Public Document

GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

DATE: Wednesday 15 January 2020
TIME: 10.00 am
VENUE: GMCA Boardroom, Churchgate House, 56 Oxford Street, Manchester, M1 6EU

1. APOLOGIES

2. CHAIRS ANNOUNCEMENTS AND URGENT BUSINESS

3. MINUTES 1 - 10

To consider the approval of the minutes of the meeting held on 11 September 2019

4. IMPROVING SPECIALIST CARE - RESPIRATORY 11 - 24

Report of Nadia Baig, Director of Commissioning at Oldham CCG and Commissioning Lead for Improving Specialist Care - Respiratory and Dr Jennifer Hoyle, Consultant Respiratory Physician at Pennine Acute NHS FT and Clinical Lead for Improving Specialist Care - Respiratory

5. HOMELESS HEALTHCARE IN GREATER MANCHESTER AND 'A BED EVERY NIGHT' 25 - 32

Report of Dr Cath Briggs, Clinical Chair, Stockport CCG

6. WORK PROGRAMME 2019-20 33 - 36

Report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA

7. ANY OTHER BUSINESS

To consider any matters of additional business, at the discretion of the Chair.

8. DATES OF FUTURE MEETINGS

Wednesday 11 March 2020 10am – 12 noon

Manchester Health and Care Commissioning, Parkway Business Centre, Princess Road, Manchester, M14 7LU

COMMITTEE MEMBERSHIP 2019/20 (FOR REFERENCE)

Member	Substitute Member	Authority
Councillor Linda Thomas	Councillor Mudasir Dean	Bolton
Councillor Stella Smith	Vacancy	Bury
Councillor Eve Holt	Councillor Julie Reid	Manchester
Councillor Eddie Moores	Councillor Colin McLaren	Oldham
Councillor Ray Dutton	Councillor Patricia Sullivan	Rochdale
Councillor Margaret Morris	Councillor Samantha Bellamy	Salford
Councillor Keith Holloway	Councillor Wendy Wild	Stockport
Councillor Stephen Homer	Councillor Teresa Smith	Tameside
Councillor Sophie Taylor	Councillor Anne Duffield	Trafford
Councillor John O'Brien	Councillor Ron Conway	Wigan

For copies of papers and further information on this meeting please refer to the website www.greatermanchester-ca.gov.uk. Alternatively contact the following Governance and Scrutiny Officer: ✉ Lindsay Dunn, Lindsay.dunn@greatermanchester-ca.gov.uk
☎ 0161 778 7009

This agenda was issued on 7 January 2020 on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority, Churchgate House, 56 Oxford Street, Manchester M1 6EU.

MINUTES OF THE MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY MEETING HELD ON WEDNESDAY, 11 SEPTEMBER, 2019 AT BOARDROOM, GMCA OFFICES, CHURCHGATE HOUSE, OXFORD STREET, MANCHESTER M1 6EU

PRESENT:

Councillor John O'Brien (in the Chair)	Wigan Council
Councillor Keith Holloway	Stockport MBC
Councillor Eve Holt	Manchester City Council
Councillor Eddie Moores	Oldham Council
Councillor Margaret Morris	Salford City Council

OFFICERS IN ATTENDANCE:

Lindsay Dunn	GMCA
Lisa Fathers	Director of Teaching School & Partnerships, Bright Futures Educational Trust (BFET) Executive Team
Michael Forrest	Deputy Chief Executive, North West Ambulance Service (NWAS)
Warren Heppolette	Executive Lead, Strategy and System Development, Greater Manchester Health and Social Care Partnership (GMHSCP)
Joanne Heron	GMCA
Dr Sandeep Ranote	Medical Director, Northwest Boroughs Healthcare NHSFT & Children & Young People MH Lead, GMHSCP
Lee Teasdale	GMCA

APOLOGIES: Councillor Stella Smith (Bury Council)

JHSC/25/19 DECLARATIONS OF INTEREST

Councillor Holloway declared that his daughter was an employee of the Oldham Clinical Commissioning Group.

JHSC/26/19 MINUTES OF THE MEETING HELD ON 10 JULY 2019

Members were asked to consider the approval of the minutes of the last meeting held on 10 July 2019.

Resolved/-

That the minutes of the last meeting held on 10 July 2019 be approved as a correct record.

JHSC/27/19 GREATER MANCHESTER MENTAL HEALTH IN EDUCATION (MHIE) PROGRAMME

The Committee considered a report from Warren Heppolette (Executive Lead, Strategy & System Development, GMHSCP); Dr Sandeep Ranote (Medical Director, Northwest Boroughs Healthcare NHSFT & Children & Young People Mental Health Lead, GMHSCP) and Lisa Fathers (Director of Teaching School & Partnerships, BFET Executive Team), which provided an overview of the Mental Health in Education programme (MHiE) being delivered across Greater Manchester and provided details on each of the initiatives. The report also explored the scope of the future ambitions for the MHiE programme both locally and nationally and the governance structure by which the programme would be managed.

Warren Heppolette advised Members that in December 2017 the government had published the green paper 'Transforming Children and Young People's Mental Health Provision'. The paper had set out the ambition to go further in ensuring that children and young people showing early signs of distress were always able to access the right help in the right setting, when they needed it. As part of the next steps in the reforms the government had agreed to support the following three key elements:

- Mental Health Support Teams
- Four-week waiting times for access to specialist NHS children and young people's mental health services
- Designated senior leads for mental health

In addition to these, Greater Manchester (GM) had been working to deliver local projects designed to test the potential implementation model for the priorities within the green paper. These GM initiatives included:

- GM Mentally Healthy Schools and Colleges Pilot
- GM Mental Health in FE Colleges Project
- GM Universities MH Service Pilot
- GM Mental Health in Education Setting Standards

Dr Sandeep Ranote advised Members that the green paper had been informed in part by the 2015 paper 'Future in Mind'. This paper had brought together children and educational mental health experts from across the country to consider child psychiatric care and set an ambitious agenda for protecting and improving children and young people's mental health and wellbeing. It was emphasised that the programme was not just about putting money into services but also about ensuring parity in the support offer across all of GM and removing the stigma that was sometimes involved in seeking mental health support. Dr Ranote stated that the level of passion from all partners to make the programme a success was hugely positive – with the programme having allowed for joint working and collaboration on a level that had not been available previously.

Information around the development of mental health support teams was provided. Education Mental Health Practitioners (EMHPs) were linked to groups of schools and colleges, and would offer individual and group help to young people with mild to moderate mental health issues including anxiety; low moods and behavioural difficulties. The support teams would work with the school or college designated mental health lead to provide a link with more specialist mental health services. This would mean schools and colleges finding it much

easier to contact and work with mental health services. These teams would provide the link between the NHS and schools, and would work alongside others providing mental health support such as school nurses; educational psychologists; school counsellors; voluntary & community organisations and social workers.

It was emphasised that the support teams would be newly trained and would not take away from the existing specialist Child and Adolescent Mental Health Services (CAMHS) provision as this was about delivering a programme that supported and added to, rather than taking away from the existing structure.

Lisa Fathers spoke to the Committee from the perspective of Bright Futures Educational Trust (BFET). She advised that a positive side effect of the programme had been that it had also so far proved to have improve the wellbeing of the teachers involved as well as the students. Schools were being helped in a strategic way on how best to embed the ethos behind the programme. An example of this good practice had been in Gorton, where children knew exactly where they needed to turn to access first aid support and mental health support. 42nd Street as the Voluntary, Community and Social Enterprise (VCSE) lead had been very helpful, working hard to increase the number of mental health practitioners. Overall there was a strong package in place, with each individual school working in tandem with others across the piece. Young Mental Health Ambassadors had also been a great help in spreading knowledge around the work being done.

Dr Ranote advised that the Mentally Healthy Schools and Colleges Project was now about to move into Phase 4. At the conclusion of the project, it would have reached 125 schools and colleges, this equated to 10% of the 1200 schools and colleges across GM – whilst it was agreed that on paper this may not seem an impressive figure, in actuality it was considerably above the national average in its level of reach. The unfortunate reality was that there was not the funding or level of resource in place to directly reach all 1200 locations. The Project had helped the partners involved to develop a set of education setting standards that would act as the framework for schools and colleges across GM going forward.

It was noted that good work was taking place at local authority level as well, with Salford developing a strong programme for example. However, there was cognisance of the need to avoid 'postcode lotteries' and that all schools within GM should receive the same high level of support.

Committee Member Comments and Questions

Members expressed concerns about the number of children having to go straight from CAMHS into Adults mental health services – with many being 'failed by the system and falling through the gaps'. With this in mind, what level of work was taking place with mental health practitioners within schools and colleges?

It was advised that it was recommended to all schools and colleges that they sent their Special Education Needs Co-ordinators (SENCOs) on the training programme. Close work was also taking place with secondary education colleges as these often included cohorts that had behavioural and educational issues in their youth and had a differing set of needs from the mainstream with many having previously already had CAMHS support for mental health issues.

Members noted their concerns around only 125 of GM's 1200 schools and colleges being directly involved in the Mentally Health Schools and Colleges Project. How could local councillors help in getting the messages about the good work being done over to the remaining 90% of schools and colleges within GM? Members also asked about the process by which the 125 locations had been selected.

It was advised that following the conclusion of phase 3 of the project, officers were in a stronger position to review the governance aspects. A dedicated programme board needed to be formed to look at this, and it was suggested that a member of the Joint Health Scrutiny Committee could form part of the membership of this programme board. Further details about the programme board including the terms of reference would be provided to Members for further consideration. Any Members wishing to be nominated were asked to contact GMCA officers.

Regarding the 125 locations chosen - Phase 1 had involved a rapid 10 day turnaround with the initial cohort of schools being chosen very quickly but with an appropriate geographical spread across all localities in GM. Phase 2 saw closer working with the locality leads to identify schools that were most in need of assistance at present. Constant re-evaluation work had been taking place, and lessons were being learnt. It was also noted that the selection process had been overseen and agreed at the highest level.

Members expressed concern about parents who were unwilling to engage with the process – what was being done to communicate the work to them?

It was explained that a key part of the work involved in the pilot was seeking to reduce the taboos and stigmas around mental health, if these common concerns could be broached and dealt with, then parents would be less likely to refuse help for their child. There however remained many challenging situations to broach – and it was therefore important that the work continued beyond the school setting, with the whole system carrying these important messages – through parent champions, parent teacher associations, school governors etc. The messages often had more power when delivered by fellow parents instead of health professionals, and helped in developing an organic increase in understanding and empathy.

Members welcomed this approach and asked that they be informed of the schools within their localities involved in the programme – so that they could be involved in meetings helping to spread the importance of the work being undertaken.

It was also advised that schools themselves could choose to prioritise the importance of the issue, by paying to send more staff on training and arm them with the skills needed to approach mental health issues. National and international learning collaborations were also being formed – for example, GM was sharing intelligence with schools in Staten Island, New York – which had a similar makeup of demographics and wealth disparities to those seen in GM.

The Chair re-emphasised the importance of local links, stating that each of GM's local health scrutiny panels should also be looking to feed this information down through their own committees and receiving presentations on the good work being done.

It was commented that mental health issues often stopped many children from achieving at the level they should at school, and that if children could be made more resilient at the right age, then they would likely be more resilient as adults.

Officers agreed, stating the importance of pathway succession. The programme was one of a number of transformation programmes taking place in children's mental health and none of them worked in isolation, with 'the dots being joined' across schools; youth services; GPs; youth centres and other relevant partners. It was not expected at the present time that this work would lead to reductions in referrals to CAHMS, but instead it should see an increase in children being referred at the right time in the right setting. It was hoped that eventually, with good embedded working across the piece, that reductions in referrals would be seen, but this would inevitably take time.

Members sought more information on addressing the stigmas around mental health. Was fear and a lack of understanding at the root of the concerns? Was this lack of understanding being addressed in order to remove the element of fear?

Officers emphasised the importance of embedding the appropriate language and making services fully accessible. There was a need to influence the harder to reach parents who might not interact with the schools, like attending parent's evenings for example – there was often a need to go out to them. Sometimes these parents had been through bad educational experiences in their youth and could be distrusting initially – with trust having to be carefully built up over time.

Dr Ranote felt that the NHS needed to use its media partners in a more positive proactive way. It was found that often communications from the NHS were only being used to address negatives – and there was a need to look at a more proactive strategy, where the media could be used to help spread positive messages.

The Chair noted that the Greater Manchester Mental Health Network was due to hold a Greater Manchester Mental Health Strategy Review at the British Muslim Heritage Centre on 30 September and asked that all the relevant details be forwarded on to the Committee Members.

Lisa Fathers advised that she could arrange a mental health workshop for members and that this could be arranged outside of the meeting.

Resolved/-

- That the progress made to date across a number of key education settings be noted by the Committee.
- That the proposals put forward be endorsed by the Committee.
- That details of the 125 schools and colleges involved in the GM Mentally Healthy Schools and Colleges Project be fed back to Committee Members.
- That details on the arrangements for the Greater Manchester Mental Health Strategy Review due to take place on 30 September 2019 be fed back to Committee Members.
- That officers be asked to confer further with Bright Futures Educational Trust around arrangements for a mental health workshop.
- That further details on the proposed dedicated governance board, including any terms of reference be fed back to Committee Members for consideration.

JHSC/28/19 NORTH WEST AMBULANCE SERVICE (NWAS) PERFORMANCE ACROSS GREATER MANCHESTER (GM)

The Committee considered a presentation from Michael Forrest on the performance of NWAS across Greater Manchester.

It was advised that following the development and implementation of a North West wide Performance Improvement Plan (PIP) in May 2018, the Trust had made significant improvements in performance throughout the 2018/19 operational year. Response performance had stabilised, leading to considerable improvements in patient safety and there was a commitment to achieving continued improvements – with 2019/20 having seen the devising of a Service Delivery Improvement Plan (SDIP) with the purpose of achieving and maintaining certain standards.

Across GM, the Trust had achieved some notable successes. During 2018/19 the Trust had conveyed over 15,500 fewer patients to emergency departments by both doubling its telephone triage capability, and increasing the number of patients managed on scene. This made a significant difference and allowed ambulances more freedom to deal with the most acute calls.

Timely access to response pathways of care was crucial to managing patients without the need for conveyance to emergency department. The NWAS referral pathway into the Wigan Community Response Team (CRT) had been developed in August 2018, with the main objective being to reduce conveyance to hospital for frail/elderly patients who could be supported within a community setting with additional support to best meet their individual need. The CRT was an existing service, however it was felt that if NWAS could access and utilise the multidisciplinary team and the wider range of services, then patient care would benefit. The Wigan CRT provided a strong example of how NWAS could work with providers across the wider health system, and it was intended that similar models of care would be pursued to ensure that patients avoided unnecessary conveyance when clinically appropriate to do so.

The level of demand for services was detailed to the Committee. Over 270,000 calls had been received but many of these were duplicate calls. For example, a significant traffic accident may result in 10+ calls to 999, and sometimes calls were made multiple times to check on the progress of an ambulance en-route. 10% of calls were now dealt with over the telephone, but this was only where appropriate and always with mindfulness of managed risk. 25% were now able to be dealt with on the scene. Good mechanisms were also in place which meant further growth could be absorbed without overburdening the department – the activity levels were continuing to increase so these appropriate mechanisms were increasingly important.

The Trust had developed a number of key strategies over the previous twelve months in order to support its ambition to be in the top three ambulance services by 2021, and to be the best in England by 2023. Urgent and Emergency Care and Quality Strategies would ensure that the right care was delivered at the right time, in the right place, every time. These were complimented by a number of key enabling strategies such as digital, workforce, fleet and estates.

It was also noted that the 111 Service contract was due for renewal in the next year. There was still some lack of understanding around what the 111 Service could do for people and this had helped to foster an undeserved poor reputation.

Warren Heppolette was invited to comment. He stated that systems working together to ensure the best level of integrated care was absolutely key. In the past the work of the NWAS would have been heard about in isolation, but that was not the case anymore, with services no longer being considered as a silo'd independent system, and instead being considered and understood within the context of the bigger picture of care models.

Committee Member Comments and Questions

Members agreed about the increasing importance and value of partnership working. When people did not have to face the trauma of entering a hospital setting and instead had an issue that could be managed on scene – it often added to the quality of life for that person.

Members asked, given the stressful and demanding nature of the job, how NWAS was coping when it came to levels of recruitment and retention.

It was advised that until recently paramedics had been on the staff shortage list, with a 14% gap. However, following a rigorous recruitment exercise – there was now a full establishment of paramedics in place. It was of course a job with challenges, it being noted that around 1300 assaults on NWAS staff were reported each year which was unacceptable – and it was found that the job had a higher than average turnover of staff. The staff could also often suffer burnout when working in the inner cities as there tended to be no breaks between call-outs. With that in mind, a transfer system had been implemented where paramedics could elect to spend some time working in a more town based/rural setting for a period, as taking care of the wellbeing of staff was vital

Reference was made to the installation of defibrillators in public spaces/businesses. It was important that these were registered so a record could be kept of their locations. The Chair recommended that members go back to their councils and work with other councillors/officers to establish the locations of defibrillators and help to build up a picture of all the locations.

Members suggested that a breakdown of the NWAS figures by district would be welcome to help them be in a position to ask the best related questions. It was advised that this information would be sourced for Members. It was advised that NWAS also made use of the 'Tableau' software system which could be signed up to for access to the catalogue of NWAS statistics.

Members expressed concern around the reliability of patient transport services, particularly in areas of low car ownership. It was advised that after being outsourced for some time, the transport patient service had now been brought back in-house, talks were taking place on how best to commission the service.

Members sought to see some of the NWAS sites on context, asking if a meeting could be held at the Parkway Centre on Princess Parkway, to look at the dispatch process in action, and also to pay a site visit to the new Wigan Fire and Ambulance Service hub. It was agreed that this

could be arranged and officers would take up the arrangement of suitable dates outside of the meeting.

The Chair drew the item towards a close – stating that three years previously he had been involved in a meeting where he had expressed serious reservations around repeated incidents of ambulance stacking, and was pleased to see that this service had been changing radically since then. He stated that statistics and data meant little to the patient at ground level – and all that mattered to them was their personal experience of being cared for appropriately and seeing a doctor or paramedic as soon as possible to assuage their fears. It was clear that NWAS had worked hard to achieve this, and examples of dealing with patients on site where appropriate so that they did not have to face the trauma of entering a hospital setting was a good example of this. The report was very welcome, and the results achieved were deserving of congratulation.

Michael Forrest thanked the Chair and the Members for their comments, stating that it was important that NWAS continued to receive an equal measure of support and challenge. He also advised that as part of looking to provide the best possible service to patients – 3000+ staff had now been trained in dementia awareness as NWAS sought a rollout of a dementia friendly ambulance service.

Resolved/-

- That the performance figures of North West Ambulance Service in GM and the opportunities to improve the service provided to Greater Manchester patients be noted by the Committee.
- That a breakdown of North West Ambulance Service figures by district be fed back to Committee Members.
- That arrangements be made for a site visit to, and meeting to be held, at the Parkway Centre.
- That arrangements be made for a site visit to the Wigan Fire and Ambulance Service Hub.

JHSC/29/19 WORK PROGRAMME

Consideration was given to the report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA.

The planned programme of work up to the March 2020 meeting was detailed to the Committee – the Statutory Scrutiny Officer asked that Members contact her if they would like to make any additions to the programme.

Resolved/-

That the work programme items be approved.

JHSC/30/19 DATES OF FUTURE MEETINGS

All meetings will take place between 10.00am – 12 noon in the Boardroom at GMCA Offices, Churchgate House, Oxford Street, Manchester, M1 6EU on the following dates:

- Wednesday 13 November 2019
- Wednesday 15 January 2020
- Wednesday 11 March 2020

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GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 15 January 2020

Subject: Improving Specialist Care – Respiratory

Report of: Nadia Baig, Director of Commissioning at Oldham CCG and Commissioning Lead for Improving Specialist Care - Respiratory and Dr Jennifer Hoyle, Consultant Respiratory Physician at Pennine Acute NHS FT and Clinical Lead for Improving Specialist Care - Respiratory

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PURPOSE OF REPORT:

This report builds on previous 'Taking Charge' and programme updates that have been provided to the Greater Manchester Joint Health Scrutiny Committee. The purpose of this report is to outline a proposed approach to progress the transformation of Respiratory services to ensure rapid improvement to the clinical service and to provide an equitable service for all patients accessing Greater Manchester Respiratory services.

Respiratory services cover the diagnosis and treatment of a wide variety of diseases of the airway and lungs, their linings and blood vessels and the muscles and nerves required for breathing.

An update reported to the Greater Manchester Joint Commissioning Board Executive, held on 17th December 2019, outlined the key areas of progress on the Model of Care and the intention to present this report to the Committee for its consideration. This follows dialogue undertaken with NHS England on this Model of Care not presenting substantial service change to patients.

RECOMMENDATIONS:

The GM Joint Health Scrutiny Committee is asked to:

- Agree that the scale of change to the Respiratory service is not substantial variation given patients will not be impacted negatively by location or delivery of services

- Note that the revised Model of Care offers an improved, equitable and standardised service to all GM residents

- Note that the new Model of Care was designed and developed in consultation with patients and their families and clinicians

- Agree that the proposed new model of care will meet the needs of patients and improve patient experience and outcomes

- Agree the review of service and transformation to the new model of respiratory care and confirm the GM JOSC is satisfied that there is not a need for wider public consultation. The change in services are all “good practice changes” which involve a better integration and use of resources and a standardised set of protocols and programmes when treating patients

- If further consultation is required, direct the Programme to what level of consultation would need to take place and within what timeframe

CONTACT OFFICERS:

- Dr Jennifer Hoyle, Clinical Lead for Respiratory, Improving Specialist Care, Greater Manchester Health and Social Care Partnership - jennifer.hoyle@pat.nhs.uk

- Nadia Baig, Commissioning Lead for Improving Specialist Care, Greater Manchester Health and Social Care Partnership - nadiabaig@nhs.net

1.0 INTRODUCTION AND BACKGROUND

1.1 People in Greater Manchester are admitted to hospital when their needs could be better met in the community. This continues to increase 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. Our population is changing so services need to adapt - 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 closer to home.

1.2 There are variations in provision and standards of care across the region. Patients with the same severity of the same condition don't always have the same outcome and sometimes are more likely to stay in hospital for an unduly long time depending on which part of the hospital system in Greater Manchester they first attend.

1.3 Our services are under pressure to meet the rising needs every year, there is immense strain on resources significant variation in our estate (i.e. our buildings and where we deliver services) in relation to location, age and quality of facilities, we face significant financial and workforce pressures. Change must happen if we are to maintain the safety and quality of care in the future.

1.4 The 'Improving Specialist Care' programme is one of five interlinking and co-dependent themes identified in the Greater Manchester (GM) Health and Social Care Partnership strategic plan '*Taking Charge'*.

1.5 The transformation priorities for the Programme were developed with clinicians, providers and commissioners over several months culminating in a proposal which was endorsed by the Association of Governing Groups, Provider Federation Board, and the Strategic Partnership Board Executive on the 19th September 2016. The following services are in scope of this Programme:

- Cardiology
- Respiratory
- Musculoskeletal/Orthopaedics
- Benign Urology
- Paediatric Surgery
- Paediatric Medicine
- Breast Services
- Vascular
- Neuro-Rehabilitation

1.6 In June 2018, the Greater Manchester Strategic Clinical Network began liaising with a wide range of respiratory stakeholders and set up a GM Respiratory Steering Group consisting of clinicians, commissioners, Taking Charge leads, Public Health and

patient/public representation. This work encompasses proposals put forward as part of the Improving Specialist Care programme for Respiratory Services and does not propose any significant changes to the patient care within acute sites where Respiratory care is delivered. The improvements focus on streamlining pathways for patients with a Respiratory disease, ensuring a consistent approach utilising a more integrated workforce.

2 DESIGN PROCESS

The design process was a standardised process to support all the identified priority workstreams (Figure 1), shown below. It should be noted that it was widely accepted at an early stage of the Model of Care development that any significant variation to acute delivery of services would not be appropriate as the greatest opportunity lies within the avoidance of an acute admission. As such, the Clinical and Patient standards, Clinical Co-Dependency Framework and Gap Analysis have a reduced role within the Respiratory work stream in comparison to other ISC workstreams.

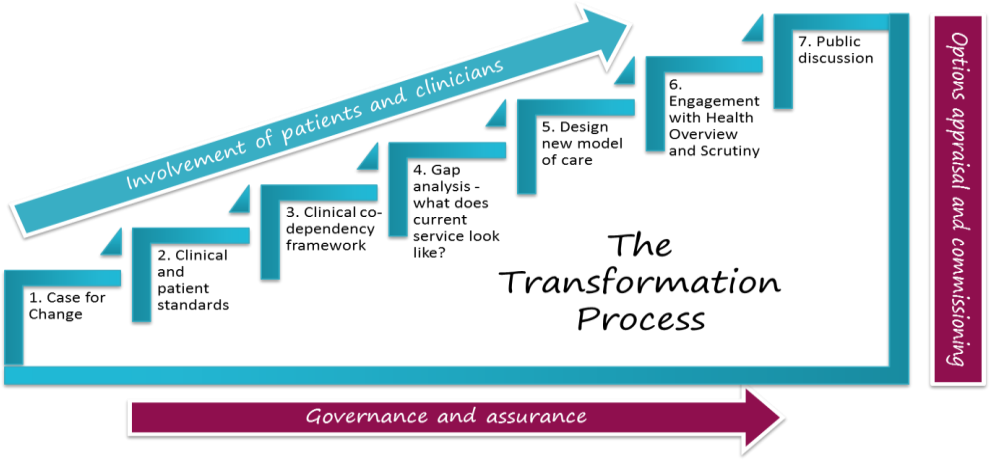

Figure 1. The Transformation Process

2.1 Step 1: Case for Change

2.1.1 Greater Manchester has some of the highest rates of respiratory disease in the country, and mortality rates for preventable respiratory disease are high. The conurbation has a high prevalence of lung cancer, COPD, asthma and unacceptable variation in length of stay across a number of respiratory disease areas. Demand for respiratory services is high and in 2016/17, there were over 50,000 hospital spells for respiratory disease and over 70,000 Finished Consultant Episodes (FCEs). When weighted by age and gender, premature mortality from respiratory disease is

significantly higher than the national rate in seven of the ten Greater Manchester CCGs, and similar for the remaining five.

2.12 From a public health perspective, Greater Manchester has higher-than average smoking rates, and insufficient smoking cessation services to meet demand (though a strategy is being put in place to address this). 18.4% of the adult population smokes compared to a national average of 15.5%, and this contributes to above-average prevalence of smoking-related disease. Greater Manchester's industrial history has also contributed to an increased incidence of industrial lung disease.

2.13 There has already been a number of localised improvements within Respiratory care across Greater Manchester, signalling the willingness to transform services. These plans have been beneficial for local areas but have in turn created or widened the variation in care across Greater Manchester. These projects have focussed on developing community services such as creation of virtual clinics, outreach respiratory nurse specialists, and even advanced nurse practitioners working alongside the ambulance service. There is now a need, for a GM wide solution, that specifically looks at reducing the number of patients escalating to needing hospital care in a consistent and high-level way. This Model of Care provides that solution.

2.14 In summary, the key drivers for change identified by clinicians and commissioners and evidenced were:

- Greater Manchester (GM) has some of the most deprived areas and the poorest respiratory health in the UK, and amongst the highest prevalence rates for lung diseases

- Significant variation in service delivery and the impact of this on outcomes. This is demonstrated by only two Greater Manchester CCGs have a mortality rate for under 75 year olds that is less than the national average

- Over 50% of acute spells in GM in 2016/17 were attributable to two main disease groupings; **chronic lower respiratory diseases** which includes: asthma; COPD; emphysema; and simple and mucopurulent bronchitis, and **influenza and pneumonia**

2.15 The Case for Change was developed from January 2018 onwards in consultation with patients, families, clinicians, commissioners and service providers. The Case for Change was reviewed and endorsed by the Programme's Clinical Reference Group in July 2018 and approved by the Programme's Board and Executive in October 2018. The full Case for Change is included as Appendix 1 of the evidence pack.

2.16 There is a compelling opportunity and need to transform Respiratory services for the many patients that access Greater Manchester services. More people are living

longer with Respiratory diseases and ensuring this is well managed, consistent and outside of an acute setting wherever possible will improve and maintain the well-being of Respiratory patients, their carers friends and families.

2.2 Step 2: Clinical and Patient Standards

As previously described, the proposed Model of Care does not result in any amendments to acute care. As such, the programme has not developed any further clinical and patient standards. However, there are a number of sources available for respiratory standards and guidance, which requires consideration and, where appropriate, incorporation into the model of care. These give clear direction as to the standards expected from the relevant aspects of the model and will be incorporated in at all stages of development.

Further details on these standards can be found within section 10.7 of the Model of Care (Appendix 2).

2.3 Step 3: Co-Dependencies

The Co-Dependency Framework (Appendix 3) was designed to identify the services that Respiratory relies upon in order to provide high quality care for patients.

As the Respiratory Model of Care does not recommend a shift of any services to be provided at an alternative location for acute care, the Co-Dependencies are not fundamental element of the proposed Model of Care.

2.4 Step 4: Gap Analysis

A gap analysis relates to a review of the current service provision across GM. All GM trusts provide some respiratory care, with high rates of emergency Finished Consultant Episodes (FCEs) across the conurbation in all respiratory disease groupings. 10 of the 13 GM hospitals providing respiratory services have a high rate of emergency presentations, classed as those with more than 4000 FCEs in 2016/17. This does not correlate with the population size in the respective areas during this time, with a range between 1.7% and 3.5% of the population being admitted to hospital, suggesting variation in the care received by these patients.

There is considerable research and development in the field of COPD management and a clear imperative to standardise pathways to reduce length of stay and overall

costs, and it is on that basis that the Model of Care largely focuses on the opportunities related to COPD.

Further information on the gap analysis can be found within section 3 of the Model of Care, found in Appendix 2.

2.5 Step 5: Design of the New Model of Care

The full Model of Care document can be found within Appendix 2. The key elements of the Model of Care are the following:

- a model of care for **Chronic Obstructive Pulmonary Disease (COPD)** with standard GM outcomes – to support an enhanced primary and community service by delivering specialist nurse outreach to more complex patients
- a single GM policy for **influenza** – to describe how GM will care for patients, educate the public, and immunise people at risk
- an audit of **pneumonia** diagnosis to understand preventability and risk management

2.5.1 Key Benefits of the Model of Care

The agreed Model of Care sets out the benefits of the proposed model for patients and the service delivery:

- Access to consistent, high-quality care regardless of location
- Timely and safe access to appropriate care throughout the whole pathway, maximising patients' capabilities and quality of life
- Seamless integration with community services, to include patient/social partnerships

2.5.2 External Assurance – External Clinical Assurance Panel

The Model of Care has been independently reviewed by an External Clinical Assurance Panel (ECAP) established by the Northern Senate. The Northern Senate is a non-statutory body made up of clinicians, who provide independent clinical advice to Commissioners. All Models of Care are being reviewed by an ECAP made up of clinicians from the Northern Senate, as Greater Manchester does not fall within their geographical boundaries which ensures impartiality and objective advice to the programme. The process of the review encompasses a written report, culminating in a panel discussion.

The panel were supportive of the model and provided some insights to enhance the model further to ensure the best possible care for patients. Consequently, a number

of recommendations have been built into the Model of Care as detailed below, with the full report available as Appendix 4:

Table 1: Overview of feedback from ECAP

Feedback	Response / Action
Pneumonia proposals need further clarity	Updated to reflect the need for compliance with NICE guidance in the diagnosis and management of pneumonia, which is the first step towards ensuring that pneumonia is only cited as the cause of death where there is a primary diagnosis. This is the starting point in addressing the panel's feedback that clinical coding and data accuracy are critical to informing a true picture of disease incidence.
Point of care testing for Influenza is imperative	The model has been updated to clarify the need for point of care testing and the isolation of patients with suspected influenza. The document will continue to reflect the capacity challenges associated with providing adequate isolation in times of high demand.
NIV standards and domiciliary care require further development	NIV standards are now referenced in the document, though further GM-wide engagement is needed to determine the final NIV model for GM.
Chest infection management of the COPD patient needs to be considered	Updated to reflect this.
Smoking cessation standards need to be agreed	This work is ongoing in GM and the document has been updated to reflect this. Reference has also been made to the GM CURE programme, which is based on the Ottawa Model for Smoking Cessation.
Risk stratification Emergency Departments and Acute Medical Units and access to specialist respiratory clinicians are important inclusions in further iterations of the model of care	GM Trusts already use a range of risk stratification tools, and further clinical engagement is required to assess the available evidence and determine the most appropriate tools for adoption GM-wide.

2.5.3 Governance and Endorsement of the new Model of Care

The Improving Specialist Care Programme works within a rigorous governance structure which ensures continuous oversight and endorsement from a range of

subject matter experts within the GMHSCP, CCGs, Trusts, Local Authority, NHS England/Improvement and includes Patient Representatives.

The governance structure is regularly reviewed to ensure it remains appropriate and effective as the ISC Programme progresses.

The table listed below provides an overview of the Model of Care sign off process. It demonstrates all the expert reference groups and Boards within the Improving Specialist Care governance route:

Table 2: Overview of endorsement of Respiratory Model of Care

Group	**Date of Endorsement**
External Clinical Assurance Panel	September 2018
Clinical Reference Group	September 2018
Finance and Estates Reference Group	October 2018
Workforce Reference Group	October 2018
CCG Directors of Commissioning	October 2018
Provider Federation Board	October 2018
Improving Specialist Care Board (previously Theme 3 Board)	October 2018
Patient Reference Group	January 2019 – *Patient Reference Group do not have requirement to sign off Model of Care, but provide valuable feedback, which is summarised within the presentation to complement this report*
Joint Commissioning Board	Sign off of Model of Care – November 2018 Progression to PCBC – September 2019

3 ENGAGEMENT

3.1 There has been an inclusive approach to clinical and patient/carer engagement to inform the development of patient standards and the proposed new models of care.

3.2 We have benefitted from establishing a robust partnership approach to engagement with clinicians, commissioners, staff members, patient support groups, carers, third sector providers and GM Healthwatch organisations.

3.3 We have also worked closely with the Greater Manchester Strategic Clinical Network to ensure a consistent and joined up approach to transformation of Respiratory services across Greater Manchester. We have ensured that each programme of work complements the other, without resulting in gaps or duplication of work.

3.4 As a result, we developed a multi-layered approach to engagement with our stakeholders to ensure involvement, co-design and co-production with stakeholders throughout the design and development process. A full engagement log can be found in Appendix 5.

3.5 Different approaches have been used to engage with patients, carers and other key stakeholders throughout the development of the Model of Care, including the following:

- Patient focus groups at GM based COPD and other respiratory disease patient groups
- Healthwatch representation on the respiratory design oversight forum, clinical reference group, ISC Board to consistently inform the Model of Care
- Patient and carer surveys undertaken across CCGs, community, trust networks to ensure a targeted engagement
- Identification of patients interested in further involvement, to invite to any further Design Oversight Forum opportunities

3.6 The key feedback received from patient focus groups gave an overwhelming voice for localised services, describing how difficult it is to access services further afield as disease progresses. This was further described in the strong message that respiratory disease is something people live with, that community access to services is essential and that people are keen to have control over their care.

3.7 The programme will continue to proactively engage with patients, their carers/families, staff and the public throughout the life-cycle of the programme. There is an opportunity to enhance current levels of engagement, reaching more patients in a more meaningful way to enhance and inform the programme as the Model of Care is developed through the transformation process. One specific example of this, as

identified through the ECAP feedback, further GM-wide engagement is needed to determine the final NIV model for GM. Patient feedback will feed directly into this model throughout its development.

4.0 TRAVEL AND EQUALITY IMPACTS

4.1 Travel Analysis

As all sites that currently provide Respiratory services are proposed to continue to deliver the same level of care to patients, there is not anticipated to be any increase to patient journeys. As such, there is no requirement for formal analysis as there will be no impact to patient journeys to and from hospital. The proposed Model of Care provides opportunities for patients to receive care within the community, significantly reducing the number of journeys into hospitals that would occur without the progression of this proposed Model of Care. There is anticipated to be a reduced amount of admissions to hospital, which will reduce the number of journeys to existing sites. An individual patient's eligibility for the nationally ran Patient Transport Service remains unchanged.

4.2 Equality Impact Assessment (EIA)

Experts have been brought into support the Programme team in undertaking equality impact assessments for all workstreams. The EIA supports the Model of Care, states that it meets the Public Sector Equality Duty and it does not have an intentional negative impact on any one protected characteristic over another.

The programme will continue to work with Equalities Officers and Communications teams, as part of meeting its ongoing responsibility under Section 149 of the Equality Act 2010 to provide evidence that protected characteristics are satisfied with the service they receive and there are no sub-optimal performance issues with these groups. This will involve talking to current patients and reaching out to community groups and charities and evaluating the level of staff training and development needs that they may have in relation to supporting people's needs. This ongoing work of assessing performance, is not a reason to delay the programme change and the introduction of the model. The EIA states that the proposed Respiratory Model of Care can be implemented at the earliest convenience.

Engagement will continue to be carried out throughout the life-cycle of the project, including that directed within the EIA and will be updated as required. The full Equality Impact Assessment is provided as Appendix 7.

5.0 CRITICAL SUCCESS FACTORS

5.1 The critical success factors for the implementation of the Respiratory Model of Care are shown below, further detail can be found within section 9 of the Model of Care (Appendix 2):

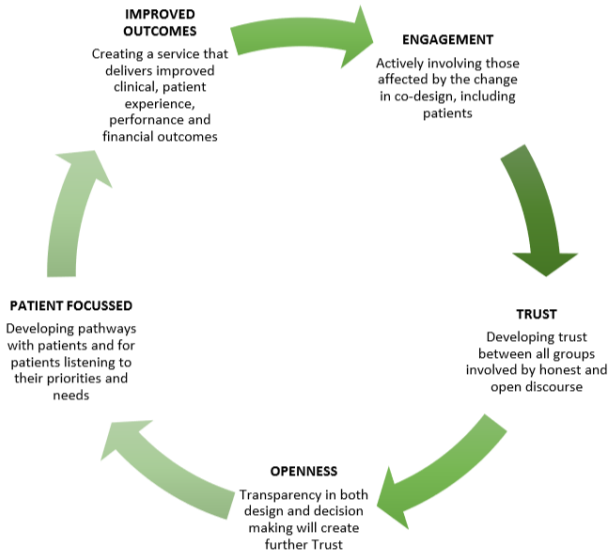

Figure 2: Critical Success Factors for the implementation for the Respiratory Model of Care

6.0 CONCLUSION

- The proposed future Respiratory Model of Care builds upon the work done by individual CCGs and trusts across Greater Manchester to improve the care and well-being of Respiratory patients. This Model of Care seeks to reduce the number of acute admissions because of Respiratory disease

- The Model of Care does not result in significant scale change, and seeks to provide a more equitable, improved patient experience with better outcomes for patients requiring these services. Furthermore, it is not proposed that care provided in an acute setting will be altered in terms of the sites where care is currently provided

- The proposed Respiratory Model of Care will enhance patient experience and ensure a consistent, high quality approach across GM

7.0 RECOMMENDATIONS

The GM Joint Health Scrutiny Committee is asked to:

- Agree that the scale of change to the Respiratory service is not substantial variation given patients will not be impacted negatively by location or delivery of services

- Note that the revised Model of Care offers an improved, equitable and standardised service to all GM residents

- Note that the new Model of Care was designed and developed in consultation with patients and their families and clinicians

- Agree that the proposed new model of care will meet the needs of patients and improve patient experience and outcomes

- Agree the review of service and transformation to the new model of respiratory care, confirm the GM JOSC is satisfied that there is not a need for wider public consultation, as the population will not 'see' a significant change in service negatively affecting them. The change in services are all "good practice changes" which involve a better integration and use of resources and a standardised set of protocols and programmes when treating patients

- If further consultation is required, direct the Programme to what level of consultation would need to take place and within what timeframe.

8.0 APPENDICES

Appendix 1 - Respiratory Case for Change
Appendix 2 - Respiratory Model of Care
Appendix 3 - Respiratory Co-Dependency Framework
Appendix 4 - ECAP Feedback
Appendix 5 - Full Engagement Log
Appendix 6 - Patient Engagement Opportunities
Appendix 7 - Equality Impact Assessment

The above appendices make up the Evidence Pack available to members of the JOSC for further detail and to supplement the above paper. All documentation can be provided on request and has not been accompanied within this paper following feedback from previous meetings.

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GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 15 January 2020

Subject: Homeless Healthcare in Greater Manchester and 'A Bed Every Night'

Report of: Dr Cath Briggs, Clinical Chair, Stockport CCG

PURPOSE OF REPORT:

This report provides an overview of work on homelessness and health overseen by GM Health and Social Care Partnership (GMHSCP), including the £2m investment from GM Joint Commissioning Board (JCB) and GMHSCP into the emergency rough sleeper programme 'A Bed Every Night' (ABEN).

RECOMMENDATIONS:

The Greater Manchester Joint Health Scrutiny Committee is asked to;

- Consider the content of this report and the progress made through the Health and Wellbeing Task and Finish Group.
- Note a further discussion at the February meeting of JCB to review any future investment arrangements and commitment from the health system to tackling homelessness.

CONTACT OFFICERS:

- Helen Simpson, Strategic Relationship Manager (Housing), GM Health and Social Care Partnership (helen.simpson11@nhs.net)

1.0 PURPOSE AND INTRODUCTION

1.1. This paper provides an update to the Committee on current work in relation to healthcare considerations and provision for those experiencing homelessness. In particular, in relation to the Greater Manchester "A Bed Every Night" initiative

1.2. In June 2019 GM Health and Social Care Partnership and GM Joint Commissioning Board agreed to invest a collective £2m into the 12-month extension of emergency rough sleeper provision 'A Bed Every Night' (ABEN), in acknowledgement of the impact rough sleeping and homelessness has on both physical and mental health and the risk to life of sleeping on the street.

1.3. This investment ensured provision was available for a further 12 months and has allowed improvements in the service model to better meet the needs of those who access it. In addition to the agreed financial investment, a commitment was made to utilise this 12-month period to support an iterative improvement process in health provision, amass understanding of current practice and use this to inform a longer-term plan on homeless healthcare.

1.4. This commitment to the system change required to improve and upscale our homeless health offer is in addition to the £2m contribution to ABEN. It demonstrates a further commitment from the health sector to invest time and additional resources in ensuring appropriate health provision is available to people experiencing homelessness.

2.0 CONTEXT

2.1. Homelessness is a Greater Manchester and Mayoral priority with a commitment to ending the need for rough sleeping and preventing homelessness. In 2017 GM Health and Social Care Partnership established a programme work capturing the contribution of the health and care system towards delivering this goal. Sat within the broader Housing and Health programme, our work on homeless healthcare has focused on identifying areas of the health system where we could ensure the right services were in place to support people experiencing homelessness. This has;

- Championed the 'right to register' with a GP for people with no fixed address, supporting the roll out of the 'Homeless Friendly' scheme and development of training.
- Developed a GM Homeless Hospital Discharge Protocol and supporting arrangements in ten localities.
- Sharing successful models of outreach and supporting localities to develop and improve models where required.

- Identified resources for and developed short term initiatives to enhance Mental Health support through care coordination outreach and Psychologically Informed Environments.
- Supported GM roll out of the Homelessness Reduction Act Duty to Refer and rolled out training to relevant staff in Acute Trusts.

- Provided advice and support to localities in improving, developing and commissioning new services for people experiencing homelessness, facilitating relationships between health and housing colleagues where required.

2.2. In the context of this activity, GMHSCP has advocated an asset-based approach to work on homelessness, building on programmes already active in localities, acknowledging that a number of areas already have a very clear sense of how they are delivering, or intending to support people experiencing homelessness. The programme has worked alongside localities to add value, provide insight and encouraged locality stakeholders to work more collaboratively.

2.3. In June 2019 GM Health and Social Care Partnership (GMHSCP) and GM Joint Commissioning Board (JCB) agreed to invest a collective £2m into the 12-month extension of emergency rough sleeper provision 'A Bed Every Night' (ABEN), acknowledging that homelessness and rough sleeping is a GM wide priority and as such required a cross system response. Alongside this, a commitment was made to utilise this 12-month period to support an iterative improvement process in health provision, amass understanding of current practice and use this to inform a longer term plan on homeless healthcare.

2.4. This has reframed the role of GMHSCP and the Housing and Health programme in relation to homelessness, giving renewed focus and remit, facilitating different governance and parts of the health system to come together to deliver the improvements that we are so keen to achieve.

3.0 A BED EVERY NIGHT

3.1. 'A Bed Every Night' (ABEN) provides a bed, warm welcome, and personal support for anyone who is sleeping rough or at imminent risk of sleeping rough in Greater Manchester. Since its launch in November 2018, ABEN has accommodated over 2600 people and supported almost 1000 people to move on to more suitable accommodation (Nov 19).

3.2. A second phase of ABEN started in July 19, funded through a variety of public sector partners and charitable contributions, acknowledging the need for all partners across

the Greater Manchester system to contribute and respond to tackling the issue of rough sleeping.

3.3. This second phase has provided the opportunity to develop a more formalised model of provision offering an improved quality of accommodation. It has also seen the provision increase across all localities in a way that better responds to the needs of rough sleepers in different areas and with different needs. A comprehensive monitoring and assurance process has been put in place to support a full external evaluation of the programme and its impact on the people who use it.

3.4. Over winter 2019/20, ABEN has committed to providing over 400 beds across Greater Manchester, dependent on demand, and currently has 456 people accommodated.

3.5. During the period that ABEN has been running, the rough sleeper figures for Greater Manchester have decreased substantially from 241 in November 2018 to 151 in November 19, a drop of 37%. These figures are a local snapshot that have been submitted to the national official count which will be published in February 2020. This forms part of an overall decrease in rough sleeper numbers of 44% since 2017, after increasing almost every year since 2010.

4.0 PROGRESS UPDATE

4.1. Homelessness Health and Wellbeing Task and Finish Group

4.1.1. At the point the investment into ABEN was agreed, the 'Homelessness Health and Wellbeing Task and Finish Group' was established to support the move from concept to delivery and to provide oversight to the investment and agreed priority work areas.

4.1.2. The group, which has met regularly since June 2019, has taken responsibility for directing capacity and resources to enable delivery and has confirmed appropriate clinical input into the programme. It has also provided officer support to GMCA with monitoring, evaluation, development of pathways and service specification to ensure the work of the Group is aligned with and informed by the priorities of the wider ABEN and homelessness programme.

4.1.3. The group is chaired by Dr Ruth Bromley, Clinical Chair, Manchester Health and Care Commissioning and it has been confirmed as a direct sub-group of the GM Homelessness Programme Board, with reporting arrangements into Commissioning Leadership Group (CLG) and JCB.

4.2. Work Programme

4.2.1. An initial set of objectives were established for the Task and Finish Group, which have been kept under review as the work has developed.

- Take forward commitments to homeless healthcare made as part of the JCB investment case.
- Better understand the health needs of the homeless population in Greater Manchester.
- Better understand provision of homeless healthcare across Greater Manchester and what 'best' looks like.
- Focus on workforce development, for those working in ABEN provision and GP practices, to improve the offer to the homeless population.
- Longer-term, take forward development of GM commissioning guidance for homeless healthcare.
- Oversee other elements of the GM homelessness and health programme for the duration of the group.

4.2.2. Key actions that contribute to achieving these objectives have been captured in a delivery plan to ensure implementation and to also provide clarity for partners. The main areas of progress for the first six months of ABEN Phase 2 (June – December 2019) are outlined below.

- Mobilising activity to understand better the presenting health needs of those accessing ABEN. A comprehensive health needs assessment (Homeless Link) has been delivered in partnership with Urban Village Medical Practice in selected ABEN provision to improve our understanding of this cohort and the most appropriate clinical response.
- Ensuring that agreed health related standards have been incorporated into ABEN service specification and are considered by service providers. This has been informed by the extensive work on temporary accommodation standards undertaken by The Booth Centre and includes reference to infection control and bed spacing.
- Development of a comprehensive training and education offer for front line staff and partners working in A Bed Every Night, with the aim to educate and better inform the workforce and bring people together to create a network to support further learning. This 'faculty of learning' for health and homelessness will launch

on 24th January 2020 with a full day even covering a range of topics led by sector experts.

- A detailed exercise to update our understanding of health and care provision for people experiencing homelessness across GM. This is in update to two previous similar exercises and now forms part of an agreed process with localities to update through the period of this work.

- Proactive engagement with GP Practices in close proximity to ABEN provision with the aim of encouraging engagement with ABEN and locality leads to develop approaches to supporting health needs over the winter period. Correspondence focused on sharing headline outcomes from the recent needs assessment and highlighting good practice where local arrangements are already underway.

- Established a single point of contact in each locality to take the lead on homeless healthcare.

4.2.3. The approach taken by the Task and Finish Group to identifying priorities and where to utilise resources has been to build on and learn from programmes already across in Greater Manchester and in localities, Taking this asset-based approach has meant working jointly alongside system leaders and experts to add value where we can, determine where the GM role is of most use and supporting locality stakeholders to work more collaboratively.

5.0 NEXT PHASE ACTIVITY

5.1. For the period to the end of ABEN Phase 2 (June 2020), alongside continued support to the ABEN and wider homelessness programmes, the group will begin work to further inform and improve the homeless healthcare offer. This will include;

- Planning and facilitation of 'homeless and inclusion health champions' training programme for clinicians and GP practice staff, including identification of 'go early' Practices and groups of clinicians based on proximity to ABEN provision and local demand.

- Establish the Homeless Families Task and Finish Group, led by GMHSCP, as a second sub group of the GM Homelessness Board. This cross-sector group will explore the issue in more detail, improve understanding and make recommendations on appropriate models of support.

- Exploring options for a standardised process and offer for GP registration for people experiencing homelessness. This will build on work already undertaken by GMHSCP and the 'Homeless Friendly' scheme.

- Launch of the GM version of 'My Right to Healthcare' cards in partnership with Groundswell, to help get people experiencing homelessness register with a GP practice. The cards will be distributed throughout ABEN provision and other GM homelessness services.

- Through the ten homeless healthcare leads, support individual localities to better understand the health needs of their specific homeless populations by undertaking their own Homeless Link Health Needs Audit.

- Using this same network to identify and formally share examples of GM best practice that can inspire and inform other localities to develop similar services where required.

- Providing support where appropriate to the agreed case management approaches for the most entrenched rough sleepers who are not accessing ABEN. This will include coordinating input into the Manchester 'Super Case Conference' and 'Task & Target' processes where required.

5.2. These actions will take us further towards development of an evidence informed model of homeless healthcare, which would seek to describe what 'best' looks like for Greater Manchester, but also in a way which influences the national agenda for homeless health as a result. Led by the GM Joint Commissioning Team, it will inform and support development of our GM homeless health services, the outcomes they deliver, and more broadly work on health inequalities and inclusion health.

6.0 FUTURE HEALTH AND HOMELESSNESS COMMITMENTS

6.1. The delivery plan set out an intention to continue collaborative work on homelessness and health post June 2020 when the investment in ABEN Phase 2 comes to an end. High-level suggestions in the plan of what this could look like included;

- Development of GM wide commissioning guidance for homeless health care, underpinned by best practice from GM and internationally. This would inform the development of excellent and appropriate health services for people experiencing homelessness.

- Continued support to an active network of homeless healthcare leads and faculty of learning, including further support to roll out training and education offer to our workforce.

6.2. As this work has developed and progressed over the initial six-month period, the requirement to review and confirm any future commitment feels crucial, so that we are able to be proactive in setting out our intentions as a health system, including any future investment. The shape that any future work and partnership takes should be informed by the evidence base compiled over the full 12-month period, our better understanding of the system and the views of localities represented by members of JCB.

6.3. It is proposed that a further discussion takes place at the JCB meeting in February to inform a process that will lead to clarification of the JCB position and allow for proposals to be developed prior to the end of this existing arrangement in June 2020.

7.0 RECOMMENDATIONS

7.1. The Greater Manchester Joint Health Scrutiny Committee is asked to:

- Consider the content of this report and the progress made through the Health and Wellbeing Task and Finish Group.

- Note a further discussion at the February meeting of JCB to review any future investment arrangements and commitment from the health system to tackling homelessness.

WORK PROGRAMME

FOR GREATER MANCHESTER JOINT HEALTH SCRUTINY

The table below and over the page sets out the Greater Manchester Joint Health Scrutiny's work programme for the full meeting for Members to develop, review, and agree. This is a 'live' document and will be reviewed and, if necessary, updated at each meeting to ensure that the Committee's work programme remains current.

For information items taken previously to Greater Manchester Joint Health Scrutiny in 2018/19 are also listed:

MEETING DATE	TOPIC	CONTACT OFFICER	REASON FOR SUBMISSION TO SCRUTINY COMMITTEE
15 January 2020	Investment in Homeless Healthcare and 'A Bed Every Night'	Dr Cath Briggs/Helen Simpson	To provide an overview of work on homelessness and health overseen by GM Health and Social Care Partnership (GMHSCP), including the £2m investment from GM Joint Commissioning Board (JCB) and GMHSCP into the emergency rough sleeper programme 'A Bed Every Night' (ABEN)
	Improving Specialist Care Programme (ISCP) - Respiratory	ISCP Team, Nadia Baig, Director of Commissioning at NHS Oldham CCG and Dr Jennifer Hoyle, Clinical Lead for Respiratory	To outline a proposed approach to progress the transformation of Respiratory services to ensure rapid improvement to the clinical service and to provide an equitable service for all patients accessing Greater Manchester Respiratory services
11 March 2020	Primary Care Update	Dr Tracey Vell	
10 July 2019	Improving Specialist Care Programme	Jackie Bene Anthony Hassall, ISCP Team	To provide an overview of the Improving

			Specialist Care Programme
11 September 2019	Children and Young People's mental health programme including an overview of the GM Mentally Healthy Schools Pilot	Warren Heppolette (GMHSCP)	To provide an overview of the mental health in education (MHiE) programme that is currently being delivered across Greater Manchester, including providing details of each of the initiatives.
	NWAS GM Quarter One Performance	Daren Mochrie/ Michael Forrest (NWAS)	To update the committee on the performance of North West Ambulance Service (NWAS) across Greater Manchester (GM).
13 November 2019	Implementation of NHS Long Term Plan in the context of the GM approach to public service reform	Warren Heppolette	To provide an update on the 'GM Delivery Plan 2020-24' – Greater Manchester's implementation guide for The Prospectus (2019) and the NHS Long Term Plan.
	Improving Specialist Care Programme	Jackie Bene and Anthony Hassall	To provide feedback to the Committee on recommendations from the GM Joint Commissioning Board (JCB) on pre consultation site configuration business case options.

Items considered in 2018-19 by the Committee

13.03.19	• Digital Strategy • GM Drug and Alcohol Strategy
16.01.19	• Working with the VCSE • Primary Care Reform Update
14.11.18	• Standardising Acute and Specialised Care – Neuro Rehabilitation Services • Lord Carter's Review into Unwarranted Variation In NHS Ambulance Trusts
12.09.18	• Automated External Defibrillator (AED) Provision across Greater Manchester • Local Care Organisation (LCO) Development across Greater Manchester
11.07.18	• Greater Manchester Health and Social Care Partnership Delivery Plans For In 2017-18 and Plans For 2018-19

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