work are to help facilitate the roll-out, testing and evaluation of fracture liaison services integrated with a range of locally designed falls prevention services in a number of Greater Manchester boroughs. The programme is set up to achieve the following core objectives.

- **Objective 1:** Using national guidelines and learning from developments locally in Wigan, develop and document a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester
- **Objective 2:** Support a number of localities in implementing the described model, recognising the local variations that may be required
- **Objective 3:** Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the model across the whole of Greater Manchester based on the evidence.

5.3.4.2 Approach to delivering objectives

Objective 1: Using national guidelines and learning from developments locally in Wigan, develop and document a replicable and scalable model, which can be tested at scale in other parts of Greater Manchester.

The project will seek to:

- work with Wigan and the National Osteoporosis Society to carry out an initial cost benefit analysis based on the findings to date and agree metrics for evaluation of future Greater Manchester implementation sites
- develop a costings model that includes staffing costs, plus all the materials, a

working budget and funds to secure the services of an expert reference group

- secure transformation funding to roll out fracture liaison services in a number of localities, which align with new models of care locally.

Objective 2: Support a number of localities in implementing the described model, recognising the local variations that may be required.

The project will seek to:

- secure and put in place agreements with those 'early implementer' sites for provision of fracture liaison services
- provide programme management and delivery support to the early implementer sites
- provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case that builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of Greater Manchester based on the evidence.

The project will seek to:

- support evaluation of FLS provision
- collate analysis from implementation sites from across Greater Manchester
- update and further develop cost benefit analysis developed for original model
- collate local lessons learned to inform future development of the model for wider Greater Manchester adoption
- gain agreement from the system to fully roll the model out to the remaining Greater Manchester boroughs
- produce and agree a plan for Greater Manchester-wide roll-out.

5.3.4.3 Target outcomes for 2016/17 and 2017/18

The programme will work towards achieving three key outcomes.

- **Outcome 1:** Transformation funding secured, via a robust business case, for roll-out of fracture liaison services in 'early implementer' sites
- **Outcome 2:** A number of Greater Manchester boroughs will have developed and implemented an FLS
- **Outcome 3:** A business case and plan for the wider roll-out of FLSs across Greater Manchester will be developed

5.3.4.4 Programme of work – scope

An FLS is typically developed around a fracture liaison co-ordinator, usually a nurse specialist, in collaboration with and supported by a metabolic bone disease specialist as named lead clinician.

The FLS and care pathway will provide specialist secondary fracture prevention assessment and management to all patients over 50 years old. The service will promote co-ordination between acute, community and primary care to ensure that care is seamless and consistent. This integrated approach will include:

- case finding in fracture clinics, emergency departments, inpatient wards and outpatient clinics
- triage and assessment of identified patients by co-ordinators/specialist nurses
- diagnosis of osteoporosis using DXA scans
- initiation of treatment for fracture risk reduction in line with agreed guidelines
- appropriate pharmacological treatment
- identification of the 'modifiable faller' and referral to a falls prevention service

- liaison with the patient's GP with the aim of optimising long-term treatment
- telephone follow-up of patients to provide education and support in primary care
- promotion of FLS to relevant hospital teams in order to maximise case finding
- specialist clinic support for secondary care clinicians in managing complex and rare bone conditions
- a database of patients assessed through the service to support follow-up and quality reporting.

The service will be available to all patients over the age of 50 years who have suffered a fragility fracture, with the primary aim of preventing subsequent fracture. The figure below provides an overview of an FLS and its key interfaces.

In some more recently established services, case finding is via diagnostics with reporting radiographers identifying patients and notifying the FLS.

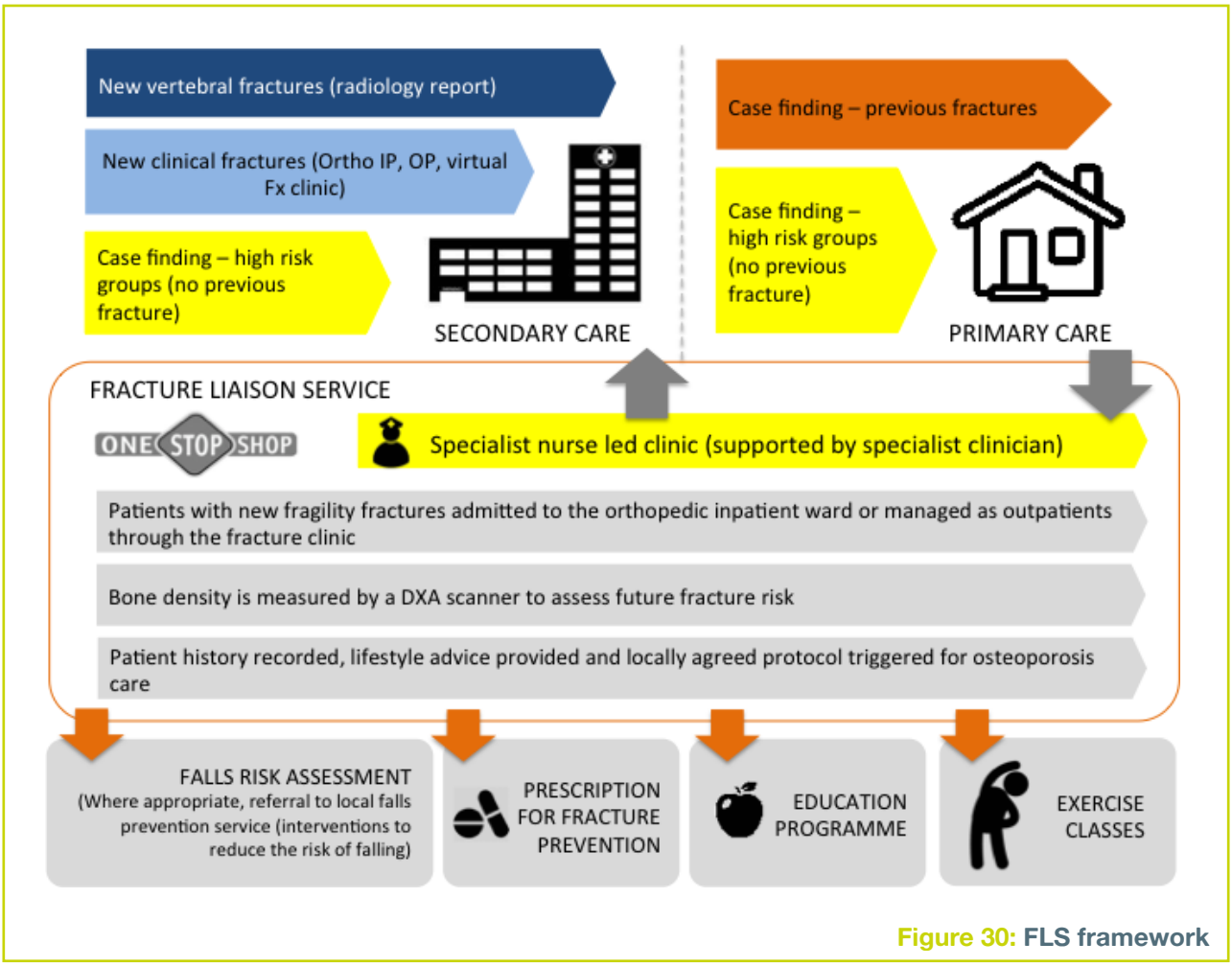


Figure 30: FLS framework

6. System reform

It is clear that an ambition of this magnitude around the delivery of the Population Health Plan requires the support of a population health system that is organised to deliver at pace and scale.

'Population health systems: Going beyond integrated care' (King's Fund 2015) identified that population health is affected by a wide range of influences across society and within communities. Improving population health is not just the responsibility of health and social care services, or of public health professionals. Instead, it requires co-ordinated efforts across population health systems.

Making this shift towards population health requires collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public working together as population health systems.

Greater Manchester has the chance, therefore, to take a co-designed approach to radically reframe the role of population health in the context of a devolved system, creating a unified population health system across 10 localities and Greater Manchester that is better able to achieve improved health outcomes for the citizens of Greater Manchester.

Our system reform proposal will therefore look to create a leadership, governance and delivery model with clear lines of accountability and responsibility for achieving Greater Manchester's population health ambitions that delivers financial sustainability and is able to future-proof against further funding changes.

In addition, the reform proposal will include the development of a unified approach to commissioning population health. This will take into account Section 7a (public health functions agreement) commissioning, local authority regulatory commissioned public health services, as well as the commissioning intentions and approaches arising from the new models of care outlined in the plan.

The final aspect of the system reform programme is looking at how public sector spend can produce a wider benefit to the community i.e. the social value benefit to the people of Greater Manchester from public sector commissioning and procurement and maximising the contribution made by the voluntary, community and social enterprise (VCSE) sector.

6.1 System reform – Creating a unified population health system for Greater Manchester

In Greater Manchester, we have a shared commitment to the most ambitious approach yet in England to place population Health at the heart of public service reform and economic growth. Rebalancing our economy also requires rebalancing our public services.

Since the implementation of the Health and Social Care Act 2012, public health leadership has become fragmented and capacity is dispersed across local authorities, the work of the Greater Manchester Directors of Public Health Group, PHE and NHS England, resulting in fragmentation of health protection, intelligence architecture and commissioning functions. This has created duplication and overlap and limited the capacity to effect significant change across Greater Manchester.

In July 2015, Greater Manchester signed a memorandum of understanding (MoU) with PHE with an ambition to create a unified public health system. This provides an opportunity to support and add value to local working by reducing the fragmented nature of public health leadership in Greater Manchester and drive the necessary prevention and integration that will be central to improving outcomes in a landscape of diminishing resources.

6.1.1 Opportunity

Reforming how public health functions are delivered within Greater Manchester is now a critical part of the wider devolution transformation, and needs to be reformed in partnership across all public services in order to deliver Greater Manchester's ambition of a well population and productive workforce.

Sharing of public health capacity (which is about embedding knowledge, skills and expertise across society in a place-based model) across Greater Manchester or within sectors in Greater Manchester, with managed deliberate intent, would enable better public health leadership on aspects of population health management.

There is an opportunity therefore to build a single population health system across the Greater Manchester economy – one that maximises both the impact and the capacities of a small and specialist public health workforce, but also that supports the embedding of the pursuit of population health as being everybody's business. This requires;

- a step-change in the way already devolved public health leadership capacity is organised across Greater Manchester
- the realignment and re-orientation of PHE resource and capacity
- building on the devolution of NHS England commissioning resource.

In addition to creating a unified leadership system for population health, we need to create a unified approach to commissioning population health that enables us to commission services at the right spatial level, in collaboration with one another and enabling us to improve population health outcomes and health inequalities as well as contributing to a more sustainable public health, health and care system.

We want to move away from focusing on organisations and separate areas of spend with a single-service planning approach, which results in a fragmented approach to commissioning health, social care and public health services. We want to focus on integrated strategic planning to achieve cumulative impact and outcomes, creating economies of scale across Greater Manchester with integrated delivery around individuals and families at neighbourhood level.

We intend therefore to:

1. Create a leadership, governance and delivery model with clear lines of accountability and responsibility for achieving Greater Manchester's population health ambitions
2. Look at extending commissioning at Greater Manchester level of activity to improve health that achieves additional impact and is complementary to that at locality level
3. Strengthen health protection functions, to be commissioned and organised on a Greater Manchester footprint with additional responsibilities aligned to wider Greater Manchester resilience and civil contingency arrangements
4. As agreed in the MoU, establish, where appropriate, a pooled budget to which all councils contribute to commission Greater Manchester-level activity and a district level budget for district activity
5. Ensure all local authorities have ready and effective access to all the necessary public health experience and skills to ensure they can fulfil their statutory requirements, and identify an appropriate public health presence in each local authority area
6. Set standard commissioning specifications required for ensuring the delivery of a population health approach across providers.

In doing this we will work to a core set of principles, such as:

- subsidiarity – the principle that decisions should always be taken at the lowest possible level or closest to where they will have their effect, for example in a local area rather than for a whole country
- looking in the first instance at functions where there are sensible economies of scale and where genuine added value is demonstrated
- ensuring far closer alignment at Greater Manchester level with the locality plans
- ensuring any proposed Greater Manchester population health resource needs to do what only makes sense to do at Greater Manchester level and still produces functionality and services that are timely and sufficiently relevant, reflective of or flexible to local requirements and integral to locality care organisation development.

6.1.2 The plan

Work has already been underway since the signing of the MoU to move towards reforming the system to achieve a unified leadership across the population health system. The devolution of NHS England Section 7a commissioning resources to Greater Manchester as outlined in the Greater Manchester Delegation Agreement was the first opportunity taken to unify public health commissioning.

The agreement saw the transfer of relevant resources to Greater Manchester Health and Social Care Partnership (GMHSC Partnership), as well as the responsibility for commissioning screening (cancer and non-cancer), immunisation and vaccination programmes, and child health information services. Screening and immunisation programmes are the largest public health interventions in Greater Manchester, delivering high-quality services across the whole life course that reduce the burden of disease and save lives. A population health team within Greater Manchester Health and Social Care Partnership was established with embedded staff from NHS England (NHSE) and Public Health England, namely NHSE public health commissioners and PHE assigned staff. A PHE relationship manager has been assigned as an associate within GMHSC Partnership's wider leadership team as the interface between PHE and the Greater Manchester population health team.

The 'Greater Manchester Commissioning Strategy: Commissioning for reform' (October 2016) signalled the intent to take a new approach to commissioning that would overcome the barriers of fragmented decision making and overlapping or duplicated investment, and to address the longstanding challenge of co-investment. Using the Greater Manchester Commissioning Strategy as a framework, we will develop a commissioning plan that will be co-created with the system, recognising that there are significant variations that currently exist across and within the ten boroughs, towns and cities of Greater Manchester. We will look to the development of the emerging LCOs to ensure how best we can commission and deliver services that meet our population health outcomes through the LCO models.

Work is already underway across Greater Manchester to align commissioning intentions and we intend to learn from that work and successful approaches being taken.

- We want to continue to commission services on a Greater Manchester footprint for Section 7a services (screening and immunisation) as it is the most effective way to deliver at scale with a lean workforce. Devolution provides an opportunity to align these programmes with the emerging LCOs and explore new opportunities for workforce planning and to build on social and digital innovation to enable people to take charge of their own health. We have the opportunity of identifying further opportunities to expand the commissioning portfolio as need dictates.
- We will ensure future commissioning and procurement approaches will take more of a social value approach and be rooted within the needs of the GMHSC partnership and public service reform.
- We need to build on existing work, such as the work undertaken by the sexual health commissioners and sexual health network, which have worked collaboratively to successfully produce a single service specification for genitourinary (GU) and contraception and sexual health (CASH) services that is being used consistently across Greater Manchester, and have also established sector-based recommissioning of core services.
- We want to look at how best to replicate the approach taken to the successful work underway under the leadership of the Association of Greater Manchester Authorities (AGMA) wider leadership team, the Police and Crime Commissioner for Greater Manchester, local authority executives and directors of public health, which is delivering a co-ordinated approach to commissioning substance misuse (for drugs, alcohol and new psychoactive substance) to deliver the best possible outcomes across Greater Manchester.

More recently we have seen the production of a set of high-level proposals – covering population health commissioning, population health intelligence systems and population health policy, strategy and workforce functions – for taking forward a unified population health system for Greater Manchester with broad stakeholder engagement.

Further work is now needed to develop those high-level proposals into a set of evidence-based options that will lead to a set of decisions and then a period of managed transition. It is the intent that we ensure that any proposed Greater Manchester population health resource needs to do what only makes sense to do at Greater Manchester level and still produces functionality and services that are timely and sufficiently relevant, reflective of or flexible to local requirements, and integral to locality care organisation (LCO) development.

6.1.3 Objectives

To deliver the plan we want to achieve the following core objectives.

- **Objective 1:** Develop a population health commissioning plan that brings together the NHS England commissioning responsibilities set out in Section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan
- **Objective 2:** Develop and test a proposal for a new Greater Manchester population health function serving localities, CCGs and Greater Manchester structures
- **Objective 3:** Develop a model for future resourcing of population health in Greater Manchester

Approach to delivering the objectives

Objective 1 – Develop a population health commissioning plan that brings together the NHS England commissioning responsibilities set out in Section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan. The population health commissioning plan will be a coherent vison and plan for population health commissioning in line with Greater Manchester's Commissioning for Reform Strategy.

The programme will seek to do the following.

1. With key stakeholders across the system, undertake an in-depth review of the 'as is' approach to commissioning for population health, and:
   - analyse current and planned population health commissioning arrangements
   - identify different population health commissioning approaches currently in use e.g. outcomes based, alliance neighbourhood level
   - review current contracts and spend for Section 7a services and council-commissioned population health services
   - Identify commissioning plans and intentions, including planned cluster level commissioning; PH grant commissioning plans.
   - review alignment of locality commissioning plans with Greater Manchester Theme 1 transformation programmes
   - identify any standard operating models and options for replicability on Greater Manchester footprint
   - review wider considerations for LCO models and pooling of commissioning budgets
   - determine different commissioning approaches currently in use e.g. outcomes-based, alliance, neighbourhood level and best fit for purpose.
2. Based on the activities outlined above, further develop a set of options for inclusion in the commissioning plan for population health.
3. Undertake an assessment and review of stakeholder support underpinned by an understanding of implementation issues, including resource requirements and the risks and barriers that will need to be addressed, with an outline timetable for change.

   Target outcomes for 2016/17 and 2017/18

   - **Outcome 1** – January 2017: The production of a set of proposals for inclusion in the commissioning plan
   - **Outcome 2** – March 2017: A supporting implementation plan that has been co-designed with stakeholders across the system
   - **Outcome 3** – 2017: An agreed programme of activity to ensure a managed transition into a new way of working

Objectives 2 & 3: Develop and test a proposal for a new Greater Manchester population health function serving localities, CCGs and Greater Manchester structures, and develop a model for future resourcing of population health in Greater Manchester.

The programme of work will seek to do the following.

1. With key stakeholders across the system, undertake an in-depth review of the 'as is' approach to determine the evidence base for the production of a set of proposals, and:
   - determine the scope of services that fall currently within Greater Manchester's remit (aligned with NHSE public health Section 7a commissioning intentions 2017/18) and those at the locality level
   - map and review current provision of those functions at various levels including Greater Manchester, cluster, locality and neighbourhood
   - benchmark cost and quality for key public health functions
   - assess current workforce provision and future provision
   - review current public health expenditure and determine any wider implications of changes to the grant such as the residual business rates pilot across Greater Manchester.
2. Based on the activities outlined above, a small number of options for a new Greater Manchester population health function serving localities, CCGs and Greater Manchester structures will be developed and tested. It is intended that those options will maximise both economies of scale and scope while staying true to the principle of subsidiarity embedded within the devolution framework. We intend to look in the first instance at functions where there are sensible economies of scale and where genuine added value is demonstrated.
3. Undertake an assessment and review of stakeholder support for the different options, with clear recommendations made on the shape and distribution of population health functions within Greater Manchester. This will be underpinned by an understanding of implementation issues, including resource requirements and the risks and barriers that will need to be addressed, and an outline timetable for change.

6.1.3.1 Target outcomes for 2016/17 and 2017/18

Outcome 1 – January 2017: The production of a set of evidence-based proposals for creating a unified leadership system for population health across Greater Manchester

Outcome 2 – March 2017: A supporting implementation plan that has been co-designed with stakeholders across the system

Outcome 3 – 2017: An agreed programme of activity to ensure a managed transition into a new way of working

6.2 Social value

6.2.1 Background

Social value asks the question: "If £1 is spent on the delivery of services, can that same £1 be used to also produce a wider benefit to the community?" This involves looking beyond the price of each individual contract or activity and considering the collective benefit to an area. A social value approach includes consideration of the social, environmental and economic wellbeing of a place and its citizens during the planning, commissioning and delivery of services, buying of goods or the procurement of works.

However, the same argument about gaining wider benefit can also be applied to business and non-commissioned VCSE activity, thereby increasing the whole economic footprint of Greater Manchester.

Since January 2013, all public bodies have had to consider social value as part of their commissioning activities under the Public Services (Social Value) Act 2012, both as part of contract specifications and as 'added value'. Under the Act, social value is an enabler that delivers additional benefits for suppliers and partners across all procurement and commissioning activity.

It is a legal obligation for local authorities and the NHS to consider the social good that could come from the procurement of services before they embark upon it. The Act allows authorities to choose a supplier under a tendering process that not only provides the most economically advantageous service but one which goes beyond the basic contract terms and secures wider benefits for the community.

The themes of social value fall broadly into three categories: economic (local jobs and growth), social (resilience and strong voluntary and community sector), and environmental (clean and protected environment). The spectrum of potential activities and measures within these categories is wide and varied, enabling individual authorities to match them to priorities and, to some extent, the resources they may have to support this work.

Furthermore, recent EU procurement regulations have increased the emphasis on achieving wider societal goals through procurement and commissioning, and with these regulations embedded within public sector procurement, Greater Manchester is now able to better commission social value.

6.2.2 Greater Manchester context

The Greater Manchester Combined Authority (GMCA) Social Value Policy approved in November 2014 provides a consistent approach across each of the Greater Manchester councils. The GMCA Social Value Policy sets out how social value is used to underpin the core objectives of 'Stronger Together: Greater Manchester Strategy 2013', which are to stimulate growth in the economy and reform the way in which public services are delivered.

The Greater Manchester Police and Crime Commissioner (PCC) has also produced a social value policy, which echoes the principles of the GMCA policy, and the AGMA Procurement Hub is currently in dialogue with the PCC and other partners to identify how a consistent approach can be taken to social value policy and measurement..

Furthermore, the Manchester Growth Company provides capacity building support to local businesses, particularly SMEs, around the generation of added value and wellbeing outcomes through being a responsible employer, undertaking sound environmental practices and contributing towards local economic gain.

Social value is an enabler that delivers additional benefits for suppliers and partners across all procurement and commissioning activity. Social value should be used to underpin the core objectives of the Greater Manchester 'Stronger Together' and 'Taking Charge' objectives by stimulating growth in the economy and reforming the way in which public services are delivered. It can be used to increase the spending power of every pound spent in Greater Manchester.

6.2.3 Opportunity

An opportunity exists to derive relevant social, environmental and economic value from everything that we do, in our business, in service delivery, commissioning and procurement; to use the huge purchasing power of the Greater Manchester devolution partners to obtain the greatest benefit for local people.

The proposed approach to social value across Greater Manchester is to use this duty to increase the spending power of every pound spent in Greater Manchester, therefore maximising the social value benefit to the

people of Greater Manchester from public sector commissioning and procurement, as well as increasing purposeful activities in the business sector and maximising the contribution made by the VCSE sector.

The longer-term impacts of this approach will be to reduce dependency on, and demand for, public services, and contribute towards increased economic growth in Greater Manchester. This is a £6 billion opportunity to create local economic, social and environmental benefit, if all procuring organisations were to adopt a common approach, and follow similar processes in relation to procurement, contract management and delivery of outcomes.

6.2.4 Plan

Objectives

Our research shows that there is a great deal of work ongoing across Greater Manchester to develop social value approaches in commissioning, procurement, business, voluntary and community activity and social enterprise – the proposed programme will seek to ensure that all Greater Manchester health and social care commissioning and procurement maximises social, environmental and economic wellbeing. Furthermore it will put in place arrangements for health and wellbeing outcomes to be realised from wider public, private and third sector investment. This will involve culture change across all devolution partners and significant effort into co-production of social value outcomes.

The objectives of the work supported through the Theme 1 population health programme will be:

- **Objective 1:** To understand and embed social value in Greater Manchester Health and Social Care Partnership commissioning and seek to work with CCG partners to scale up this work across the healthcare economy
- **Objective 2:** To develop the GMCA Social Value Policy to cover health and wellbeing outcomes described in the Greater Manchester Strategic Plan 'Taking Charge' for implementation across all public sector procurement in Greater Manchester
- **Objective 3:** To embed social value into the culture of the health and social care workforce, through values-based discussion, training, awareness raising and participation in service design to maximise social value benefits
- **Objective 4:** To put in place a number of enabling activities that will maximise the co-production of social value from the expenditure of health and social care budgets, including work with NHS providers, the VCSE sector and relevant parts of the business sector.

Approach to delivering objectives

The activities that will deliver these objectives will all take place within the period April 2017 to March 2019, and can be summarised as follows.

Objective 1: To understand and embed social value in Greater Manchester Health and Social Care Partnership (GMHSC Partnership) commissioning and seek to work with CCG partners to scale up this work across the health care economy.

- Provide training for commissioning staff around social value
- Undertake a review of current practice and policy and undertake a procurement spend analysis
- Develop a social value framework through which GMHSC Partnership can continuously monitor the social value of its suppliers
- Develop a toolkit for practitioners to use when commissioning social value

- Identify, test and share good practice in return on investment in a healthcare commissioning situation
- Work with CCGs to look at how this work could be scaled up across Greater Manchester

Objective 2: To develop the GMCA Social Value Policy to cover health and wellbeing outcomes described in the Greater Manchester Strategic Plan 'Taking Charge' for implementation across all public sector procurement in Greater Manchester.

- Further develop the existing GMCA Social Value Policy for procurement activity across all public sector partners, to include the strategy and outcomes described in 'Taking Charge'
- Work with partners to agree a clear description of what social value means in Greater Manchester for all of the partners in Greater Manchester devolution
- As required, work to support and embed the revised policy into custom and practice across the Greater Manchester reform partners, including the health and social care system

Objective 3: To embed social value into the culture of the health and social care workforce, through values-based discussion, training, awareness raising and participation in service design to maximise social value benefits.

- Build from and roll-out the existing Greater Manchester Commissioning Academy work to embed the single methodology for commissioning social value across health and social care into practice
- Support individual leadership and responsibility in social value across the health and social care workforce, embedding a culture of 'social value is everyone's business' through a series of interactive service design events
- Develop a small number of thematically or geographically focused projects that engage the workforce in activities to generate more social value; including employee volunteering schemes, wellbeing activities and energy-efficiency projects

Objective 4: To put in place a number of enabling activities that will maximise the co-production of social value from the expenditure of health and social care budgets, including work with NHS providers, the VCSE sector and relevant parts of the business sector.

- Build capacity for the devolution partners to monitor, report and be accountable for their own social value as employers of local people, in their own right and spenders of public money
- Work with the Greater Manchester Social Value Network to roll out a series of information-sharing and networking events throughout the programme
- Develop a web portal/website for the programme to allow the consistent sharing of practice case studies, documentation, policies and other information
- Provide a health and social care perspective in wider discussion around social value in Greater Manchester

6.2.5 Outcomes (2017 - 2019)

The following 'signs of progress' will be evaluated to demonstrate the difference that this proposal has made over the two years of its operation.

- Social value is embedded in GMHSC commissioning arrangements
- Social value framework model tested in GMHSC rolled out to interested CCGs
- Increased understanding of social value and how to maximise its achievement through commissioning and procurement among the partners in Greater Manchester health and social care devolution

- Achievement of the outcomes in the Greater Manchester Strategic Plan 'Taking Charge' as 'added benefits' from investment outside of the health and social care budget
- Increased volume of 'purposeful' business sector activity in Greater Manchester that targets Greater Manchester population health outcomes
- The development of a values-based culture in both the health and social care workforce and the operational leadership of the devolution partners
- Increased ability of the partner organisations in health and social care devolution to monitor, report and be accountable for the social impact that they generate
- Increased return on investment/value for money in health and social care expenditure
- Evaluation work carried out as part of this programme will put in place a comprehensive dashboard and methodology for measurement of these outcomes

7. Next steps

7.1 Scoping and delivering via a blended approach

Over the coming months there will be a concentrated effort to mobilise a core team that will drive delivery and implementation of the Population Health Plan's aims and objectives, realising the outcomes and benefits that are to be delivered through the initiatives identified and those that are burgeoning within the localities.

There are some fundamental principles for delivery:

1. Governance will be transparent.
2. GMHSC Partnership will provide enabling and oversight as a minimum capability.
3. Implementation will be a blended-delivery model based on the party best placed to deliver the business and social impact.
4. Delivery will be driven through an alliancing model, where each member contributes and takes specific responsibility in delivery.

7.1.1 Governance will be transparent

To maintain momentum and also to hold to account the system partners, it is important to have good governance across the system. A Theme 1 Executive Board, with membership from providers and commissioners from health and social care across Greater Manchester, has been established to organise, direct and ensure delivery of the work set out in this plan as well as to oversee the deployment of any transformation resource and the achievement of investment deliverables. Each of the programme areas outlined in this plan has its own delivery arrangements, which will bring together resources from across the system to enable delivery.

The Theme 1 Executive Board has direct lines of reporting and accountability into the Transformation Portfolio Board, which reports directly into the Greater Manchester Strategic Partnership Board Executive and the Greater Manchester Strategic Board. Resources are being allocated across the system, such as a dedicated senior responsible officer (SRO) plus operational support in each of the localities, to support the implementation of the plan. The GMHSC Partnership team will be supporting the SROs in the wider leadership and delivery, and has invested in an enabling portfolio/programme/project

management office (PMO). All localities, through the submission of their locality plans, have aligned their local priorities with the commitments laid out in this plan.

As we move into delivery we will seek to define and design a localised light-touch governance model that will provide autonomy to implement and rigour in oversight to enable effective decision making and progress monitoring without creating unyielding bureaucracy.

7.1.2 GMHSC Partnership will provide oversight and enabling as a minimum capability

As many localities will embark upon the delivery and implementation of the initiatives it is anticipated that there will be a requirement for a core capability that will be able to support the localities. These core capabilities are the enablers in Figure 31 that will be required for all the initiatives implemented. The benefit of providing these centrally is that it will enable a specialist function to develop that can be deployed and allocated to each initiative, creating the rapid transfer of knowledge and learning quickly between initiatives. This will also have the benefit of reducing project overhead costs as these are carried centrally instead of by each project.

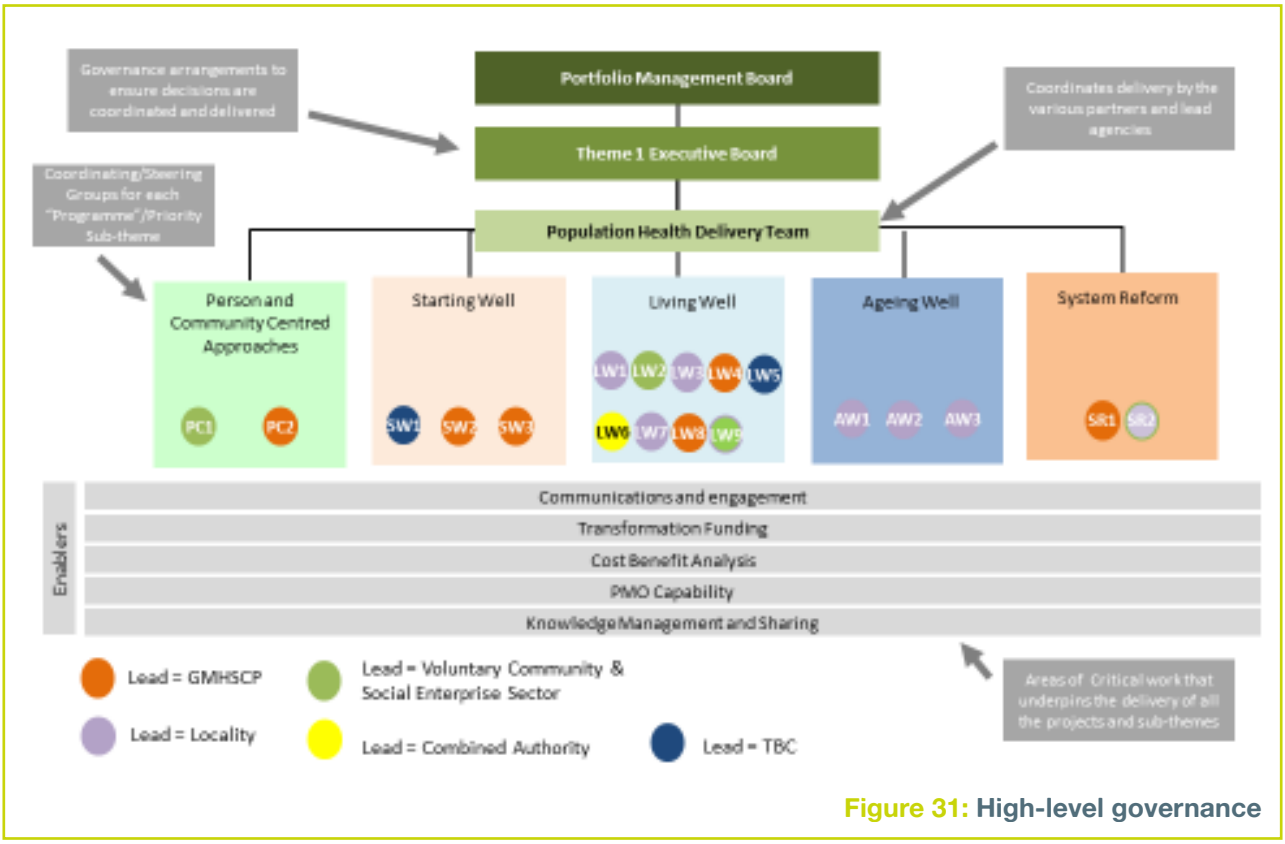


Figure 31: High-level governance

7.1.3 Implementation will be blended, based on the party best placed to deliver the business impact

Throughout the Population Health Plan we have identified a number of initiatives that are either ready for scaled deployment or concept testing i.e. 'piloting'. To be able to generate the changes and reform proposed, it will be necessary for the entirety of Greater Manchester community members to work collectively in the delivery of the volume, scope and scale of the work ahead. We believe that the most opportune means to achieve this is through a blended responsibility for delivery by GMHSC Partnership, localities, the voluntary, community and social enterprise (VCSE) sector and the Greater Manchester Combined Authority, as proposed in Figure 31 and Figure 32.

7.1.4 Delivery will be driven through an alliancing model - where each member contributes and takes specific responsibility in delivery

Due to the multiple parties involved in the delivery of each initiative, the approach to commencing each project will need to be established clearly. This will include clear terms of reference, objectives and benefits, and a clear schedule and profile. It is important that responsibility and scope is clear from the outset and that the accountable parties are clear on their role and remit.

A full project initiation approach and structure will be developed for all stakeholders to critique and endorse in the early part of 2017. This process of engagement with stakeholders will also enable all parties to reach a consensus on leadership roles and responsibilities.

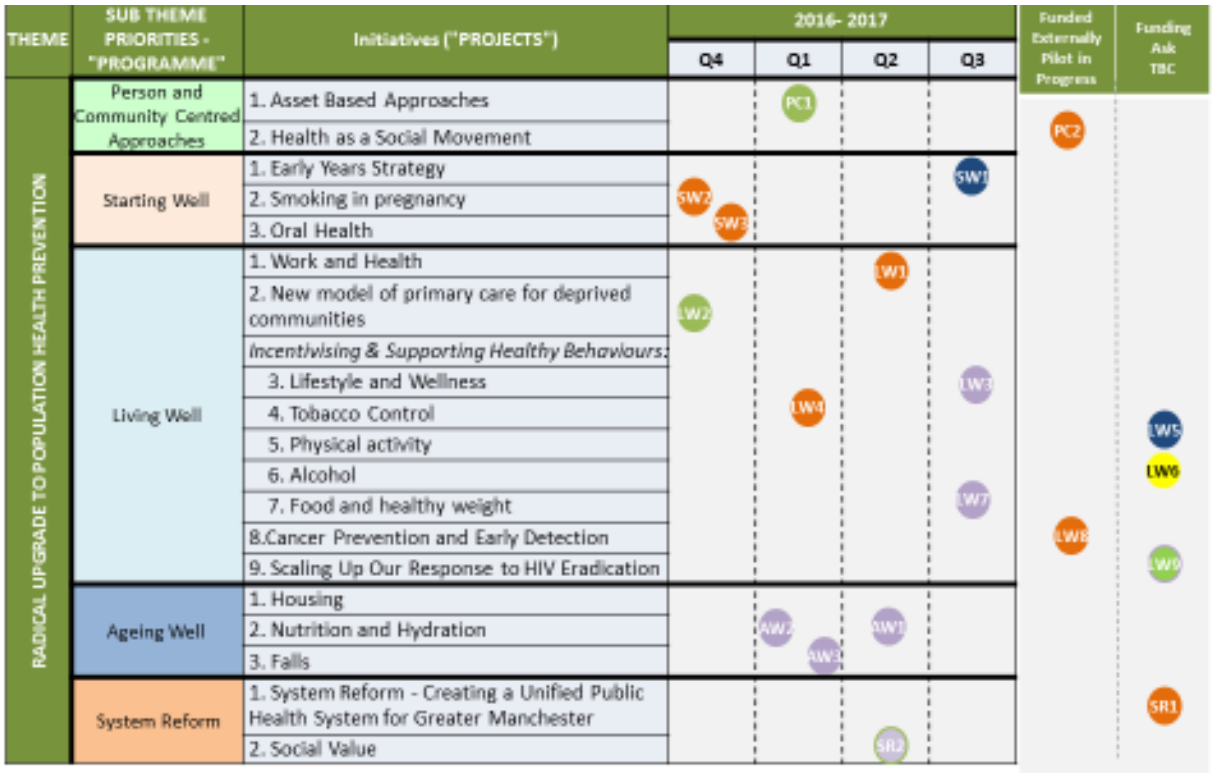


Figure 32: Transformation funding application development phases

7.2 Equality analysis and impact assessment

In alignment with the Greater Manchester Strategic Plan, this Population Health Plan is to be delivered with the ongoing commitment to advance equality and reduce health inequalities. The aim is to ensure that equality and diversity are prioritised in the design of the new system, and are embedded into the structures and delivery frameworks governing key relations between GMHSC Partnership, Greater Manchester Combined Authority and the VCSE sector. Working under the guidance of the expanded remit of the Greater Manchester Equalities Group, the Population Health Plan will seek to assess the equality impact of this plan and within each initiative to ensure they seek to mitigate and minimise any inequalities through their development and implementation

7.3 Delivery schedule

A detailed delivery scheduled will be developed and held for monitoring by the GMHSC Partnership core team as an enabling capability. A high-level schedule has been outlined in Figure 33 and will be developed in greater detail in collaboration with all the delivery partners.

7.3.1 High-level schedule

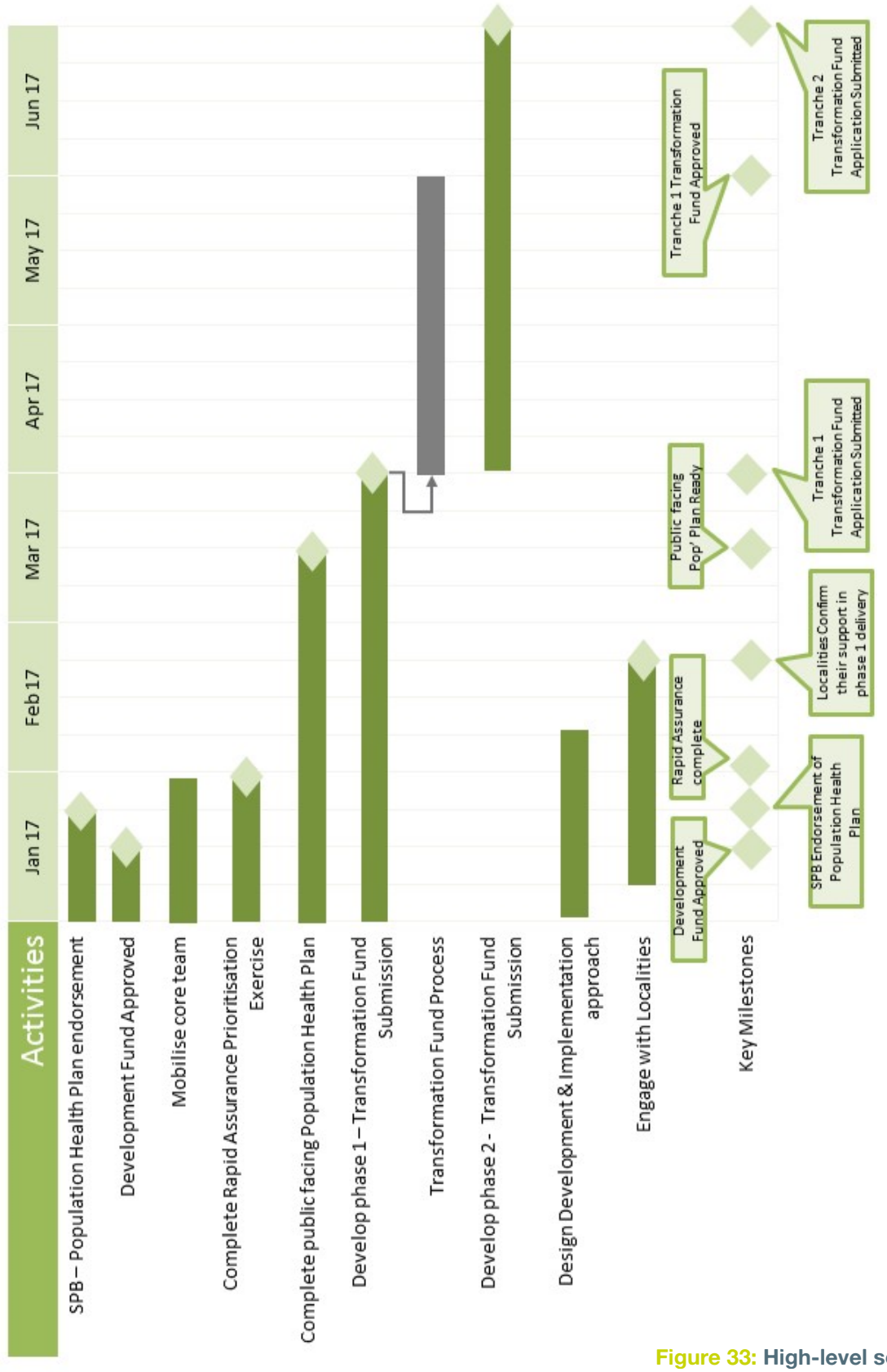
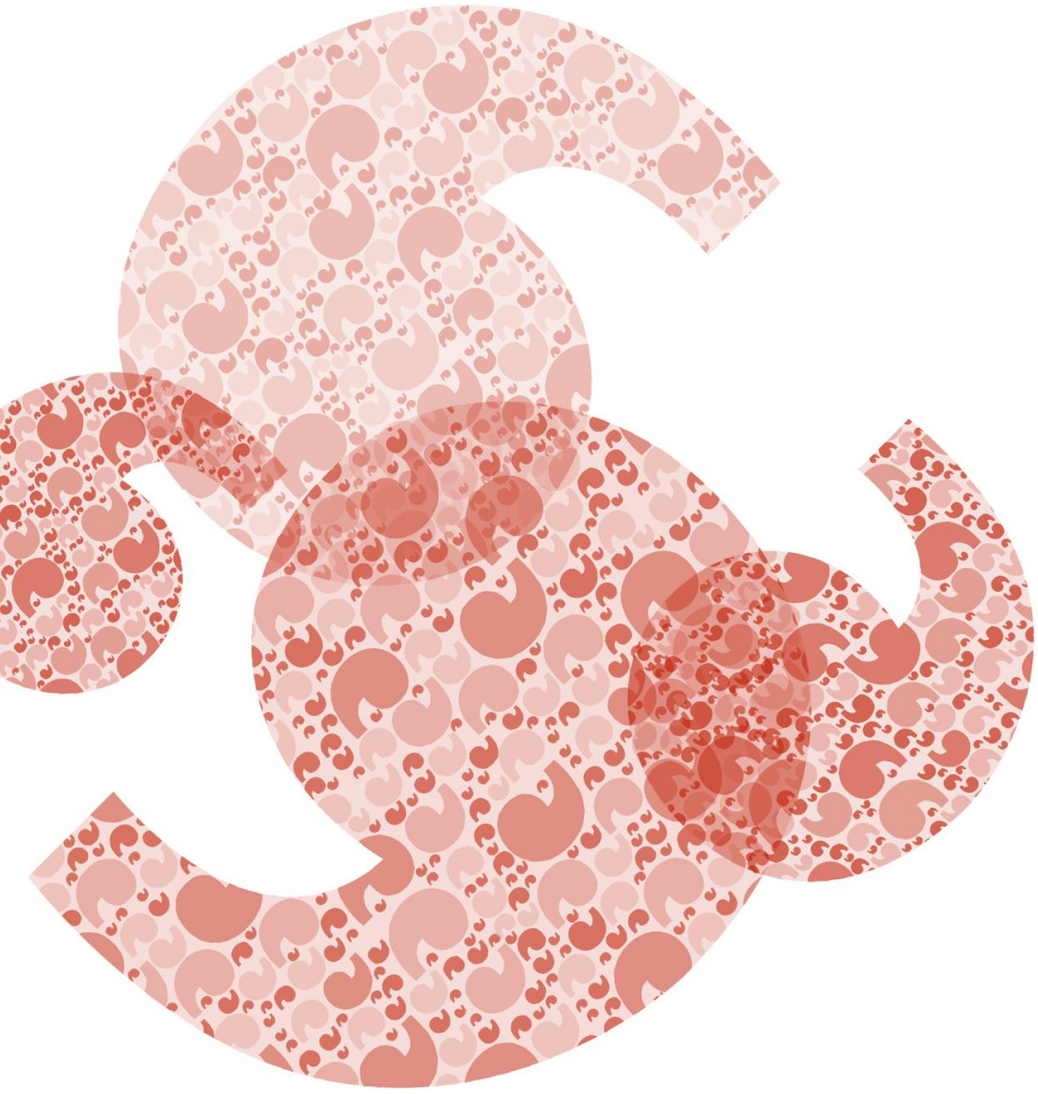


Figure 33: High-level schedule


Rochdale
Bolton
Bury
Oldham
Wigan
Salford
Tameside and Glossop
Manchester
Trafford
Stockport

healthwatch Trafford



PERFORMANCE REPORT

1st June 2018 – 31st August 2018

Contents

Chair's report – 1st June to 31st August 2018

Health Scrutiny Committee

Following a meeting with the new Chair of the Health Scrutiny Committee, I am pleased to report that I have been welcomed as a de-facto member and we have agreed that we will be working closely together on a range of issues in the coming months. We believe that this will strengthen scrutiny which was one of the criticisms made in the CQC local review of services' feedback at the beginning of 2018.

We have also agreed with the Executive member for health and social care that our shared priorities will be prevention, quality in care homes and dementia.

There was a presentation on the One Trafford response at Health Scrutiny. This is the second presentation we have attended. Whilst recognising the potential benefits of this pilot we are concerned that, to date, there has been no financial evaluation undertaken. We are told that the main issues identified relate to mental health but we understand also that GMMH have been unable to second a practitioner to this pilot because of pressures on their community staff and that new investment is not available. We are also unclear how, in the longer term, this pilot will fit with the local care alliance preventative work but look forward to further updates over the coming months.

Mental Health in Trafford

In terms of mental health more generally, we believe that there has been a 30% increase in referrals and we hope that more investment will be forthcoming in the Autumn budget to meet identified local priorities, particularly in the community. Healthwatch England is launching a new mental health programme at its October national conference and they have created a survey on maternal mental health aimed at the whole of England. During August Healthwatch Trafford's Healthwatch 100 project is looking at maternal mental health aimed at new parents. Our Advisory Group will be receiving a presentation on the new GM-wide service at the end of September. Healthwatch England will share its data for Trafford and, combined with our August HW100, this should paint a rich picture of how well we are doing on maternal mental health. Healthwatch Trafford has also agreed, as part of its work plan, to engage with Healthwatch England in setting up some focus groups in the New Year.

Later in the year, we will be looking at Healthy Young Minds – particularly at transition – as the Healthcare Safety Investigation Branch has recently published a report stating that only 4% of young people are happy with the care they receive. There is also the Government's response to the Young People's mental health green paper consultation to be considered. We were disappointed that there was insufficient time at the Health and Wellbeing Board to discuss Trafford's plans, although we had passed on our comments prior to the meeting. We continue to be concerned about the level of investment devoted to Healthy Young Minds and to the fact that information to performance monitor the service has been lacking.

New board members

We have appointed two new members to our Board who attended our August Board meeting. They will bring a range of expertise to our deliberations particularly around finance and legal issues.

Ageing Well

There have been several meetings and workshops around the topic of 'Ageing Well'. I attended a workshop on this topic at the Museum of Science and Industry and the Trafford table brainstormed the types of initiatives that would benefit our population. We look forward to seeing the outputs of the day.

The Ageing Well Sub-Board of the Health and Wellbeing Board met to finalise the draft Dementia Strategy – another requirement of the CQC local review – this strategy will be circulated for consultation with the expectation that the recommendations will be included in the appropriate commissioning and provider action plans.

Intermediate care

There have been several meetings with the CCG in relation to intermediate care and services to meet the needs of people with dementia and challenging behaviour in particular. Some progress is being made. We are about to look at the second element of intermediate care by interviewing people who have care provided at home. We will be working with the Council on this topic.

Greater Manchester Healthwatch

I reported in our last update to Governing Body that the 10 GM Healthwatch were being reviewed. Two independent Consultants have been invited to undertake this work which involves a 360-degree assessment, involving the Health and Social Care Partnership, commissioners, providers and other partners across GM. A final report is due in September.

Personal Independence Payments (PIP)

We have been fortunate again this year in having a Manchester University intern placed with us for 8 weeks. The topic this year is to discover what the impact has been on people with disabilities who have had their Personal Independence Payment withdrawn and/or downgraded. As well as a survey, individual stories have been recorded, many of which are thought provoking.

NHS at 70

We attended the unveiling of the Urmston mural by Kate Green, the MP for Stretford and Urmston. This was one of several events we attended to celebrate the 70th birthday of the NHS. Ann Day was recognised for her long service as a former children's nurse and former Chair of Healthwatch Trafford by Kate Green and Councillor Joanne Harding.

At the weekend 70th NHS celebrations we also held drop ins at the Town Hall asking the public to

provide us with their views on the NHS. We had dozens of responses and a busy day (except during the England football match)! These responses are currently being analysed as part of our HW100. We have also used the HW100 to undertake a survey on information about care homes.

Volunteers

We were also delighted that the Mayor of Trafford offered to host our volunteer get-together on 11 July to help us celebrate the time and commitment given to Healthwatch by our volunteers. We visited the council chamber where the Mayor, Cllr Tom Ross, invited us to take refreshments in his parlour and to visit the council chamber where he helped us present special certificates to Pete Longmire (business support), Georgina Jameson (Engagement), Kevin Costello (Research) and our young champions Yousuf and Sohail Shabbir, students at Altrincham Grammar School for Boys who, between them, helped us to collect 250 patient experiences!

We are also pleased to announce that we now have eight volunteer researchers who will greatly assist us with our reports and surveys.

Mental Health in Greater Manchester

We attended a GM mental health service user conference in Oldham where Andy Burnham and Jon Rouse took questions on the many issues posed by over 100 service users and carers from across GM who attended this event to launch the Greater Manchester service user network.

Key issues raised included:

- Big gaps between physical and mental health (Parity of Esteem)
- Small amounts of money spent for small lengths of time in the voluntary sector
- CAMHS and particularly transition, training for foster carers, particularly those looking after children in care.
- Inequity for people from BME groups
- social prescribing which was viewed as failing

A full report on the proceedings will be published by the GM Health and Social Care Partnership in due course.

We also attended the service launch of the Greater Manchester Mental Health Trust service user strategy. Again, around 100 people attended, and the Chief Executive gave his personal support to this initiative.

This event was followed by the GM Mental Health Adult Board at which a presentation was made in relation to a 'Deep Dive' on Early Intervention in Psychosis. At the next meeting there will be a deep dive related to out of area

placements which is seen as a key priority and something that Healthwatch Trafford is particularly concerned about.

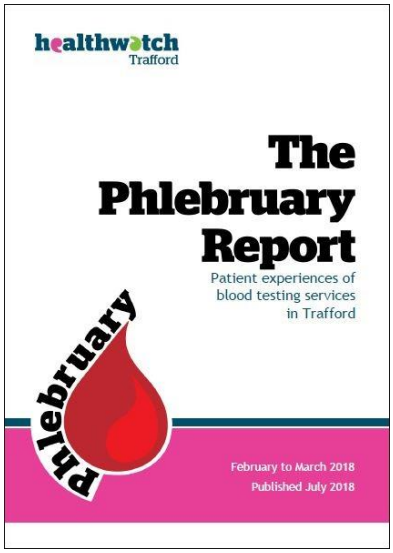
Advisory Group

Our Advisory Group met towards the end of July. Although not as well attended as usual (for which the August holiday season can be blamed) there was, nevertheless, some useful discussion on a range of topics including the work of the Health and Wellbeing Board, our Annual Report and our report on phlebotomy.

Phlebotomy

We published the 'Phlebruary' Report in July providing 327 patient experiences of blood testing services in Trafford. We used the patient feedback we received to make six recommendations on the way forward. 100 people complained specifically about waiting times.

- People wanted to be able to book specific times to have their bloods taken
- There was a need to standardise the information provided to patients
- Some provision for early evening/weekend provision was requested
- More effective matching of staffing availability to patient demand patterns
- A preference to have bloods taken at patients' GP practice for a significant majority of those who responded.
- Increased capacity at Trafford General and Altrincham hospitals and more effective preparation for staff absences.



There are clearly efficiencies to be made through more effective organisation of these services. We were particularly concerned that staff at our two hospitals were reported as being subject to harassment and abuse by patients who were exasperated by the length of waiting times.

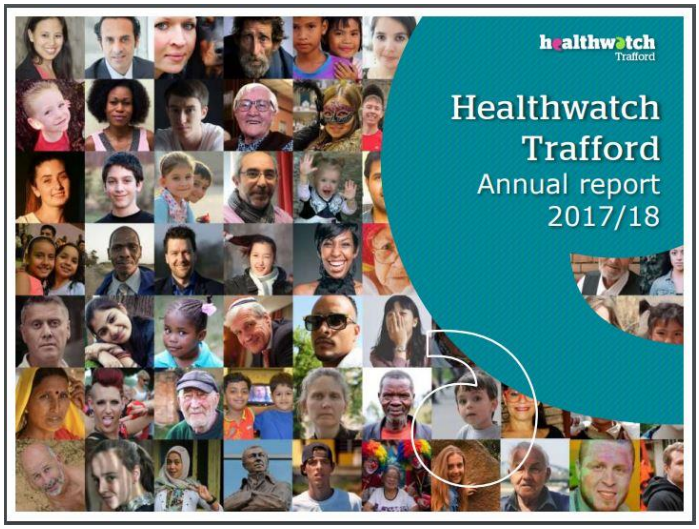
We are also aware that patients lose money, particularly if they are on zero hours' contracts and employers must be frustrated at the loss of working time. Abortive visits incur additional expenses for patients, either through repeat attendances or having to move between clinics. What is particularly worrying being when patients just give up waiting thereby potentially impacting on their health and wellbeing as they may not have a clear idea as to why their bloods need to be tested or even view testing as necessary. Our Advisory Group felt that when GPs refer they should indicate whether the bloods are urgent or routine.

In direct response to our report, the Group Chief Executive of Manchester University Foundation Trust has already indicated that his Trust will move to an appointment system and the Trust will work with the CCG to introduce an electronic resource called the 'hub' appointment system at GP practices to improve information for patients on available services. The Trust is also committed to looking at the potential to introduce an out of hours' phlebotomy service and

more staff have been recruited. There still remains, however, the issue of whether GPs are able to offer blood testing and we hope that the CCG will continue its efforts to encourage such services being provided in general practices across Trafford.

Health Scrutiny Committee has set up a task group to look at our phlebotomy recommendations. As requested at the last Governing Body, we have committed to looking at phlebotomy for children and have had some early discussions with senior staff at Trafford General Hospital.

Annual report



June also saw the publication of our Annual Report which was widely distributed. During 2017/18, we published 13 reports ranging from dentistry to intermediate care. We undertook several enter and view visits to care homes the findings of which we have again shared widely. Our website was visited 22,000 times and the most popular page of all was our guide on 'how to get seen by as doctor'. Healthwatch 100 is also proving a successful means of gauging public opinion – in fact GM Healthwatch would like to adopt it across all 10 boroughs and possibly rename it Healthwatch 1000! In total we had around 900 views using this mechanism, the highest response being on phlebotomy, followed by women's health, allergies and GP access.

We continue to balance 'big ticket' issues as well as representing the views of hard to hear and minority groups. I pay tribute to our staff and volunteers but also to those Directors who continue to provide us with 'hands on' help and support our various activities.

Ongoing issues yet to be satisfactorily addressed:

1. Public Consultation processes reinforced by the results of the recent CCG Improvement and Assessment Framework.

Issues raised during June/July/August

2. Phlebotomy – where we hope to see the CCG's response in relation to GP surgery provision.
3. Healthy Young Minds – where we hope to see additional and significant improvements in investment in 2019/20 as part of the prevention agenda.

Chair
Healthwatch Trafford

Appendix 1 - Public engagement

	2017-18 Totals	2018 - 19 to date	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
Public drop-ins -total	**52**	**16**	3	5	5	3	0							
Locality 1	11	3	1	0	0	2	0							
Locality 2	16	5	1	1	3	0	0							
Locality 3	9	4	0	2	2	0	0							
Locality 4[1]	16	4	1	2	0	1	0							
Number of public contacts[2]	**1977**	**659**	145	148	139	227	0							
Number of complaints/ concerns recorded	**49**	**12**	4	4	3	1	1							
Number of public signpostings	**82**	**24**	6	7	4	7	1							
Healthwatch 100 (# of people signed up)	**197**	**307**	45	35	10	18	2							

[1] The four localities of Trafford are defined as:
Locality 1 - Old Trafford, & Stretford, - Gorse Hill, Longford, Stretford and Clifford; Locality 2 - Sale - Bucklow St Martin's (Sale) Ashton upon Mersey, Brooklands, Priory, Sale Moor and St Mary's; Locality 3 - South Trafford - Altrincham, Bowden, Broadheath, Hale Barns, Hale Central, Timperley and Village; Locality 4 - Urmston & Partington - Bucklow St Martin's (Partington), Davyhulme East, Davyhulme West, Flixton and Urmston.

[2] 'Public contacts' are defined as members of the public engaged with at public events (this excludes all other public contact e.g. regarding complaints/concerns, signposting, HW100, social media tweets/shares, visits to website – so does not duplicate other figures in this table)

Healthwatch 100 # of surveys conducted	**9**	**3**	1	1	0	1	1							
Number of new volunteers (total)	**(42)**	**(43)**	0	3	0	0	6							
Number of volunteer hours	**1058**	**517**	99	91	96	141	90							
Business support	98	57	11	18	16	12	14							
Engagement/ Outreach	411	168	33	43	35	57	0							
Research	278	101	27	25	33	16	46							
Strategic	137	34	3	2	12	18	18							
Vol management /Training	134	68	25	4	1	38	12							
Radio interviews	**2**	**0**	0	0	0	0	0							
Website visits	**22672**	**8288**	1943	1765	2154	2426	2496							
Reports published (*not inc. performance reports)*	**13**	**0**	0	0	3	1	1							

Online and social media statistics June - July 2018

Twitter
New followers : 37
Total followers : 2093
Tweets : 266
Impressions : 73.4k people

Facebook
Likes : 147
Following :143
Posts : 4

Instagram
Posts : 2
Likes : 415
Followers : 434

Website
Visits : 7,015
Page views : 11,429
News articles : 70

Appendix 2 - Feedback analysis

Feedback by service type 1st June to 31st August 2018

Key: For each row and column green indicates the highest rating and red the lowest.

Service type	Number of reviews	% of reviews	Overall rating	Cleanliness	Staff attitude	Waiting time	Treatment explanation	Quality of care	Quality of food
Hospitals	50	53.76	3.50	4.35	4.19	2.68	4.06	3.98	3.19
GPs	31	33.33	3.58	4.54	3.81	3.37	4.08	3.88	5.00
Dentists	6	6.45	4.17	4.83	3.67	3.17	4.17	4.17	3.00
Opticians	0	0.00							
Community Based	2	2.15	3.00			1.00			
Emergency Care	0	0.00							
Pharmacies	0	0.00							
Social Care	1	1.08	1.00		1.00				
Other	3	3.23	4.67	5.00	5.00	5.00	5.00	5.00	5.00

Overall feedback across all Trafford services

Category	Average rating	Number of reviews
Overall rating	3.57	93
Cleanliness	4.46	78
Staff attitude	4.01	83
Waiting Time	2.98	83
Treatment explanation	4.10	69
Quality of care	3.99	73
Quality of food	3.37	19

Where our feedback has come from in Trafford (*where location was given*)

Area	Count	% of feedback	Average of feedback
Sale	14	15.05	3.71
Altrincham	21	22.58	3.43
Timperley	12	12.90	3.83
Stretford	2	2.15	5.00
Urmston	3	3.23	2.33
Hale	7	7.53	4.14
Flixton	0	0.00	
Partington	0	0.00	
Old Trafford	5	5.38	3.20
Davyhulme	2	2.15	3.50
Bowden	0	0.00	

Appendix 3 – Healthwatch 100

Maternal Mental Health

Status of information	Output	Key findings
Survey open	Possible report.	Info not currently available. Information collection is being carried out via Healthwatch England survey system.

The NHS at 70

Status of information	Output	Key findings
Survey closed, Information being analysed	Likely to inform information products eg. Guides and leaflets	So far: 120 replies. Many suggestions for improvements to local services.

Care home information

Status of information	Output	Key findings
Being analysed	Likely to inform information products eg. Guides and leaflets	So far: • 20% of respondents have no idea where to get info on care homes • 45% didn't know what NHS funded nursing or what NHS continuing healthcare is • Many want a live database showing where current vacancies are and cost.

Phlebotomy

Status of information	Output	Key findings
Report published	Report published July 2018	• Two-thirds of the 327 respondents have indicated they would prefer to book a specific time for a blood test. • Most of the qualitative feedback focuses on lengthy waiting times / understaffing. Some respondents turned away from clinics as wait was too long.

Pharmacy & prescription services

Status of information	Output	Key findings
Report Published	Report published August 2018.	• The most prescribed item for respondents was prescription only painkillers and medication, followed by over-the-counter painkillers and medicines. • Independent pharmacies were used most (36%) followed by chain pharmacies and those in supermarkets. • In the last year, 50% or more had used a pharmacy for disposal of medicines and advice on minor ailments or healthy living.

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Enter & view Report:

healthwatch Trafford

Heathside Retirement Home

74 Barrington Road

Altrincham

WA14 1JB

Tel: 0161 941 3622

Owner: Mr Andrew Meehan &

Mrs Frances Ann Meehan

Manager: Clair Talbot

Date of visit: 25th July 2018

Date of publication: September 2018

Contents

What is Enter & View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and view visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand. The aim of the Healthwatch Enter and View visits is to give relatives and carers a perception of what daily life it is like for residents living at a care home and whether the home is somewhere they would place their family member.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit. In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the Care Quality Commission [CQC] where they are protected by legislation if they raise a concern.

Acknowledgements

Healthwatch Trafford would like to thank the Manager, staff and residents of Heathside Retirement Home and the relatives of the residents for their contribution to the Enter and View programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users, only an account of what was observed and contributed at the time.

Executive Summary

Findings and Recommendations

Findings

- Heathside Retirement Home provides care for up to 30 older people, over 50% of the residents are living with varying degrees of dementia. At the time of the visit there were 26 people living at the home.

- The home is a large detached house with accommodation provided over three floors. All bedrooms are single rooms; 21 bedrooms are ensuite. There is a large accessible garden area to the rear of the property.

- The home offers long-term residential care and short-term respite care a day care service.

- At the time of the visit the Manager had been employed at the home for nine years. The home does not use agency staff and are able to cover any shifts required from within the staff team. This means there is continuity of staff supporting people.

- The Manager kindly agreed to mail out 26 questionnaires to relatives of residents living at the home, 7 completed questionnaires were returned to us. All questionnaires informed us that they felt their relatives living at Heathside Retirement Home were treated with kindness and compassion, see full results here:

- On approaching the home, we observed notice boards in the porch showing the large variety of activities that take place and the trips planned for the forthcoming month. At the time of the visit 'pamper sessions' were taking place, we observed several residents having their hair and nails done. Television sets were on in the communal lounge areas but did not dominate the rooms enabling people to hold a conversation.

- On the day of the visit we observed all staff, including the Manager and owner interacting with residents in a caring and kindly manner.

- Staff we spoke to told us that they were very happy working at the home and felt supported by the Manager and the home's owners.

- Costs are in the order of £550 - £750 per week.

- A CQC inspection of Heathside took place in July 2018. Following the inspection, the home was given a 'Good' rating. Please go to: https://www.cqc.org.uk/location/1-117483647 to access the CQC full report

Recommendations:

- *Consider incorporating into the Heathside newsletters or correspondence with residents' relatives the "you said, we did", to demonstrate the action taken by the home regarding issues and suggestions raised.*

Good practice identified:

Internet access and the use of technology to connect residents with family members, through Skype 'face to face' technology.

The Manager's weekly buzzer test to monitor staff response time.

Cover is provided by in-house staff eliminating the need for agency cover and maintaining continuity of care for residents.

Consider adoption of the other good practice initiatives:

http://www.bbc.co.uk/rd/blog/2017-02-bbc-rem-arc-dementia-memories-archive

A programme to encourage reminiscence in people with dementia.

https://www.carehome.co.uk/news/article.cfm/id/1574414/paper-armband-care-workers-malnutrition.

This is a paper armband, which can be routinely used to identify changes in nutrition or hydration.

https://www.nice.org.uk/guidance/ng48
A link to the National Institute for Health and Care Excellence [NICE] for 'Oral health for adults in care homes'

Purpose of the Visit

The visit to Heathside Retirement Home is part of an ongoing planned series of visits to care homes to discover what residents and their families think about the health and social services that are provided and examples of good working practice by:

- Observing and identifying best practice in the provision of care homes for vulnerable older people requiring social care or nursing care.
- Observing residents and relatives engaging with the staff and their surroundings
- Capturing the experience of residents and relatives

An Enter and View visit is not an inspection.

Strategic Drivers

We are using all/some of the following criteria for the timing of our visits.

- Ageing population in Trafford requiring care homes
- Good practice
- Length of time since the last Care Quality Care [CQC] visit so that we are not placing an unfair burden on care home management and staff by having two visits in close proximity.
- Where any issues of concern are raised with Healthwatch either by a resident or their carer. Residents' family/carers will be asked to complete a questionnaire anonymously.
- If there are specific questions of quality of care raised by Trafford Council, Healthwatch [as an independent body] will consider whether a visit is warranted.
- When invited by care homes to publicise good practice or points of learning.
- CQC and partners 'dignity and wellbeing' strategy:
- http://www.cqc.org.uk/content/regulation-10-dignity-and-respect
- Changes in management of the home.

These visits are a snapshot in time, but our reports are circulated widely and can be used by care homes to acquaint the public with the services offered.

Methodology

This was an announced Enter and View visit.

Contact was made with the home explaining our reasons for the visit. Posters were supplied to alert our visit to staff, residents and family members.

We sent a questionnaire to the Manager of the home and received responses prior to the visit (Appendix A).

We sent a questionnaire to residents' family and carers for them to respond anonymously (see Appendix B).

We looked at local intelligence including CQC reports. The CQC inspected the home in May 2017 and gave a 'requires improvement' rating, please follow link to access the full 2017 report: https://www.cqc.org.uk/location/1-117483647

We were guided by staff on the residents we could approach to answer our questions. We talked to five residents, one relative and seven members of staff. It should be noted that many of the residents had dementia.

Healthwatch Trafford Authorised Representatives

- Susan George
- Marilyn Murray [Lead Representative]
- Jean Rose

The visit

Introduction

Healthwatch Trafford visited Heathside Retirement Home on 25th July 2018.

Healthwatch Trafford undertake Enter and View visits of any care home, GP surgery, hospital or other health or social care facility which is publicly funded either in part or in whole. These visits aim to paint a picture of residents' and patients' experience and we hope that our reports will be used to inform the public and potential users of the service on what they can expect.

These visits are not inspections; they are a snapshot of what we observed on the day of the visit. As these visits are not inspections, we have framed our questions in such a way that they reflect how residents and their carers feel about the quality of service on offer. We have also observed governance arrangements to see how the home is run and assessed whether we feel it meets standards the public should expect.

Before our visit, we sent questionnaires out to the Manager of Heathside and to the residents' families/carers who were asked to anonymously provide their views. The questionnaire for management and the Manager's response is provided at Appendix A and the questionnaire for residents can be found at Appendix B. The responses to Appendix B are summarised on page 13.

Profile of Heathside Retirement Home

Heathside is a care home registered to provide personal care, the home also provides respite accommodation and a day care service. The home is privately owned by a Mr & Mrs Andrew Meehan.

Heathside is a large traditional detached house, that has been extended to accommodate up to 30 residents. It is situated on a busy main road in the Altrincham area of South Trafford, there is limited car parking space at the front of the home. Accommodation is over three floors and consist of 28 single bedrooms and one shared double bedroom. The home has kitchen area, three lounges and a dining room. Twenty-one bedrooms have en-suite facilities. There is a lift to all floors. At the time of the visit there were four vacancies at the home. The home has access to an enclosed well-maintained garden that is wheelchair accessible. There are very good public transport links to Altrincham town centre which is close by.

General Observations

In the porch leading to the front door of Heathside, there is a notice board displayed informing visitors of the activities on offer at the home along with a diary of events, including trips out that had been planned for July and August. We observed the food hygiene rating for the home and the CQC registration notice displayed at the front of the home.

Access to the home is security coded, staff activate the door release to let visitors in and out of the building. On entering the home there is a large, bright hall. Access to the Manager's office is from the entrance hall making it easy accessible for staff, residents and visitors. There is a visitors' book strategically place for people to sign in on entering the home. We observed various information notices for visitors visibly displayed on the walls. The large secure garden is set up with gazebo, metal table and chairs and the home had organised a garden party for August.

A large stairway situated in the entrance hall leads to the upper floors of the home. There are lifts available to all the floors. The communal lounges are light, well decorated, and homely. We observed plenty of seating in the communal areas for residents and visitors. At the time of our visit residents finishing off their breakfast in the dining area and we witnessed several residents serving themselves to extra toast and drinks. We were told by a member of staff that residents are encouraged to do this as it helps to maintain independence.

The home boasted several activities such as, gardening, computer, painting, book club, cake making, photography, pottery making film and DVDs. One resident informed us that she enjoys doing the 3D collage activity at the home. On the morning of the visit we observed 'pamper sessions' taking place where residents can have their hair done and nails painted. We were informed by staff, residents and relatives that the pamper days that take place every Wednesday at the home are very popular. All residents appeared well groomed with many of the female residents displaying well-manicured finger nails.

When speaking to residents we learned that several had landlines in their rooms, one resident enjoyed ordering a Tesco delivery and listening to music in his room. He also had a friend who visited him on a regular basis. We learnt that the home has internet connection for residents and this has enable one resident to face-time her relatives in New Zealand keeping her in contact with family and friends.

One resident told us that he had been at the home for 12 months and that he like to watch TV and do a bit of gardening. He stated:

"It's very good [the home], the best of the last three I have been in. I speak to most people, I would like to get out to the shops more, but I am unable to move around and would need to be accompanied when going outside. I used to use the public transport, I miss going on the public transport".

Another resident told us:

"I have been here for six years, I must like it. Good meals, I go in the garden sometimes".

When we asked one resident if there was anything that could be improved for him at the home, he replied:

"I just want a walk in the countryside".

We noted that the home has recently taken residents out on trips to Dunham Massey and to the Lake District, which were very popular with those who took part.

The relatives we spoked to on the day of the visit appeared keen and sincere in their praise on the care their loved ones received at the home, comments such as:

"My mother has dementia but wouldn't have come into Heathside if she thought it was a care home. She is very happy here, staff are always talking to her, they are so friendly. The dining room is set out beautifully with napkins for meals times, my mother thinks it is an hotel. My mother's mobility has improved since coming to live at Heathside and she looks amazing!"

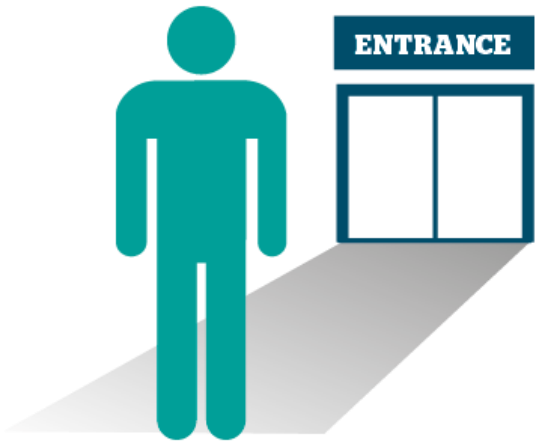
Another relative told us:

"...the home is fantastic, staff provide quality care to the residents and my father-in-law has gained weight since moving here".

The home's main cook works Monday to Friday with the home providing weekend cover for cooking duties. Staff informed us that the home provides a cooked breakfast every morning for all residents, followed by morning coffee, lunch, afternoon tea, tea-time and supper. The cook emphasised that there is always a choice for residents if they wish to have alternative to what is on the menu that day and that residents can eat in the dining room or in the own rooms if they desire. One resident we had previously spoken to when asked about the meals stated:

"I enjoy the meals, particularly hash browns"

We observed drinks readily available and within easy reach of residents and on the day of the visit which was a warm day we observed several residents in the communal lounges eating a medley of fruit, grapes, pineapple and water melon. We were informed by staff and residents that during the hot weather residents have been enjoying eating ice cream delivered to the home by a local 'ice cream vendor'.



The ambience throughout the home appeared very relaxed and friendly. The home smelt clean and fresh with no odours. One visitor stated:

"I *attend the home regularly on different days and at different times, on the odd occasion when I have detected a slight odour in the home it has gone when I come to visit the following day, the home is kept very clean".*

All communal areas and corridors of the home were uncluttered. On the day of the visit we had the opportunity to observe some residents' bedrooms, which were odour free, clean and appeared comfortable for the resident. One resident who is blind told us that he was very happy at the home and spends most of his time in his room but does have concerns about a resident that wanders and come into his room. To address this, the home has erected a curtain over his doorway to deter the dementia resident from entering the room.

We observed buzzers in residents' rooms and were told by one resident that she waits a while for staff to respond to her buzzer when she wants to go to the toilet. The Manager

informed us that she carries out an unannounced weekly buzzer test from various locations within the home to observe how long it takes a member of staff to respond and that staff are responding quickly every time.

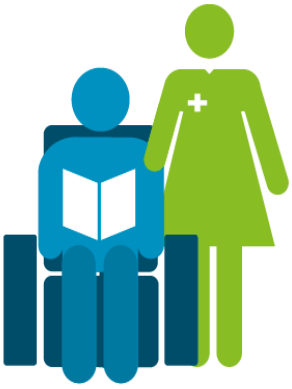
Signage to facilities such as WC/bathrooms was clearly visible. We observed fire extinguishers situated around the home and staff informed us that alarms are checked Tuesday every week. All staff are trained on fire evacuation and the home has three evacuation sledges to ensure residents are transferred out of the home safely. [see link: http://www.medsled.com/hospitals-nursing-homes/ In case of evacuation, residents would be taken to Claremont Care Home. However, negotiations are currently taking place with Altrincham Methodist Church, which is in the immediate vicinity.

We asked about laundry and how the home ensures that residents' clothes are labelled and returned correctly. The Manager stated, that there is a persistent problem with the labelling of clothes, for example, some iron-on labels do come off, however we are constantly trying to improve this matter. On the day we visited, the residents looked well cared for in their surroundings and appeared very comfortable with all the staff working at the home.

During the visit we witnessed an array of picture cards that care staff use to communicating with residents whose first language is not English and others who have difficulty in communicating verbally.

The staff members told us we that they were happy in working at the home and caring for the residents whom they appeared to know very well. All staff felt supported by the Manager and owners of Heathside Retirement Home.

Profile of residents



The residents we observed on the day of the visit were elderly, of mixed gender and ethnicity, with over 50% living with various levels of dementia. The people we saw on the day of the visit were a combination of residents who lived at the home and those who used the home's day care service.

Management of the Home –

The following comments should be read in conjunction with **Appendix A** which was completed by the Manager of the home on the day of the visit. The Manager of has been employed at the home for nine years.

When we asked how residents and their families provide feedback or raise any concerns, the Manager informed us that the home has a complaints procedure that is made available to all residents and relatives. The home has monthly resident/relative meetings and those relatives who do not wish to attend the meeting will receive all relevant information from the home. The Manager stated that the home also sends out quality assurance surveys to residents, relatives, staff and outside agencies on an annual basis.

When we asked about accessing GP Practices, we were told that currently 14 Heathside residents are seen by one GP practice [named] the Manager stated: "*there are no problems with the GPs Practices that serve the home as we know them all very well*". When we asked how often the home calls the 999-emergency ambulance service, the Manager told us, *virtually never*, however, during the current heatwave we have called upon the service three times.

Prior to our visit, we asked what measures were taken if a resident has a fall, the Manager informed us that all falls are recorded. When auditing falls we will put into place required action to prevent falls. The Manager added that the home has sensory mats in bedrooms and response buzzers.

On enquiring about residents' food and liquid intake, we were informed by the Manager drinks and snacks are readily available for residents and that residents intake of meals is discussed at staff meetings. If we have any concerns referrals can be made to the Trafford dietician.

The Manager informed us that the all staff at the home are using the CareDoc system to input accurate up to date records of the care and wellbeing of the individual residents they are looking after. The system is working very well, giving a 'real time' account of the care being delivered to the individual. For further information please go to: https://www.caredocs.co.uk/

We did not ask the Manager about dental services; however, we were informed by a resident at the home that he accesses the dentist that is situated across the road from the home for his dental care, which is very convenient and is accompanied by a member of staff when his appointment is due.

When enquiring about staff retention, we were informed that the home has a good record of staff retention. The Manager stated that there are no special problems with staffing and no agency staff are used at the home. The home's registered staff members will provide all staff cover when required even at a last minute's notice.

The Manager informed us that all staff must complete the home's mandatory training and all staff appraisal take place on a quarterly basis, please *see page 19 of this report for further information*. The Manager praised all the staff at Heathside for their excellent work.

The home has advance directives, and these are discussed when a person enters the home. A resident last wishes section is included in their care plan.

Deprivation of Liberties [DOLs][1]

We were informed by the Manager that there are significant waiting times for full authorisation from Local Authority for DoLs. However, the Local Authority currently issue pending authorisation of DoLs monthly to the home and this is working well.

[1] *The **Deprivation of Liberty** [DoLs] Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests.*

*Deprivation of Liberty Safeguards. The (**DoLS**) are part of the Mental Capacity Act and aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.*

Summary of relatives' responses to questionnaire

(see relative questionnaire in appendix B)

We left 26 relative questionnaires with the management of Heathside Retirement Home to send out to relatives of residents living the home. We received seven completed questionnaires from relatives. All the relative questionnaires informed us that they felt that their family member is treated with kindness and compassion.

Below are the comments we received from relatives and carers. The comments are taken verbatim from the relatives and carers questionnaires. Please note that, whilst we received seven completed questionnaires from relatives and cares not all choose to complete the comment box section.

1. *"My father is very contented in the home, staff very friendly and they let me know straight away if he is poorly etc. We are happy, and we know he is being looked after properly".*

2. *"My loved one is very negative about life in general and always has been. I am satisfied that she is well cared for, but she is also difficult to manage and will refuse aspects of care and most activities that are offered. I do know that she would hugely welcome trips out to the local shops and/or a trolley offering confectionary, magazines etc provided in the home. At the moment I am the only person who takes her to the shops".*

3. *"A lot of extra money is required for spends on fruit juice, fruit, tissues, outings etc".*

   Response from Management: The Home's does not charge for fruit juices.

4. *"If I ask about my relative I know that I would be informed re: medications etc. But it is on a need to know basis. I have absolutely no qualms about the commitment of all the staff at Heathside and I am so glad that by serendipity, I found the home".*

5. *"I am happy with the care my loved one receives at Heathside, the staff are caring and compassionate and there is a good range of activities".*

6. *"I feel my mum is looked after with care and compassion".*

Appendix – A
Management questionnaire and responses

Please note that responses are listed as they were received.

Pre-visit questionnaire for the Manager of Heathside Retirement Home, Altrincham –

Q1. How do you facilitate your residents and their families in raising any concerns they may have? Do you do this on a routine basis and, if so, how often?

The home has a complaints procedure for people to access.

Q2. Do volunteers come into the in the home? If so what type of activities do they do?

From Trafford College students and carers.

Q3. Do other organisations come into the home? If so who are they and what do they offer?

We have a physiotherapist visiting the home and a lady who provides chair exercises.

Q4. Do residents have fresh fruit and vegetables on a daily basis`?

Yes, available as part of their meal.

Q5. Are drinks available and within easy reach? Are drinking levels monitored and recorded in care plans where there are concerns?

Yes, and there are water foundations situated in the home for residents' use. Individual residents are monitored when it has been recorded in their care plan to do so.

Q6. Do you seek advice from nutritionists where there are concerns (residents losing weight or experiencing any level of pain)?

We will refer to Trafford dietitian.

Q7. How do you gauge that residents enjoy their food and drink?

Residents intake of meals is discussed at staff meetings. Residents have a choice of meals. Everybody has a cooked breakfast every day, which residents enjoy.

Q8. Does a single GP practice cover the medical needs of the home or do residents retain their own family doctor?

There are 26 residents currently living at Heathside, 14 are registered with the GP Practice on Barrington Road. There are no problems with the GPs Practices that serve the home as we know them all very well. For example, if we have a resident with a urinary tract infection [UTI] we can use a dip stick test to assess the severity of the infection and contact the relevant GP by phone. If it is a mild case, the GP will arrange for a prescription to be made up or attend the resident if the condition is more severe. This procedure works very well.

Q9. Which healthcare professionals visit the home at your request e.g., chiropody/podiatry, physiotherapy, district nurse, dentist or social worker?

District Nurse and podiatrist. The home has a hairdresser attending on a weekly basis which residents pay for.

Q10. If professionals do not come into the home, how do you access their services?

As and when needed, the District Nurse is contacted by the home before contacting a GP.

Q11. Are residents likes and dislikes recorded in care plans?

Yes.

Q12. Are residents encouraged to talk about their past lives and how do you encourage this? Examples might include local history books, old photographs or films.

The home always takes past history in the “this is me” section on residents’ care plans.

Q13. Do residents have choice over what they wear each day?

Yes.

Q14. How do you cope with making reasonable adjustments in relation to residents with dementia, learning disability or other special needs such as autism or challenging behaviour?

There are no residents with special needs and challenging behaviour at the moment. We have two residents that are under the dementia crisis team.

Q15. How do you address the needs of people from minority ethnic groups or of different cultures and faiths?

The home has a “key ring” that holds a selections of picture cards that helps residents to communicate their needs and desires to staff members.

Q16. Do you have visiting faith leaders in the home?

It is recorded in residents' care plans and some faith leaders come every week if this has been requested by the resident.

Q17. Do you encourage family and friends to think about having advance directives?

Yes, on entry to the home. A resident last wishes section is included in their care plan.

Q18. Do you invite the community to bring in pets?

A member of staff will visit with her dogs.

Q19. Do you have regular meetings with residents' families?

Yes, monthly.

Q20. Do you take residents out into the community?

Yes, shopping, to church, to coffee shop. Residents are accompanied by a member of staff.

Q21. If a resident falls, what measures do you follow? Do you call a GP, the ambulance service or utilise other measures? Do you record falls in every care plan, however minor or major?

The fall is recorded on an accident form and a 48 hours observation period is put into place. We carry out a monthly falls audit to access if there are any patterns or trends are appearing.

Q22. What preventative action do you utilise to prevent falls? Have you access to a falls advisor?

We have sensory mats in bedrooms and response buzzers. The home's handyman checks and cleans zimmer frames, and walking stick every week.

When auditing falls we will put into place required action to prevent falls, for example, one resident was experiencing falls around the tea-time period and we put extra staff during this period to watch the resident and prevent any further falls.

We have access to the falls team in Trafford and staff members attend falls prevention awareness training.

Q23. What feedback have you had from residents in the last three months which have resulted in change?

The home has organised trips and outing for residents to the Lake District and Dunham Park and have increased the range of activities provided at the home for residents.

One resident requested a brighter light in bedroom and this was carried out.

Q24. How do you keep abreast of good practice? Examples might include e-learning packages, formal training, mentoring, staff appraisal?

Staff complete mandatory training.

End of life awareness training, dementia and mental capacity training and the ECDL *[Europe Computer Driving License]* programmes levels two and three.

Quarterly staff appraisals take place and are recorded. We also arrange for speakers, such as Parkinson's nurse to speak to staff working at the home.

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Q25. How do you prevent residents' feelings of loneliness or isolation?

All staff know the residents very well and would notice if a person shown any signs of depression.

The home has an activities coordinator who encourages residents to participate in activities.

Q26. What are the practical everyday things that would help you to provide the best possible care for your residents? Please describe?

Feel free to continue any answers onto a separate piece of paper if necessary, but please add the question number to the answer.

For more information, please contact us at:

Appendix - B
Relatives' questionnaire

1. Do staff talk to you regularly about your loved one's:-			
General Health?	[ ] Yes	[ ] No	[ ] Don't know
Bathing and personal care?	[ ] Yes	[ ] No	[ ] Don't know
Hobbies/interests?	[ ] Yes	[ ] No	[ ] Don't know
Medication?	[ ] Yes	[ ] No	[ ] Don't know

2. Do you think that your loved one;-			
Is happy with the care received?	[ ] Yes	[ ] No	[ ] Don't know
Has plenty to occupy them?	[ ] Yes	[ ] No	[ ] Don't know
Enjoys their meals?	[ ] Yes	[ ] No	[ ] Don't know
Enjoys the company of other residents?	[ ] Yes	[ ] No	[ ] Don't know
Is lonely?	[ ] Yes	[ ] No	[ ] Don't know

Do you know whether:-			
Staff know about the work or family interests of your loved one?	[ ] Yes	[ ] No	[ ] Don't know
Take them out into the community (shops/libraries, local events etc.)	[ ] Yes	[ ] No	[ ] Don't know
Are they treated with kindness and compassion?	[ ] Yes	[ ] No	[ ] Don't know

Are you:-			
Consulted on changes needed to care plans?	[ ] Yes	[ ] No	[ ] Don't know
Are you kept informed about the home's developments/plans etc. (i.e. Carers/residents meetings)?	[ ] Yes	[ ] No	[ ] Don't know

Please add in any other comments or observations you would like to make in the box below.

Would you recommend this home to anyone else?

[ ] Yes [ ] No [ ] Maybe

Overall, on a scale of 1 to 10, how would you rate this home?

(with 1 being very poor and 10 being excellent

out of 10

Distribution

This report will be sent to the following organisations:

The Care Quality Commission (CQC)

Trafford Council:

- Trafford Health and Overview Scrutiny Committee
- All Age Commissioning Team

Trafford Clinical Commissioning Group (CCG)

Healthwatch England

Chief Nurse, NHS Trafford CCG and Corporate Director of Nursing Trafford Council

The provider visited

It will also be published online on the Healthwatch Trafford website (https://healthwatchtrafford.co.uk/our-reports/)