Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

GREATER MANCHESTER

JOINT HEALTH SCRUTINY COMMITTEE

DATE: **Wednesday 8 March 2023**

TIME: **10.00 am**

VENUE: **Boardroom, GMCA, Broadhurst House, 56 Oxford Street, Manchester M1 6EU**

AGENDA

1. APOLOGIES

2. DECLARATIONS OF INTERESTS 1 - 6

To receive declarations of interest in any item for discussion at the meeting. A blank form for declaring interests has been circulated with the agenda; please ensure that this is returned to the Governance & Scrutiny Officer at least 48 hours in advance of the meeting.

3. MINUTES OF THE MEETING HELD 18 JANUARY 2023 7 - 16

To consider the approval of the minutes of the meeting held on 18 January 2023.

BOLTON	**MANCHESTER**	**ROCHDALE**	**STOCKPORT**	**TRAFFORD**
BURY	**OLDHAM**	**SALFORD**	**TAMESIDE**	**WIGAN**

Please note that this meeting will be livestreamed via www.greatermanchester-ca.gov.uk, please speak to a Governance Officer before the meeting should you not wish to consent to being included in this recording.

4. GREATER MANCHESTER INTEGRATED CARE STRATEGY (ICS) - 5 YEAR STRATEGY 17 - 48

Presented by City Mayor Paul Dennett, GMCA Deputy Mayor and Portfolio Lead for Homelessness, Healthy Lives and Quality Care and Chair of the Integrated Care Partnership (ICP).

5. ADDRESSING THE INCREASED PRESENTATION OF YOUNG PEOPLE EXPERIENCING MENTAL HEALTH ISSUES 49 - 68

Presented by Sandeep Ranote, Medical Executive Lead - Mental and Xanthe Townend, Greater Manchester Programme Director for Mental Health, NHS Greater Manchester Integrated Care.

6. GREATER MANCHESTER PEOPLE AND CULTURE STRATEGY 69 - 100

Presented by Janet Wilkinson, Chief People Officer, NHS Greater Manchester Integrated Care.

7. GREATER MANCHESTER ELECTIVE CARE RECOVERY AND REFORM 101 - 112

Presented by Vicky Sharrock, Greater Manchester Programme Director for Elective Care, NHS Greater Manchester Integrated Care.

8. DATES AND TIMES OF FUTURE MEETINGS

To be advised.

Committee Membership		
Name	**Organisation**	**Political Party**
Councillor Jacqueline Radcliffe	Bolton Council	Conservative
Councillor Elizabeth FitzGerald	Bury Council	Labour
Councillor Sandra Collins	Manchester City Council	Labour
Councillor Sajed Hussain	Oldham	Labour
Councillor Patricia Dale	Rochdale Council	Labour
Councillor Margaret Morris	Salford City Council	Labour
Councillor David Sedgwick	Stockport Council	Labour
Councillor Naila Sharif	Tameside MBC	Labour
Councillor Sophie Taylor	Trafford Council	Labour
Councillor John O'Brien	Wigan Council	Labour

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 & Scrutiny Officer: jenny.hollamby@greatermanchester-ca.gov.uk

This agenda was issued on 28 February 2023 on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority, Broadhurst House, 56 Oxford Street, Manchester M1 6EU

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Declaration of Councillors' Interests in Items Appearing on the Agenda

Name and Date of Committee……

Agenda Item Number	Type of Interest - PERSONAL AND NON PREJUDICIAL Reason for declaration of interest	NON PREJUDICIAL Reason for declaration of interest Type of Interest – PREJUDICIAL Reason for declaration of interest	Type of Interest – DISCLOSABLE PECUNIARY INTEREST Reason for declaration of interest

Please see overleaf for a quick guide to declaring interests at GMCA meetings.

Quick Guide to Declaring Interests at GMCA Meetings

Please Note: should you have a personal interest that is prejudicial in an item on the agenda, you should leave the meeting for the duration of the discussion and the voting thereon.

This is a summary of the rules around declaring interests at meetings. It does not replace the Member's Code of Conduct, the full description can be found in the GMCA's constitution Part 7A.

Your personal interests must be registered on the GMCA's Annual Register within 28 days of your appointment onto a GMCA committee and any changes to these interests must notified within 28 days. Personal interests that should be on the register include:

1. Bodies to which you have been appointed by the GMCA
2. Your membership of bodies exercising functions of a public nature, including charities, societies, political parties or trade unions.

You are also legally bound to disclose the following information called Disclosable Personal Interests which includes:

1. You, and your partner's business interests (eg employment, trade, profession, contracts, or any company with which you are associated).

2. You and your partner's wider financial interests (eg trust funds, investments, and assets including land and property).

3. Any sponsorship you receive.

Failure to disclose this information is a criminal offence

Step One: Establish whether you have an interest in the business of the agenda

1. If the answer to that question is 'No' then that is the end of the matter.

2. If the answer is 'Yes' or Very Likely' then you must go on to consider if that personal interest can be construed as being a prejudicial interest.

Step Two: Determining if your interest is prejudicial

A personal interest becomes a prejudicial interest:

1. where the wellbeing, or financial position of you, your partner, members of your family, or people with whom you have a close association (people who are more than just an acquaintance) are likely to be affected by the business of the meeting more than it would affect most people in the area.
2. the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice your judgement of the public interest.

For a non-prejudicial interest, you must:

1. Notify the governance officer for the meeting as soon as you realise you have an interest.
2. Inform the meeting that you have a personal interest and the nature of the interest.
3. Fill in the declarations of interest form.

To note:

1. You may remain in the room and speak and vote on the matter

   If your interest relates to a body to which the GMCA has appointed you to, you only have to inform the meeting of that interest if you speak on the matter.

For prejudicial interests, you must:

1. Notify the governance officer for the meeting as soon as you realise you have a prejudicial interest (before or during the meeting).
2. Inform the meeting that you have a prejudicial interest and the nature of the interest.
3. Fill in the declarations of interest form.
4. Leave the meeting while that item of business is discussed.
5. Make sure the interest is recorded on your annual register of interests form if it relates to you or your partner's business or financial affairs. If it is not on the Register update it within 28 days of the interest becoming apparent.

You must not:

Participate in any discussion of the business at the meeting, or if you become aware of your disclosable pecuniary interest during the meeting participate further in any discussion of the business,

participate in any vote or further vote taken on the matter at the meeting.

MINUTES OF THE MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE HELD ON 18 JANUARY 2023, GMCA, BOARDROOM, 56 OXFORD STREET, MANCHESTER M1 6EU

PRESENT:

Councillor John O'Brien	Wigan Council (Chair)
Councillor Elizabeth FitzGerald	Bury Council
Councillor Andrea Taylor-Burke	Bolton Council
Councillor Patricia Dale	Rochdale Council
Councillor Sophie Taylor	Trafford Council

OTHERS PRESENT:

Councillor Linda Grooby	Derbyshire County Council

OFFICERS IN ATTENDANCE:

Rob Bellingham	Director of Primary Care and Strategic Commissioning, NHS Greater Manchester Integrated Care
Warren Heppolette	Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care
Jenny Hollamby	Governance & Scrutiny Officer, GMCA
Ben Squires	Head of Primary Care, NHS Greater Manchester
Nicola Ward	Statutory Scrutiny Officer, GMCA

JHSC/25/23 APOLOGIES

Apologies were received and noted from Councillors Jacqueline Radcliffe (Bolton Council), Sandra Collins (Manchester City Council), City Mayor Paul Dennett and Margaret Morris (Salford City Council) and Naila Sharif (Tameside Council).

JHSC/26/23 DECLARATIONS OF INTEREST

RESOLVED/-

No declarations of interest were received.

JHSC/27/23 MINUTES OF THE MEETING HELD ON WEDNESDAY 9 NOVEMBER 2022

RESOLVED/-

That the minutes of the meeting held on 9 November 2022 be approved as a correct record.

JHSC/28/23 PROVISION AND ACCESS TO NHS DENTISTRY

The item was introduced by the Director of Primary Care and Strategic Commissioning and a presentation was delivered by the Head of Primary Care, which provided an update on the provision of, and access to, NHS primary, secondary and community dental services and delivery of oral health improvement activity across Greater Manchester. The report also highlighted the actions taken to address health inequalities and to improve access to dental services to ensure patients were able to receive dental care and oral health improvement in a safe way.

The Committee welcomed the comprehensive report and informative presentation. NHS Greater Manchester Officers agreed to feed this back to their colleagues to who had co-authored the materials.

Officers were asked to explain the contractual arrangements around dentistry. Members heard that the NHS held contracts with dental practices rather than individual dentists. Practices were paid, not on the number of patients but to provide a set number of Units of Dental Activity (UDA) for the annual contract value. The UDA was a measurement of a course of treatment related to its complexity. There

were different units of value for different treatments along with banded courses of treatment. In terms of payments, should a practice not provide their contracted UDA they would be asked to undertake a review and could be financially penalised. However, should a practice provide more UDA, they would not be paid more than the contract value. The current contract came into place in 2006 and renegotiation work was ongoing. It was reported that relationships with dentists and practices were positive, but it was difficult given the complexity of the current contract.

Whilst it was reported that 60% of Greater Manchester residents had access to a NHS dentist, a Member queried access for Rochdale residents and asked what more could be done. Officers clarified that the 60% reported was the pre-pandemic level and this may have increased. However, to improve services and access, further investment was needed. The Integrated Care Board (ICB) was considering this aspect and would invest in the priority areas. More work was needed with dental practices to encourage them to see new patients to deliver against their contracted UDA levels. However, practices were concerned because of the potential excessive treatment need and if they surpassed their contracted UDA.

A discussion took place about how it was financially advantageous for practices to carry out six-monthly patient check-ups even though there was no clinical requirement. A public education programme was needed about the recall period and practices needed to be persuaded to use appointments to see new patients, over unnecessary check-ups.

A Member was concerned about the profound dental issues in children under five and how this issue could be addressed. It was reported that improved oral health meant less treatment. The Oral Health Improvement Greater Manchester Transformation Programme was about improving oral health in conjunction with Districts via a programme of support to reduce health inequalities across the priority oral health areas, offered supervised toothbrushing for children aged 2 to 5 years, delivered Health Visitor 0 to 3 years training, and supported the distribution of fluoride dental packs. There was also the challenge of introducing fluoridated water, even though it was having a positive impact in other areas of the country. Members heard there had been a shift towards prevention and early intervention, which linked

to the wider Integrated Care Partnership Strategy (the Strategy). Whilst there was a need to have services in place, it was recognised that it was more beneficial to prevent problems in the first instance. The importance of preventative activity in school and at home was also acknowledged.

Regarding the illustration within the report which compared Districts percentage of 5-year-old children with obvious dental problems with the national average, a Member asked how this would be levelled up. Targeted work was taking place in challenging areas and evidenced based programmes to improve oral health for children were being introduced.

The Member from Rochdale was asked about the picture in her District. Members heard that the health needs including dentistry in Rochdale were shaped by deprivation, there were more health problems and poorer life expectancy. How dental practices worked needed addressing along with the recruitment of more dentists.

A Member enquired about capacity and ask why the patient count had dropped from 1.2m to 800k. The drop reduction was attributed to the pandemic, reduced attendance, and how information was reported 2021/22.

A Member asked about the 85% of practices in Greater Manchester whose activity was more than 30% of their contracted delivery. It was explained that it was expected that practices would have achieved 50% of their contracted delivery by this stage. If practices had only undertaken 30% then they would have to achieve 70% of their contracted delivery by the end of the year. It was suggested that footfall had reduced because of the complexity of treatment.

A discussion took place about underperforming practices, links to the Strategy, and how renegotiation of contracts was a priority. Officers reported that should a practice be underperforming, there was the option of clawback, but work would take place with practices before this happened. Members were informed that the contracts would be reviewed nationally. However, there had been some changes to the Public Contracts Regulations in October 2022 around complex treatments which further

incentivised dentists to undertake these. Officers were considering what scope there was locally and discussions were taking place with NHS England's Director of Primary and Community Care to influence national policy and to understand if there was any flexibility in the national contract.

A Member was concerned about the price of toothpaste given the problems with oral health. It was reported that Population Health was undertaking work in this area as oral health had deteriorated during the pandemic. The cost-of-living crisis was making the challenge even harder. It was suggested that Officers visit a toothpaste manufacturer to encourage them to support oral health programmes with free products.

It was suggested and agreed that a dentistry update be provided at the Committee's meeting in due course.

RESOLVED/-

1. That the committee noted the report.
2. That Member's comments about the report and presentation be fed back to the co-authors.
3. That a further dentistry update be presented to the Committee at a future meeting.

JHSC/29/23 DEVELOPING THE GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP (ICP) STRATEGY: UPDATE

A report provided by the Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care, was considered, which provided an overview of the background to the Strategy, the process undertaken to develop it; and the engagement planned until February 2023.

A presentation accompanied the report, which covered the following key issues:

- Our Model of Health and Care

- Shared Outcomes and Shared Commitments
- A Greater Manchester Where Everyone

A Member asked about funding and how much would be available for NHS Greater Manchester, compared to previous years. It was advised there was approximately £6.5m of funding, which was an increase that included specialist care but did not include social care. There was around £800m available for social care and an extra £200m for extra care home beds.

A Member welcomed the diagram, which illustrated the Greater Manchester Model of Health and Care and asked about culture change and the role of the ICB, jobs and accountability to health and preventative measures. The Member also suggested, in terms of hard-to-reach communities and volunteers, there was a generation of people coming through the system who were less healthy and would be unable to sustain and skill volunteering work. The Member asked how it would be addressed and how would health as an outcome be embedded. In response, it was explained that discussions were taking place with housing providers, schools, colleges, universities and local people about their role and the relationship between good work and health. There was also a more fundamental shift, which needed to be progressed through the Trailblazer negotiations about control of the skills system across Greater Manchester and the connection between priorities for where good employment required development and growth. There was a need for a link between the skills and careers in care, which was an ambition of the Trailblazer. The culture change identified in the diagram was recognised as important in terms of health practitioners, GPs, hospital doctors and nurses needing to understand that good quality housing and good work were health outcomes, which recognised there was a benefit to support and provide clinical intervention alongside medical interventions and pathways.

A Member agreed that Greater Manchester Model of Health Care illustrated comprehensively the full health and care picture. The Member highlighted that there had been a wave of people with chronic pain problems following the pandemic, which was adding further pressure to the system but the conditions for a good life

were not accessible for some residents. Deprivation was highlighted as a particular problem and determinant of health.

Members were concerned about the £800m deficit reported. Members heard that reductions would be needed in the cost base, efficiency and productivity, and measures were being considered. Radical changes would be challenging, and difficult choices would be needed moving forward. A financial roadmap would be developed to understand the picture. Members agreed that innovative thinking and a move to early diagnosis and prevention were key.

A Member enquired, in light of the £800m deficit, how the backlog of elective surgery would be undertaken and how the 62-day wait figure for treatment would be reduced given it was reported as deteriorating. The Member also drew attention to the dramatic reduction in the 78-week waiting list figure from 2,578 to 675 patients and congratulated the workforce. Regarding the waiting figures, it was reported that it equated to over 0.5m people in Greater Manchester and the Strategy would need to include a description for the first year about what work was taking place to reduce the lists with available resources with a focus on the reduction of wait times. In recognising the move to prevention, it would not be reliant on NHS resources but on investment across all public services. Conversations with the private and business sectors would take place to understand how they could support good health across the population. Members agreed that innovation was key, and the Member from Rochdale described how GPs in her ward were working collaboratively around resources and had employed five Social Prescribing Link Workers to help provide support and advice in relation to social issues. Patients would be helped to access the services that were already in place to improve their good health and it freed up time for GPs to concentrate on clinical issues.

A Member enquired who paid for Social Prescribing Link Workers in practices. It was advised that resources were part of the primary care contract.

Officers agreed that social prescribing to add capacity and lighten the load of GPs, could potentially be something to value and grow.

The Chair encouraged Members to watch the BBC's Panorama programme, which aired on 21 January 2023 about hospitals struggling with soaring demand, increased waiting times and workforce issues. The programme investigated what could be done to fix the health and care system.

A Member asked if the Greater Manchester Model of Health and Care diagram could be shared outside of the meeting. Officers explained that it would be updated and shared with Members following the meeting.

Further to a Member question raised at the last meeting about the Edenfield Centre and it being considered at a Greater Manchester level, it was reported that it was being scrutinised locally as there was an impact on other services given the special measures intervention.

A Member asked, and Officers agreed to update the Annual Health Check Performance diagram include Rochdale.

RESOLVED/-

1. That Committee noted the report.
2. That Members considered and endorsed the set of key questions on the draft Strategy (paragraph 4.3 of the report).
3. That the Greater Manchester Model of Health and Care diagram be updated and shared with Members.
4. That the Annual Health Check Performance diagram be updated to include Rochdale.

JHSC/30/23 INTEGRATED CARE BOARD QUALITY AND PERFORMANCE UPDATE 21 DECEMBER 2022

The report, which was for Member's information, was considered by the Integrated Care Board on 21 December 2022 and covered reporting against all constitutional standards and system oversight framework indicators, the material risks/issues raised by localities, system boards, the Joint Planning and Delivery Committee, and

the Quality and Performance Committee. The report had been presented to Members in response to their questions at the last meeting around performance measures.

RESOLVED/-

That the report be received and noted.

JHSC/31/23 WORK PROGRAMME FOR 2022/23 MUNICIPAL YEAR

Members considered a report provided by the Statutory Scrutiny Officer, GMCA, which set out the draft Work Programme for the 2022/23 Municipal Year. The Work Programme was a working document, which would be updated throughout the year.

RESOLVED/-

That a dentistry update be provided in September 2023 be added to the Committee's Work Programme.

JHSC/32/23 DATE AND TIME OF NEXT MEETING

The next meeting would be held on 8 March 2023 at 10.00 am, Boardroom, GMCA.

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Greater Manchester Joint Health Scrutiny

Date: 8 March 2023

Subject: Greater Manchester Integrated Care Partnership – 5 Year Strategy

Report of: Mayor Paul Dennett, (GMCA Deputy Mayor) Homelessness, Healthy Lives and Quality Care

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Purpose of Report:

This report updates on the development of the five-year Greater Manchester Integrated Care Partnership strategy. It includes the current draft of that strategy, developed across the Partnership and reflecting the priorities expressed through public engagement. It is offered to support the Committee's consideration and input to the development and finalisation of the strategy.

Recommendations:

The GM Joint Health Scrutiny Committee is requested to:

1. Discuss the content of the draft strategy
2. Support the process to finalise the strategy and establish its delivery plan, the Joint Forward Plan

Contact Officer:

Warren Heppolette, Chief Officer, Strategy & Innovation, NHS Greater Manchester Integrated Care

warrenheppolette@nhs.net

1.0 Background

1.1. The Integrated Care Strategy (referred to here as the GM Integrated Care Partnership (ICP) strategy) is described in NHS England (NHSE) guidance as setting "the direction of the system … setting out how the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life".

1.2. From the national perspective, it also "presents an opportunity to do things differently to before, such as reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services". For GM, this is not a change but an affirmation of approaches we have been taking formally together since 2015.

1.3. The ICP strategy will be owned by the GM Integrated Care Partnership Board (GMICPB). ICPs have a statutory duty to create an integrated care strategy to address the assessed needs, such as health and care needs of the population, including determinants of health and wellbeing such as employment, environment, and housing.

1.4. The strategy will be a health and care strategy for GM, within the wider context of the strategy for GM, described in the Greater Manchester Strategy (GMS), seeking to develop GM as "a greener, fairer and more prosperous city-region".

1.5. The ICP strategy therefore shares the same vision as the GMS: We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region.

1.6. Within the GM context, the ICP strategy is the successor document to *Taking Charge of our Health and Social Care in Greater Manchester* – the plan published in 2015 as part of the devolution of health and care funding to GM.

1.7. It will be an integrated care strategy for the whole population of GM, covering health and social care, and addressing the wider determinants of health and wellbeing through partnership working. It aligns with:

- The four objectives for Integrated Care Systems specified by NHS England; and

- The shared commitment in the GMS related to health: “We will reduce health inequalities experienced by Greater Manchester residents, and drive improvements in physical and mental health”, whilst recognising that achieving this is not solely the role of the health and care system.

1.8. The shared outcomes, commitments, and ways of working in the ICP Strategy will be a common framework for reference for all plans and strategies. The strategy will not describe in detail the full range of the ICP’s activities over the next five years but will reaffirm key activities already recognised and underway which remain central to achieving our objectives. It will also confirm, through its development and prioritisation, a small set of key missions, central to our vision, relevant to our workforce and the times we find ourselves in, and to making a difference so that people in GM can live a good life.

1.9. Guidance says that the ICP strategy should build on previous system-level plans: “It is not about taking action on everything at once, nor should the key strategic priorities for system-level action be overly prescriptive on what is occurring locally”.

2.0 Framework for the Strategy

2.1. Through engagement with the system over the last few months, we agreed that the strategy should comprise a set of shared outcomes and a set of shared commitments supported by a description of how we will work together (“Ways of Working”) and a set of high-level progress measures. This is the same framework as used in the GMS.

2.2. The ICP strategy is therefore a framework for bringing together activities and identifying key system priorities, not about imposing a new set of programmes or activities on the partners within the ICS. GM’s history of working together across the city-region is a strong basis for this strategy.

2.3. The strategy (the draft of which is attached) brings together the key sources of evidence, evaluation, and assessments framing the challenges facing our communities and those we face as a health and care system. It describes the challenges of working across organisations and sectors to achieve shared commitments, and in the changes necessary to reduce inequalities. The behaviours and system rules required to enable us to work together in that way, and learning from our history since devolution, is articulated in the strategy.

2.4. The strategy proposes 2 main areas for action. First a continued focus on developing and embedding the model for health which partners across GM have been working on for the past 6 years. That is a model which is ambitious about affecting the broadest range of determinants of health, is preventative, is consistently integrated and rooted locally, is quick to innovate and which benefits from collaboration between care providers. Second, it proposes 6 system-wide missions to prioritise our response to the challenges we face now. They are each deeply relevant to the shared outcomes which sit as the basis for this strategy but recognise the specific challenges which exist now across Greater Manchester.

3.0 Engagement to Date

3.1. Engagement on the strategy is required in national guidance, with a statutory responsibility to involve (as a minimum) “local Healthwatch organisations … and people who live and work in the area.”.

3.2. Early engagement from March to May last year, through a survey for people and staff across Greater Manchester, sought to understand perceptions of the vision and shared outcomes as described at that time.

3.3. This was followed by a wider-ranging programme of engagement in the autumn of 2022 – *The Big Conversation: Phase 2.* Over 2,000 people were engaged using a range of methods across all 10 GM localities.

3.4. The engagement included older and younger people, carers, LGBTQ+, people with disabilities, multiple BAME communities, asylum seekers, refugees and other excluded groups including sex workers and the street homeless

3.5. The top five themes from the exercise were:

- Access to services: widespread concern the difficulties experienced in accessing GP appointments, as well as other access problems such as waiting times for hospital care
- Funding and staffing: widespread concern with funding and staffing levels for the NHS, as well as social care and the local VCFSE
- Personalised care: a demand for more personalised and person-centred care, which takes account of the different needs of different individuals and communities, and recognises that one size does not fit all
- VCSE partnership working: a demand for more and better partnership working with the VCFSE sector which is seen as ideally placed to help statutory services negotiate some of the above
- Wider determinants of health: an expressed need for more action on prevention and the wider determinants of health, including help with the cost of living

3.6. In respect of system engagement, we established a strategy working group comprising a range of stakeholders from across the system, including localities, which has met regularly since March last year, to support the strategy development work.

3.7. The Integrated Care Partnership Board has considered the strategy at its October meeting, at an extraordinary meeting on strategy in December and in more detail at its February meeting.

3.8. The developing strategy has also been discussed at Board sessions in individual organisations in GM and other key forums in the system throughout January and February.

4.0 Next Steps

4.1 The Strategy is scheduled for finalisation at the GM Integrated Care Partnership Board at its meeting on 24th March 2023. The immediate work will focus on the development of its delivery plan.

4.1. NHS England guidance states that before the start of each financial year, each ICB and its partner must publish a five-year Joint Forward Plan (JFP). For this first year (2023-24), however, NHS England has said that the date for publishing and sharing the final plan is 30th June 2023. We propose to develop the JFP as a delivery plan for the ambitions in our Integrated Care Partnership Strategy and set out the actions to achieve those ambitions in detail, and confirm the bodies with lead responsibility for each element as appropriate.

5.0 Recommendations

5.1 The GM Joint Health Scrutiny Committee is requested to:

1. Discuss the content of the draft strategy
2. Support the process to finalise the strategy and establish its delivery plan, the Joint Forward Plan

Greater Manchester Integrated Care Partnership Strategy

Improving health and care in Greater Manchester 2023-2028

Foreword

To be drafted by Mayor Paul Dennett and Sir Richard Leese

1. Executive Summary

To follow

2. Introduction

The way in which health and care services are organised in every part of England changed on 1 July 2022, as new national legislation came into force. Greater Manchester is now an Integrated Care System – a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in Greater Manchester.

There is a requirement for all ICSs to develop a strategy. NHS organisations and local authorities must then have regard to this strategy when making decisions about the use of health and care resources.

This document is Greater Manchester's Integrated Care Strategy. It sets out how we intend to work to address the health needs of the 2.8m residents of Greater Manchester. It focuses on the health and care contribution to enabling everyone to live a good life through improved wellbeing.

In Greater Manchester we had a strategy for health and care, called "Taking Charge"[1] which was developed in 2015, following the devolution of funding for health and social care from Government to Greater Manchester. This was intended to cover the first five years of devolution and so now, in 2022, it is time for this to be refreshed and updated. This strategy is the successor to "Taking Charge".

This strategy builds on the work undertaken across Greater Manchester through Taking Charge, sustaining and extending examples of progress whilst acknowledging and addressing evident challenges.

It recognises and responds to today's context of an extended period of austerity affecting public services, the aftermath of a global pandemic and the pressures associated with the cost of living crisis on families, businesses, charities and public services. Those stresses have shown the impact of deprivation on health outcomes for our citizens compounded by a multitude of wider inequalities. This is a challenge for the whole of Greater Manchester and reinforces the ongoing need for a broad public service reform agenda, linked to a demanding environmental agenda and the building of a more inclusive economy, and in both, integrated health and care has a significant role to play.

2. Context

About Greater Manchester

Greater Manchester is one of the country's most successful city-regions. Our vision is to make Greater Manchester one of the best places in the world to grow up, get on and grow old. We're getting there through a combination of economic growth, and the reform of public services.

Greater Manchester is home to more than 2.8 million people and with an economy bigger than that of Wales or Northern Ireland. Greater Manchester's population in the 2021 Census is estimated to be

[1] taking-charge-of-our-health-and-social-care-plan.pdf (greatermanchester-ca.gov.uk)

2,867,800. This is an increase of 185,272 on the 2011 Census final estimate and represents a growth of 6.9% in the ten years, higher than the growth across England and Wales (6.3%) over the same period. All Greater Manchester local authorities have seen population growth since 2011 with the highest rate of growth being in Salford (15.4%). The City of Manchester's population has grown by the most within Greater Manchester an increase of 48,873 in the ten years. Amongst the 36 metropolitan districts in England only Birmingham (71,855) had a larger actual growth than Manchester. Salford (15.4%) had the highest actual percentage growth of any metropolitan district.

The Greater Manchester Combined Authority (GMCA) is made up of the ten Greater Manchester councils and Mayor, who work with other local services, businesses, communities and other partners to improve the city-region.

The ten councils (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan) have worked together voluntarily for many years on issues that affect everyone in the region, like transport, regeneration, and attracting investment.

The Greater Manchester Strategy

The Greater Manchester Strategy (GMS) sets out how, working collectively across Greater Manchester, with our communities, we can deliver the vision:

"We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region"

The GMS focuses on improved wellbeing for the people here, with better homes, jobs and transport. The strategy describes how work to make Greater Manchester a great place to visit, invest and study, with thriving businesses which are UK and world leading, in sectors including low carbon and digital, will continue. The GMS is designed to ensure that activity supports the achievement of a greener, fairer and more prosperous Greater Manchester, in a way which is inclusive, innovative and forward thinking, building on the pioneering and progressive culture which underpins Greater Manchester. It also shows how Greater Manchester can be held to account, with a delivery plan showing the collective actions being taken, and a performance framework to demonstrate progress.

The GMS focuses on shared outcomes:

The Wellbeing of our People

- A Greater Manchester where our people have good lives, with better health; better jobs; better homes; culture and leisure opportunities; and better transport
- A Greater Manchester of vibrant and creative communities, a great place to grow up get on and grow old, with inequalities reduced in all aspects of life

Vibrant and Successful Enterprise

- A Greater Manchester where diverse businesses can thrive, and people from all our communities are supported to realise their potential
- A Greater Manchester where business growth and development are driven by an understanding that looking after people and planet is good for productivity and profitability

Greater Manchester as a leading city-region in the UK and globally

- Greater Manchester as a world-leading low carbon city-region
- Greater Manchester as a world-leading digital city-region

3. The Greater Manchester Integrated Care Partnership

The way in which health and care services are organised in Greater Manchester changed in July 2022, in line with the Health and Care Act 2022.

The **Greater Manchester Integrated Care Partnership** (covering the Integrated Care System - the ICS) connects NHS Greater Manchester Integrated Care, the Greater Manchester NHS Trusts and NHS providers across the whole of primary care with the GMCA, Councils and partners across the VCSE, Healthwatch and the Trades Unions. Together these partners set the strategy and take the actions which will make a difference to the health of the population of Greater Manchester.

Greater Manchester Integrated Care Partnership Board is a statutory joint committee of the ICB (see the next point) and LAs within Greater Manchester. It brings together a broad set of system partners to support partnership working and it is the responsibility of this Board to develop this 'integrated care strategy' - a plan to address the wider health care, public health, and social care needs of the population.

NHS Greater Manchester Integrated Care (the Integrated Care Board – ICB) is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in a geographical area. It supports the ten place-based partnerships in Greater Manchester (Bolton, Bury, Heywood Middleton and Rochdale, Manchester, Oldham, Tameside, Trafford, Salford, Stockport and Wigan) as part of a well-established way of working to meet the diverse needs of our citizens and communities.

The Greater Manchester ICS is one of 42 ICSs across England, is one of the largest and one of only two which is coterminous with a Mayoral Combined Authority.

Our Shared Vision & Commitments

As partners and participants to the Greater Manchester Strategy, we want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region.

For the Greater Manchester Integrated Care Partnership this means a Greater Manchester which pursues health equity to ensure:

- Everyone has an opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care and support where and when they need it
- Health and care services are integrated and sustainable

Our shared commitments to ensure we achieve those outcomes are to:

- Ensure our children and young people have a good start in life
- Help people, families and communities feel more confident in managing their own health
- Support good work and employment and ensure we have a sustainable workforce
- Play a full part in tackling poverty and long-standing inequalities
- Drive continuous improvements in access, quality and experience – and reduce unwarranted variation
- Use technology and innovation to improve care for all
- Ensure that all our people and services recover from the effects of the pandemic as effectively and fairly as possible
- Help to secure a greener Greater Manchester with places that support healthy, active lives

- Manage public money well to achieve our objectives
- Build trust and collaboration between partners to work in a more integrated way

How we work

The creation of NHS Greater Manchester, and our new statutory Integrated Care Partnership, gives health and care partners the opportunity to work together to face the challenges the current economic climate presents to our communities and to public services. In doing that we will aim to accelerate the journey to improve our population's health and wellbeing we have been on for the last five years, and so play our part in delivering the city region's vision.

Transforming public services, integrating care to provide solutions which are more than medicine, and working with communities and not simply 'doing to' fundamentally challenge our approaches to delivery and working together. The way that we work together will play an important part in achieving our vision and will challenge us to work together, and with the communities we serve, more effectively to achieve the outcomes we want to see.

Our Ways of Working:

Behaviours	We will …
Understand and tackle Inequalities	Take action at individual, team and organisation levels, with data needed to enable understanding. Raise awareness and take targeted action.
Share risk and resources	Set out our expectations of each other, and share data effectively, as well as supporting joint working with resource and a culture of collaboration. This must happen at every level and in every place and can lead to more effective use of resources.
Involve communities and share power	Consistently take a strengths-based approach with co-design, co-production and lived experience as fundamental ingredients.
Spread, adopt, adapt	Share best practice effectively, test and learn, and celebrate success, with supportive governance and resources.
Be open, invite challenge, take action	Be open and honest, and consistent and respectful in working with each other, within a supportive environment
Names not numbers	Ensure we all listen to people, putting the person at the centre, and personalising care

This will involve rapidly increasing the level of integrated neighbourhood and locality working that connects all partners and communities who can contribute to improving health and tackling inequalities, and moving more quickly to a stronger model of collaboration at the Greater Manchester level, ensuring more consistent and standardised responses to systemic challenges.

To ensure we play our part in delivering our shared vision across Greater Manchester, we will capitalise on both:

- The connection with neighbourhoods and communities that locality working offers – to integrate health and care with wider public services and tackle the root causes of poor health; and
- The scale that a single Greater Manchester organisation offers – to drive consistent improvement; reduce unwarranted variation; and make the best use of our collective resources

Figure 1 below, highlights how partners across health and care, wider public services and the VCSE work together as part of integrated neighbourhood teams; across whole districts, towns and cities in place-based partnerships; and, where appropriate, across the whole of Greater Manchester to ensure consistency of access and experience and pursue improvements at scale.

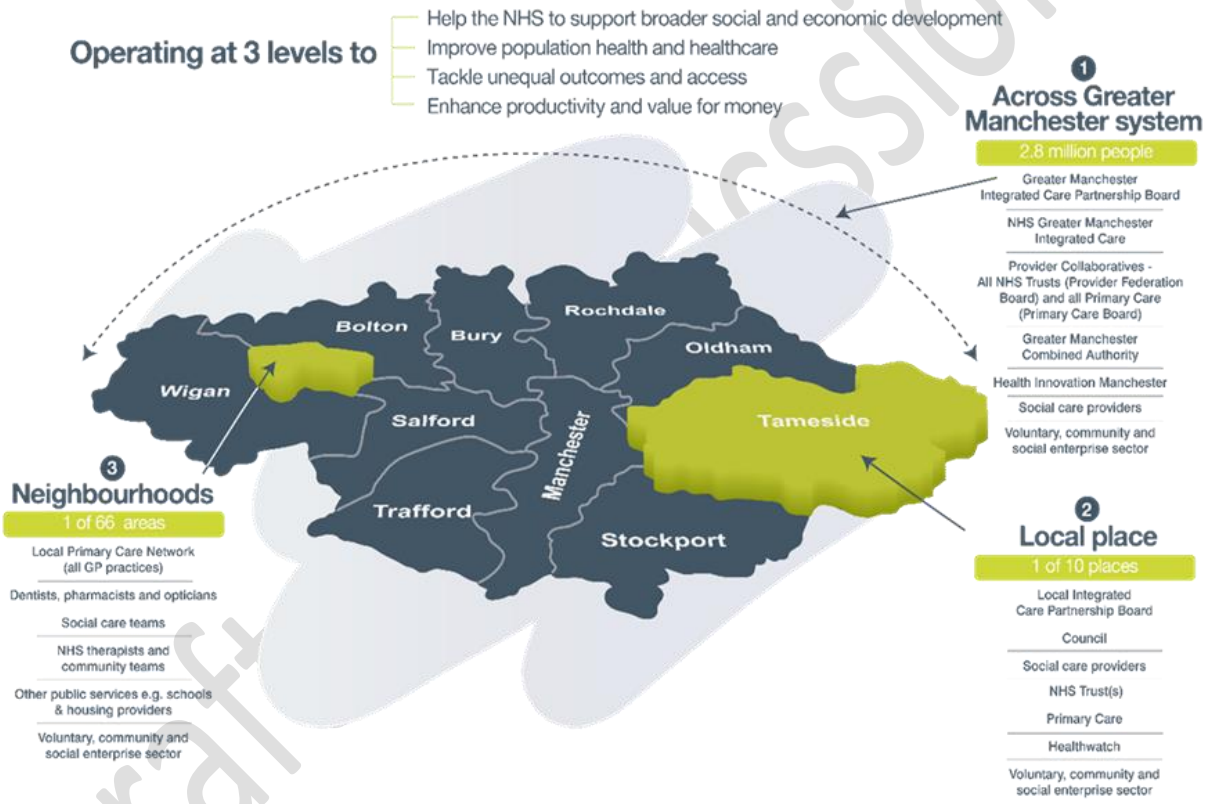


Figure 1

Within Greater Manchester we have arrangements for providers to work together effectively at scale, including:

- The Greater Manchester **Provider Federation Board** (PFB) is a membership organisation made up of the eleven NHS Trusts and Foundation Trusts who provide NHS funded services across Greater Manchester and East Cheshire. It includes the NHS providers of 111, 999, patient transport services (PTS), community mental health and physical health services and hospital mental health and physical health services
- The Greater Manchester **Primary Care Board (PCB)** has been supporting collaboration and integration since 2015 and will continue to support the delivery of outcomes at all levels of,

and across, the system, through its various programmes and its work with all 67 Primary Care Networks (PCNs) in Greater Manchester.

- Greater Manchester **Directors of Adults and Children's Social Care** collaborating to support transformation of social care at scale. For Adult Social Care this also includes joint working with the Greater Manchester Independent Care Sector Network.
- **Voluntary, Community and Social Enterprise (VCSE) sector providers** are part of a three-way agreement (the VCSE Accord) between the GMCA, and the Greater Manchester ICS and the VCSE Sector represented by the Greater Manchester VCSE Leadership Group, based on a relationship of mutual trust, working together, and sharing responsibility, and providing a framework for collaboration. The VCSE has also established an Alternative Provider Federation as a partnership of social enterprise and charitable organisations operating at scale across Greater Manchester, providing an infrastructure for alternative providers to engage with the ICS on a Greater Manchester footprint.

4. Influences on this Strategy

We have drawn on a variety of sources, in addition to each of the Joint Strategic Needs Assessments and locality plans developed through each Health and Well Being Board, in order to identify our vision and shared outcomes going forward. These sources include

- What the data and research is telling us about health needs
- What the evidence and evaluation is telling us
- The pressures on current services and the health & care workforce
- What residents are telling us

Data and Health Needs

Among its population of 2.8m people, Greater Manchester has some of the lowest life expectancy in England, with differences between the most and least deprived areas of 9.5 years for men and 7.7 years for women[2].

Significant disparities exist between and within Greater Manchester's ten districts. In some of the 10 local authorities that make up our city-region, those living in the neighbourhood with the shortest life expectancy can, on average, expect to die a whole decade before their compatriots in areas which fare best. In some places the disparity is as big as 17 years.

Further disparities exist between communities according to race and ethnicity, gender, disabilities, poverty and social exclusion, sexuality and age. For example:

- The poorest children are four times as likely to have a mental health difficulty as the wealthiest.
- Black people are many times more likely to be subject to the Mental Health Act. Amongst the five broad ethnic groups, known rates of detention for the 'Black or Black British' group (343.5 detentions per 100,000 population) were over four times those of the White group (74.7 per 100,000 population).
- People with autism, learning disabilities and long-term physical health problems have higher rates of mental ill health that are often never even identified.
- More than eight in ten women in Britain have felt as though they have not been listened to by healthcare professionals

[2] Codling, K. & Allen, J., Health Equity in Greater Manchester: The Marmot Review 2020. London: IHE, 2020

- 45% of trans young people (aged 11-19) and 22% of cis LGB young people have tried to take their own life. Among the general population the NHS estimates this figure to be 13% for girls and 5% for boys aged 16-24.
- Black women are four times more likely to die during pregnancy or childbirth compared to White women with women from Asian backgrounds facing twice the risk of maternal mortality.

In each case there are direct implications for the design, and delivery of health and care services to achieve heath equity for timely access, experience of care and the outcomes of that care.

The 2021 Census confirmed the broad trends of continuing population growth that we see for Greater Manchester, and especially the cities of Manchester and Salford, over the past ten years, are a continuation of the changes experienced in the two decades before. The scale of growth in recent decades across Greater Manchester outstrips the population losses of the 1970s and 1980s.

The scale and characteristics of the growth in Greater Manchester's population will have implications for services such as health and social care for the elderly, school places and public transport but will also mean that Greater Manchester authorities funding from central government will change in accordance with these population changes.

In 2020, the **Institute of Health Equity** (IHE), led by Professor Sir Michael Marmot, published an update on the 2010 Marmot Review of health inequalities in England, which included a parallel report dedicated to Greater Manchester[3].The IHE followed this with a detailed analysis of how Greater Manchester could become a Marmot city region by tackling inequalities across the life course, published as Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives[4].

The principle of Proportionate Universalism emphasised as part of that work recognises that greater help will be needed by those with greater challenges to overcome in order to reduce inequality.

The **Independent Inequalities Commission** (IIC), showed the main socioeconomic inequalities to be centred on housing and the lived environment; education and skills; power, voice and participation; income, wealth and employment; connectivity; and access to care and support. In a bid to address these inequalities, the IIC recommended that Greater Manchester focus its energy and resources on attaining two main goals: equality and wellbeing. The IIC identified that in terms of income, wealth and employment:

- Nearly a quarter of Greater Manchester adults of working age (24%) are economically inactive, well above levels for England as a whole (21%)
- For people from minority ethnic groups in Greater Manchester, employment rates are over ten percentage points below the overall working-age employment rate
- Only half of Greater Manchester working-age residents with a disability are in employment
- 37% of the city region's working-age population have higher level (Level 4+) skills, compared to the England average of 40%; and Greater Manchester has a disproportionately high proportion of working-age people with no qualifications (9%)
- The skills deficit reinforces the predominance of lower value, low pay employment in the city-region compared to the south of England and Greater Manchester's international comparators. Low income levels underpin high levels of child poverty (26%) in Greater Manchester, which are well above the national rate of 18%

[3] Codling, K. & Allen, J., Health Equity in Greater Manchester: The Marmot Review 2020. London: IHE, 2020.
[4] Marmot, M., Allen, J., Boyce, T., Goldblatt, P. & Morrison, J., Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives. London: IHE, 2021.

- There is compelling evidence of ageism in recruitment and retention of older workers, leading to low incomes and lack of social roles in mid-life and later life

Greater Manchester commissioned an **Independent Prosperity Review** in 2019 which was updated in 2022[5], in the light of COVID-19, the UK's exit from European Union and the inflation and energy shock. It showed that:

- Greater Manchester's productivity has been about 10% below the national average in recent years.
- Among the causes – explaining about 30% of the productivity gap is lower labour market participation caused by health problems.
- There are very strong correlations between employment levels and health conditions. Research found that as much as 75% of the variance in employment rates across the neighbourhoods of Greater Manchester is accounted for by health (correlations for mental and physical ill-health were similar)

Greater Manchester is relatively deprived compared to other ICSs in England – with the third highest % of the most deprived areas in England, compared with the 42 ICSs.

Evidence and evaluation

The years following devolution from 2015 onwards have been times of change for the whole population and a range of improvements in health were achieved. Reductions in smoking prevalence, supporting more children to be school-ready, reductions in people who were physically inactive and positive employment outcomes for people with health related barriers to work each showed sustained performance compared to the rest of England.

Taken together, these changes contributed to an improvement in life expectancy against comparable areas. A study by University of Manchester researchers published in the Lancet Public Health shows life expectancy in Greater Manchester was higher than comparable areas between 2016 and 2019, after the city-region took control of its health and care spending in a 'devolution deal' with Government. In the short-term, life expectancy remained constant in Greater Manchester but declined in comparable areas in England. In the longer-term, life expectancy increased at a faster rate in Greater Manchester than in comparable areas. The study showed the benefits linked to devolution on life expectancy were felt in the most deprived local authorities where there was poorer health, suggesting a narrowing of inequality.

There is much about our model for health creation, connecting social, medical and behavioural factors which has been demonstrated to work and must remain the focus of our work with communities in each neighbourhoods throughout the life of this strategy.

Pressures on current services and the health & care workforce

Like all health and care systems, Greater Manchester is facing a range of challenges, some of which can be addressed within Greater Manchester whilst others also require changes at a national level. How we aim to address these in Greater Manchester is described in this strategy. The impact of the pandemic has been huge, and exacerbated many of the challenges which were already having an impact on the wellbeing of staff and the sustainability of services:

Demand for NHS services

[5] https://greatermanchester-ca.gov.uk/what-we-do/economy/greater-manchester-independent-prosperity-review/ipr-2022-evidence-update/

- Over 535,000 people were waiting for treatment as at February 2023 compared to 220,000 before COVID-19. Greater Manchester is required to eliminate waits of over 18 months by end March 2023
- Prior to COVID-19, Greater Manchester was not meeting core Cancer Constitutional Standards, and the equivalent of five additional theatres are required now, five days, every week, to address the cancer surgical backlog.
- Mental health demand and acuity is high as a direct consequence of the pandemic with national predictions for mental health needs to remain at elevated levels for some time to come.
- 2/3s of GP practices are reporting increased levels of demand, with a further 1/5 reporting significant or very significant increased demand and 1% of practices at critical status. Over a quarter of pharmacies, 2/5th of dental practices and 2/5th of Optometrists are reporting challenges – sometimes significant challenges - to the delivery of their service.

NHS Resources

The Greater Manchester ICS has both an efficiency and a productivity challenge. The ICB inherited a structural budget deficit (commitments over revenue) of over £500 million (out of a total budget of £6.5 billion) on its establishment on 1st July 2022. This mainly reflects the ongoing cost of additional resources (mainly workforce) put in place during the COVID pandemic. One of the requirements on an ICS is bring the system into balance.

Demand for social care

- Significant increase in referrals to adult social care for mental health, domestic abuse, unpaid carers breakdown
- 600 people a day join a waiting list nationally
- 64% of councils are not confident in their ability to delivery statutory care related to market sustainability. 65% said that quality of care that could be delivered had decreased
- 7 in 10 reported local providers closures, contract hand backs, or ceased trading
- The ten Greater Manchester local authorities spent £481m on children's social care in the financial year April 2021 – March 2022. This was 3.4% more than the £465m spent in 2020/21, with net expenditure exceeding budget in 8/10 localities.
- The financial challenges in children's services are being driven largely by a combination of increased demand for and cost of LAC placements alongside unprecedented workforce challenges, particularly around recruitment & retention of social workers and other professionals with increased use and rising cost of agency staff, presenting significant financial challenges to the budgets of some children's services departments.

Pressures on the health and care workforce

- Recruitment and retention – but with particular pressures in nursing and midwifery, dental nursing, care workers and within the VCSE sector. We also know that we have an ageing workforce and a high turnover of people within adult social care.
- Health and wellbeing - the pandemic and subsequent recovery has been really challenging for our workforce, and many of our people are facing, or already experiencing, burnout. As a result, sickness absence levels remain extremely high, putting further strain on our workforce and our finances.
- Lack of diversity amongst our workforce must be addressed, to ensure decisions are being made and care is being provided that meets the needs of everyone.
- Lack of parity between the NHS and social care - the living wage, access to occupational sick pay and wellbeing needs to span the totality of the workforce including those providing services from the VCSE.

- Cost of living crisis – our staff, in common with our communities face increasing fuel and food costs. In areas of primary care and social care we know that turnover is impacted by people finding better pay in the retail sector.
- Financial challenges - the workforce crisis is contributing to this with high sickness absence rates, agency and locum spend and reduced workforce productivity. Resolution to the workforce crisis must focus on retention, as well as thinking about working in a different way, embracing digital advancements and reducing costly agency and locum spend.

What residents are telling us

Phase 2 of the Big Conversation took place in October 2022 and involved a range of methods for engaging people across the length and breadth of Greater Manchester. More than 2,000 individuals were involved, including men and women, older and younger people, carers, LGBTQ+, people with disabilities, members of different BAME communities, asylum seekers, refugees and other excluded groups including sex workers and the street homeless.

Across Greater Manchester, residents told us there is:

- widespread concern with funding and staffing levels for the NHS, as well as social care and the local VCFSE
- widespread concern the difficulties experienced in accessing GP appointments, as well as other access problems such as waiting times for hospital care
- a demand for more personalised and person-centre care, which takes account of the different needs of different individuals and communities, and recognises that one size does not fit all
- a demand for more and better partnership working with the VCFSE sector which is seen as ideally placed to help statutory services negotiate some of the above, and
- an expressed need for more action on prevention and the wider determinants of health, including help with the cost of living.

Throughout the engagement, the first two themes overshadowed all others.

Our latest Residents' Survey highlights relevant challenges relating to the cost of living crisis:

- As a result of the cost of living crisis, employed respondents in Greater Manchester are more likely than those across Great Britain to be working more hours than usual (33% vs. 18%); looking for a job that pays more money (23% vs. 18%) or working more than one job (13% vs. 3%)
- 40% of December respondents had a food security level classified as 'low' or 'very low' – and have experienced food insecurity in last twelve months.
- 36% of respondents noted that their household experienced some form of digital exclusion. Disabled People and older residents are more likely to be digitally excluded.

Young people in Greater Manchester, participating through #BeeWell (a programme that annually measures the wellbeing of young people across Greater Manchester) have indicated:

- In 2021, the average life satisfaction and mental wellbeing scores of young people across Greater Manchester were lower than those of young people in England (in studies using the same measures as in #BeeWell). This remains the case in 2022.
- 16% of young people responding to the Me and My Feelings measure reported a high level of emotional difficulties.

- The life satisfaction average score is 6.2 out of 10 for girls but 7.2 for boys. There are sizeable inequalities for young people who identify as LGBTQ+.
- Across Greater Manchester, 1 in 3 young people (34%) are reaching the recommended levels of physical activity set by the Government's Chief Medical Officer of at least one hour per day. This falls to 27% of girls, 27% of Asian pupils, and 18% of Chinese pupils.
- Pupils from a range of ethnic groups (for example, over a third of Black and Chinese pupils) report experiencing discrimination because of race, skin colour, or where they were born (occasionally, some of the time, often or always).
- Over a third of young people who identify as gay or lesbian report at least occasionally experiencing discrimination because of their gender, and this rises to around 40% for young people who identify as bi or pansexual, or transgender.

5. Responding to the Challenges

There are 3 key elements confirmed through this strategy which will hold the actions we will take to respond to these challenges and ensure we hold ourselves to account as we deliver:

i. *Embedding the Greater Manchester model for health* – This includes how we work with communities to prevent poor health and ensure support is available before crises occur to reduce demands on formal NHS and social care services. It includes how we work together to provide consistent and high quality care where Greater Manchester residents can be assured that the standards are equally good wherever they access care. Finally, how we connect our academic, industry and technology assets to ensure that we remain at the forefront of innovation and discovery.

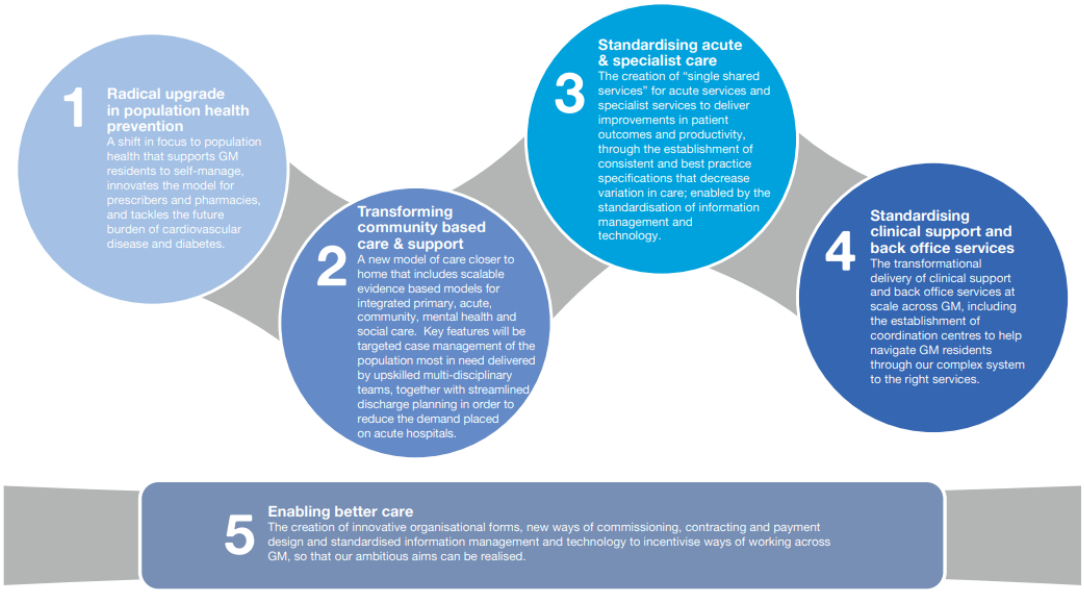
i. *Prioritising our missions to address the systemic challenges of today and the coming 5 years* – This strategy will not describe everything we will do together across the next five years. It will however confirm those shared missions which will connect the whole system to our most significant and deep rooted challenges. Each of those priority missions will respond directly to the influences informing this strategy – what the residents of Greater Manchester have told us, the pressures facing public services and our workforce, the evidence and research into what drives our health needs and the evidence of what works to respond to them.

ii. *Monitoring our progress* – ensuring that we are clear about the rate of progress we intend to make, that we can be held to account by the residents of Greater Manchester, and that we can hold each other to account for delivery.

6. Embedding the Greater Manchester model for health

In 2016 we confirmed the key elements to transforming our health and care model. That new approach, responding to NHS England's Five Year Forward View committed us to:

- A radical upgrade in population health and prevention
- Transforming community based care and support
- Standardising acute and specialist care
- Standardising clinical support services
- And enabling better care.



This was ambitious, comprehensive and relevant to the long term transformation of health and care. There are significant areas of progress as well as important areas of further development, but we can now describe what our radical model for health looks like.

We have been developing a comprehensive model for health and integrated care for the last seven years. It is based on core principles of co-production and working with people and communities and not 'doing to'. We have exceptional examples of integrated neighbourhood working, mature provider collaboration and public service reform and evidence of impact. We also have enhanced potential to realise a 'social model' for population health and prevention given the depth of relationships between the NHS, Local Government, wider public service partners and the VCSE. This is a model which offers more than medicine and positively addresses the full range of determinants of our health.

We have, through Health Innovation Manchester, a unique vehicle to drive our research, innovation and discovery efforts and support deployment at scale.

Our challenge, is that this is not universally realised across Greater Manchester. Our aim through the strategy therefore is to confirm the actions and approaches necessary to reach the tipping point to ensure maximise the effectiveness of how we work together to improve our outcomes.

The following section confirms the core characteristics of the model and the focus of its further development.

Creating the conditions for a good life in good health

We have pursued a 'health in all policies' approach to maximise our influences on the social determinants of health.

Good Homes - tackling and preventing homelessness and developing homeless healthcare as part of an inclusion health approach; connecting with the GMCA, local government and Greater Manchester's housing providers to improve the availability, and quality of housing, including supported housing.

Healthy places - developing neighbourhoods with cleaner air, access to green spaces where communities can come together, connect and support each other, to improve and enjoy their local environment benefitting their physical and emotional health; where active travel through walking and cycling is made easy and supported by our collective work through GM Moving. Ensuring that places are age-friendly and that older residents can contribute to and benefit from sustained prosperity and a good quality of life to ensure they can age well.

Case Study – GM Moving

Strong and connected communities – we saw, as part of the response to the pandemic, that improved levels of volunteering assisted wellbeing and health of both those volunteering and those receiving support. The appetite for rapid innovation saw services were being blended to accommodate the VCSE sector due to their direct reach into communities, services run from local community buildings, and befriending services bridged the gap for people unable to do for themselves. The willingness to care and volunteer offers real potential to secure a lasting legacy.

Diet and Food Security – improving diets and tackling food insecurity to improve physical and mental health, educational and economic outcomes. In children, food security positively affects happiness and life satisfaction, social skills, and quality of life scores.

Inclusive economy - a people centred approach to economic development where everyone can participate in local economic life; where local resources and wealth are redirected into the local economy and where local people have more control. Where we maximise the contribution of public

services through our social value framework and our contribution as local economic anchors in relation to employment, procurement, building and land use, and our environmental impact.

Skills, education and good work - supporting early years development to support more children to be school ready; ensuring successful educational experiences in schools and colleges which support positive mental health; and securing more control of the post-19 skills system to lead to better employment opportunities across the city region. Focussing also on good work through the spread of the Greater Manchester Good Employer Charter improving pay and supporting well-being in work.

Establishing an upstream model for health creation and disease prevention

Screening and immunisation - identifying those at greatest risk and supporting early detection and therefore earlier treatment and support. Reducing health inequalities and addressing differences in uptake among different groups.

Reducing harms from tobacco, alcohol and drugs - reducing smoking prevalence as part of our Make Smoking History Programme; reducing alcohol and tobacco harms especially during pregnancy; and changing lives with those experiencing multiple disadvantage and struggling with the complexities of drug, alcohol, mental health and associated problems. This has been at the heart of our Public Service Reform journey for over a decade now and ensures we work across sectors to tackle the root causes of demand and improve population health on a more sustainable basis.

Case Study – Make Smoking History

Health & justice – addressing the health, social care and criminal justice factors that can lead to life-long poor physical and emotional health, and reduced life-expectancy, for people who are seen in the criminal justice system, as offenders or victims. Working with Greater Manchester Police, National Probation Service, education professionals, youth justice and local authorities to address the underlying causes of violent crime and work together with communities to prevent it. It forms part of Greater Manchester's approach to tackling serious violent crime, ensuring victims of violent crime get the right support, and improving the criminal justice response to all forms of serious violence.

Proactive health & care and support in our neighbourhood model

Providing proactive primary care and support and reducing demand on acute services through a comprehensive neighbourhood model spanning public services, local business and community led groups. Our refreshed blueprint for primary care will underpin this ambition.

Integrated neighbourhood teams - typically organised for 30-50,000 residents and coterminous with primary care networks. Connecting the full span of primary care including GPs, dentists, pharmacists and optometrists with community, social and local acute care, local VCSE and wider public services (such as housing providers, schools, employment support and the local police and fire and rescue service).

The neighbourhood model is the key to making a social model for health a reality through comprehensive person and community centred approaches ensuring that people are supported to live well and continue doing the things they love, with the support they need, whether they're diagnosed with cancer or dementia, or at the end of live and receiving palliative care.

Locality case study – impact on reducing demand

We will not miss the opportunity to maximise the enormous potential of community pharmacy with those integrated teams to demand across the care system and reduce pressure on GPs and local hospitals.

Utilising population health management tools to anticipate care needs and provide support and preventative care before crises occur. Integrating local urgent care to provide an urgent community response and reduce the need for people to need ambulance or hospital support. Our digital transformation objectives are key to connecting and improving this aspect of the model through improved data availability particularly for community services, ensuring comprehensive risk stratification to support enhanced case finding, and the expansion of remote monitoring and virtual wards. We are ensuring the ongoing enhancement of the GM Care Record and its use for direct care, secondary uses, and research. For the integrated care workforce we are promoting the development of neighbourhood based integrated health and social care roles, including the expansion of the blended roles programme.

Living well at home – social care in Greater Manchester is fundamentally about better lives, not services. It is rooted in the power of co-production with people, carers and families to deliver better outcomes for all. It is much more than how we met the challenge of supporting flow in our hospitals, although that remains a critical challenge, it includes all the changes needed to ensure people have greater independence and enhanced wellbeing within stronger, more resilient communities. Our adult social care ambitions supporting people to live well at home, as independently as possible, making sure that the care and support people experience responds strengths and what matters most to them; valuing and respecting carers through recognition and support; supporting people with complex needs with enhanced care at home to prevent people going into hospital and to return home as quickly as possible; and working with social care providers to improve quality and ensure a resilient and diverse market for care.

Locality Case study – Manchester Better Outcomes Better Lives

Supporting children and young people - providing early help to families with a focus on improving educational attainment, speech and language and healthy weight; ensuring good emotional well-being with earlier targeted intervention and expansion of community based mental health services; co-produced support for children and young people with special educational needs; support through transitions as part of a 0-25 model; and boosting outcomes for young people leaving the care system through support in education, employment and training, health support, and achieving financial stability.

Ageing Well - responding to the opportunities and challenges of an ageing population in our city-region, focusing on reducing inequalities and ageing well. This requires change in approach to health & social care to ensure more proactive care. Preventing poor outcomes through healthy and active ageing. Quality improvement in existing acute & community services ensuring people get the right care when they need it.

Providing exceptional specialist care led through our local providers

Urgent and emergency care - using a clinically guided Greater Manchester approach to develop the pathways between local urgent care services such as GP out of Hours, 111 and A&E and more specialist emergency care such as for Major Trauma, Hyper-Acute Stroke, and heart failure. Empowering the Greater Manchester Provider Collaboratives to organise and deliver a consistent approach to triage, treatment and transfer across urgent and emergency care sites.

Planned care - using the provider collaboratives to direct planned care recovery and address the backlog through a single shared patient list, targeting health inequalities, offering virtual outpatients and managing staff well-being. Managing the flow of new patients needing diagnosis and treatment enabling access to specialist opinion and developing models for community diagnostic hubs. Reducing

unwarranted clinical variation through approaches including Getting It Right First Time and maximising bed and workforce capacity.

End of Life and Palliative Care - The Greater Manchester Commitments to Palliative and End of Life care provide the foundation for working collaboratively to ensure people can live well in the last year of their life, before dying as comfortably as possible, in the place of their choice. Equitable access to high quality, holistic, personalised palliative and end of life care, at home and through our hospices and other providers, not only ensures a more positive experience of death and dying for Greater Manchester individuals and their families, it also protects other health care services, under unprecedented strain even before the impact of COVID.

Cancer care - comprehensive preventative approaches to reduce people's risk of developing cancer. Orientating the whole system towards early detection, diagnosis and treatment to improve survival outcomes and experiences. Considering the full range of people's needs to enable them to live well with and beyond cancer. Bringing together world class researchers and clinicians with our research bodies to constantly improve the lives of people affected by cancer.

Mental Health - multi-disciplinary team working that connects to neighbourhood and community based care and is strengths based, increases access to evidence based clinical interventions, psychological therapies and social support. Using "Thrive" principles to meet dynamically changing needs of children, young people, adults and older people with common mental health problems, severe mental illness, and those with very complex needs who may not currently meet the thresholds for secondary care services. People receiving support can move between different types of help as their needs change.

Sustainable services – responding to the need for a proactive approach to acute service sustainability, to identify services that could fail without intervention and take earlier action. The initial priorities are in dermatology and ophthalmology.

Ensuring that we stay at the forefront of health innovation and discovery.

Health Innovation – reducing the time from discovery to spread by connecting the healthcare system with academia and industry to respond to health and care challenges and stay at the forefront of the national and global agenda in discovery science, innovation into practice and population health. We are developing our approaches to unlock the full potential of our digital and data assets to support redesign and transform care to benefit Greater Manchester residents.

Finally, we aim to significantly grow our activity in community based research. Through the Health Innovation Manchester model, in Greater Manchester we are well configured to use our available resource for research and innovation most effectively towards local problems, develop and deploy proven innovation at scale through leveraging industry resource and investment. This model enables us to maximise the leverage of national and Greater Manchester system funding through grants raised and industry resource and link directly to increasing our contribution to economic development in Greater Manchester.

Case Study – from HInM

7. Meeting today's challenges – Our 6 Priority Missions

Section 4 sets out the challenges this strategy now seeks to respond to.

Everyday life for many is precarious and repeated shocks affecting people's sense of security and wellbeing are now widespread. This is evident in the **effects of the cost of living crisis** and what that

means for food and fuel security, digital exclusion, housing and employment security. These represent profound risks for the health and wellbeing of our population.

Poor health remains the single most important factor driving long term **exclusion from employment** and participation in the economy. That exclusion affects a quarter of our working age population.

Participants in our Big Conversation emphasised their concern about the problems **accessing core health and care services**. Reducing long waits as core services are restored is essential to maintain the confidence of those residents requiring our care.

The **failure to prevent illness and its late detection** means that our health and care system remains locked in a cycle of responding to crisis. Greater Manchester's population, experiences higher mortality than it should, and people spend a greater proportion of their lives in poor health. Especially those with disabilities, those from racially minoritised communities those facing multiple disadvantage. An upstream model of care and earlier intervention remains a consistent ambition across each of our locality plans.

The health and care workforce is at breaking point and faces an unprecedented crisis. Addressing our **workforce challenges** is the biggest barrier to improving the way we provide health and care for our communities. The Greater Manchester public expressed its own concerns for the pressure on our health and care workforce. We must also recognise the additional pressure and challenge faced by unpaid carers supporting their loved ones every day. The more that stresses emerge in public services, the greater the consequent demands move to families and carers.

The **pressure on public finances** over an extended period is evident in our inability to ensure resources match the demand on health and care services and ensure long term financial sustainability. The financial challenge facing the system is greater than at any point in the last 20 years.

It is this agenda which has confirmed for us six pre-eminent missions requiring action in each neighbourhood, in all ten localities and across the whole of Greater Manchester:

i. Strengthening our communities
ii. Helping people get into, and stay in, good work
iii. The recovery of core NHS and care services
iv. Helping people stay well and detecting illness earlier
v. Supporting our workforce and our carers
vi. Achieving financial sustainability

Strengthening our communities

This strategy must meet the moment, and recognise the stresses on daily life for many of our residents have been significantly increased through the cost of living crisis. This will translate into a crisis in health. Helping people, families and communities feel more confident in managing their own health is possible only if we strengthen front line support immediately through the cost of living crisis, build resilience across the system to deal with the impacts of climate change and ensure accessibility of universal services for all and directly tackling digital exclusion.

Critically, this about helping communities support each other. We are working closely with leaders from Greater Manchester's VCSE sector and have put in place an Accord agreement which contains eight commitments which are shared across the sector, the Integrated Care Partnership, as well as the

GMCA and its constituent local authority members. Our shared aim is to further develop how we work together to improve outcomes for Greater Manchester's residents and strengthen our communities.

Our focussed actions here include:

- Leverage our social prescribing infrastructure in Primary Care Networks to connect residents to social and financial support locally
- Coordinate our response to food, fuel, and transport poverty.
- Address historic under-investment in Mental Health and expand our community based provision through the Living Well model
- Embed the VCSE Accord to grow the role of the VCSE sector as an integral part of a resilient and inclusive economy
- Progress our Net Zero climate change contribution to achieve a net zero NHS GM Integrated Care Carbon Footprint by 2038
- Deliver a Greater Manchester-wide consolidated programme to deliver better outcomes for those experiencing multiple disadvantage building on learning and effective approaches from the Supporting Families (Troubled Families) programme, Rough Sleeper Initiative, Housing First, Changing Futures and Working Well.
- Partner, through the Digital Inclusion Action Network, to equip all under-25s, over-75s and disabled people with the skills, connectivity and technology to get online.

Helping people get into, and stay in, good work

The fourth purpose of Integrated Care Systems is to support wider social and economic benefits from NHS investment. This is important everywhere, but for place like Greater Manchester it has the potential to be nationally significant in raising overall productivity and supporting a necessary rebalancing of the economy.

Current Government economic policy is centred on creating the conditions for accelerated economic growth. The public sector in the North makes a greater contribution to GDP, employment and economic activity than elsewhere in the country. We believe that approaching this mission with focus and energy is essential to help address the widening inequalities that we see across our communities. We also believe that supporting people to have full lives and be healthy and well is the best way to reduce service demand pressures over the medium and long term.

Whilst all ICSs are developing their roles in relation to the anchor role of the NHS (such as procurement and local employment), there is the bigger question of what needs to be done to drive prosperity across Greater Manchester and the role of the Integrated Care Partnership in achieving this. In considering this we need to face the central questions of why children fall behind, why long term worklessness persists, and how Greater Manchester's health and skills inequalities need to be addressed we are to turn around longstanding and structural inequality.

Case study – a new approach to recruitment (Salford & Oldham)

The opportunity is to place ourselves at the heart of a more comprehensive Health and Wealth framework covering:

- Inclusive Economies
- Education, work and skills (early years, pathways into careers in care, health interventions addressing barriers to employment)
- Social value in capital developments
- Research and Development, Innovation, industry relations and life sciences contribution

- Advocacy and leadership on raising housing quality/regulation of the private rented sector,
- Influencing transport infrastructure developments to support active travel and clean air
- Procurement and supply chains that benefit local economies

Our focussed actions here include:

- Expansion across each of our Work and Health Models including Working Well Early Help to prevent people falling out of work, and the Specialist Employment Service supporting people with Learning Disability, Autism and Severe Mental Illness to place and then train people in work.
- Working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter to ensure new and existing jobs right across Greater Manchester are underpinned by a commitment to equality, fair pay, and giving employees a say in how their workplaces are run.
- Scaled application of Greater Manchester Social Value Framework and Community Wealth Building approaches through a Greater Manchester Anchor Network

The recovery of core NHS and care services

Improving access to high quality, core services and reducing long waits is the pre-eminent expectation of Greater Manchester residents participating in the Big Conversation and will be delivered through our Strategic Approach to Recovery.

It will span the full range of core services where reliable and timely access has been set back.

Our focussed actions here include:

- Improving ambulance response and A&E waiting times
- Reducing elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- Make it easier for people to access primary care services, particularly general practice
- Continue to value parity between mental and physical health and ensure universal coverage of core services
- Pursue best practice pathways to improve quality and reduce unwarranted variation
- Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- Make it easier for people to access primary care services, particularly general practice.

There are key activities underway already to ensure these improvements occur, however, we are also signalling where further action needs to be confirmed as part of this strategy. Recognising that NHS Greater Manchester Integrated Care must have regard to this strategy in developing its own plans with NHS partners, additional detail is proposed here in relation to those areas where it has most direct influence.

Primary Care – We will firstly recognise Primary Care's role as part of the wider Greater Manchester Urgent and Emergency Care System and aim to deliver responsive same day services. In organising primary care we should always seek to balance convenience and continuity of care in relation to who sees you in primary care and between online or face to face appointments according to patient's wishes and needs. NHS Greater Manchester should seek to secure additional capacity when periods of surge demand occur, linked to our pressures reporting model. Primary Care providers enable the spread access to online advice on symptoms and self-care, going to a community pharmacy, a general practice appointment, an urgent treatment centre, or the 111 out-of-hours clinical assessment service. NHS Greater Manchester Integrated Care and Primary Care providers will also engage on

options to address the current issues surrounding access to NHS Dentistry to inform a dental access plan.

Urgent and Emergency Care – Our collective improvement activities will support people to be seen more quickly in emergency departments through better ambulance handover and front door streaming. Improved flow across the system will be supported through embedding Discharge to Assess; and to reduced need for hospital attendance and admission through a 2 hour Urgent Community Response in all ten parts of Greater Manchester, improved NHS 111 call handling, and Enhanced Health in Care Homes.

Planned Care –we will widen the implementation of surgical hubs to protect capacity for elective activity. We will improve productivity and efficiency by standardising patient pathways and embedding Getting it Right First Time, increase system theatre utilisation, reducing length of stay for elective patients and overall day case rate. We will expand the availability of Virtual Wards to increase capacity available for elective activity. Improved support for patients waiting for treatment will be provided through better care navigation, consistent patient initiated follow up and more While You Wait and My Recovery resources. A focus on health inequalities must run through each of the pillars of the elective recovery plan.

For children and young people, we will reduce waiting times to within national standards through a Greater Manchester -wide approach to paediatric elective recovery with common clinical prioritisation, establishment of dedicated paediatric surgery hubs, sharing of best practice to maximise activity and implementing end-to-end pathway transformation.

Cancer Care – We will strengthen system compliance with best practice pathways initially in Breast, Skin, Head & Neck, Breast and Gynaecology and on to tumour sites where national guidance does not yet exist. We will improve diagnostics through enhanced mutual aid, increased first line diagnostic capacity and reporting dedicated to cancer. We will deliver the Single Queue diagnostics roll out, including PET and Interventional Radiology and increase sustainable diagnostic capacity through Community Diagnostic Centres. We will implement the Greater Manchester Lung model of care and accelerate roll out of targeted lung health checks.

Mental Health & Learning Disability – In the short term we will continue to support high levels of mental health needs and support the ongoing provision of crisis services to enable the increased number of people in crisis to be supported including increases in liaison and system working with GMP and NWAS and working in partnership to support people with a Serious Mental Illness to access housing and employment. To recover long waits, additional support to tackle waiting lists will be sought alongside reducing waits for physical health checks for people with a Severe Mental Illness or a Learning Disability.

We will provide a proactive approach to supporting Children and Young People now to reduce the impact of mental health problems, and specifically to improve the whole system pathway for eating disorders and improve Tier 4 interfaces with the whole system including admission, alternatives to admission and discharge.

Over the lifetime of this strategy we must aim to increase our longer-term baseline investment. This recognises both that demand now is substantially above pre-Covid-19 levels and that Greater Manchester has historically under-invested in mental health compared to other areas. Services across the NHS, primary care and VCSE partners, working with Local Authorities, must be adequately resourced going forward in order to support this fundamental shift in the mental health needs of the Greater Manchester population. This will position difficult choice for Greater Manchester, but will be

consistent with seeking parity of esteem for mental health services with physical health services and acknowledge comparable historic under-investment.

Helping people stay well and detecting illness earlier

Many conditions which can contribute to shorter healthy life expectancy are preventable. We have set out the features of a Greater Manchester population health system , focused on putting health at the heart of all are city region policies, integrating public services that work together to address the wider determinants of health alongside NHS Greater Manchester's ambitions re upstream models of health and care.

We need to collaborate with focus and purpose across the system to deliver comprehensive, scaled approaches to the main modifiable risk factors for our biggest killers i.e. Tobacco, Physical Activity, obesity/food and alcohol.

At the same time we must prioritise secondary prevention (across hospitals and, through the Greater Manchester {Primary Care Blueprint), to embed a coherent, scaled and evidenced based approach to reducing the burden of poor health and early death from cancer, cardiovascular, diabetes and respiratory diseases. This means moving away from siloed approaches by partnering with our residents and communities and utilising innovative data architecture and capability to develop interventions and models of care that better engage those from higher risk populations.

Finally, we must recognise that specific communities face greater barriers to prevention, early detection and early treatment. These include people with severe mental illness, people with disabilities, communities facing disadvantage or discrimination as a result of ageism, racially minoritized communities and communities in poverty. We will, therefore, embed a comprehensive approach to reducing health inequalities and through our Build Back Fairer Framework and the Core20plus5[6] priorities to deliver improved equity, equality and sustainability across health and care.

Our focussed actions here include:

- Scaled application of CORE20PLUS5 to drive early cancer diagnosis, hypertension case finding, reduce hospitalisation for COPD, increase health checks for people with severe mental illness or learning disability, and improve maternity outcomes
- Expansion of culturally appropriate services that better reach into disadvantaged communities
- Evidenced based Falls Prevention applied consistently across Greater Manchester.
- Monitor and target unwarranted variation to target populations based on inequalities and variation in care.
- Ensure further improvement to Primary Care access, and expansion of key tools for enhanced case finding and anticipatory care partnering with our residents.

Supporting our workforce and our carers

These are extremely challenging times for our health and care services as we face significant financial pressures and a workforce crisis. We have spiralling sickness absence rates, recruitment and retention challenges and a workforce that feels overstretched and often under-valued. As an integrated care partnership we need to take action to create the conditions to allow our people to provide the best possible care.

[6] Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

We have already set out a People and Culture strategy to promote integration, better partnership working and good employment practices. The strategy also seeks to address the causes of sickness to keep our workforce well and addressing the inequalities we know people face in the workplace.

Our intention is to ensure we have more people choosing health and care as a career of choice, and that they feel supported to develop and stay in the sector. A cultural shift is sought to create a more compassionate and inclusive leadership culture, bolstering a culture of collaboration and a culture where wellbeing matters.

Our actions will demonstrate, through action and reward, the value we place on those providing care across health and care, our statement of commitment to support, retain, develop and enable wellbeing in our workforce, as well as at home for unwaged carers.

This focussed actions here include:

- Increase in Good Employment Charter membership and payment of the Real Living Wage. Supporting organisations to achieve Charter membership will also improve employment standards across all areas covered by the Charter, including security, flexible working, employee engagement, recruitment, people management wellbeing provision and inclusion.
- Develop an Equality, Diversity and Inclusion Framework for inclusive leadership
- Develop our Greater Manchester careers approach to reach into our communities and engage with school leavers as well as those looking for a new career
- Develop the Social Care Careers Academy to support growth, retention and development of the social care workforce
- Develop and deliver the Greater Manchester retention plan: focusing on the experience of our health and care people and integrated roles
- Work closely with HEE to create more development opportunities and help enable people to have the protected time to participate
- Support primary care employers to utilise Additional Roles Reimbursement Scheme (ARRS) funding and strengthen the multi-disciplinary approach and take targeted action to recruit and retain key primary care roles including GPs, nurses, community pharmacists, NHS dentists and dental nurses working in primary care
- Targeted action on nursing, midwifery and AHPs – including student recruitment, placement capacity and promotion of working in Greater Manchester in partnership with HEE.
- Building on the Greater Manchester Carers Charter and the Greater Manchester Working Carers Toolkit to provide more consistent and reliable identification and support for Greater Manchester's unwaged carers.

Achieving financial sustainability

Action is urgently required to address the drivers of both cost and demand in the system. In the initial phases of this strategy a necessary focus on financial recovery will lead our activities. That programme will be specific and well-defined and require close monitoring and tracking of each of the system financial improvement interventions.

The critical first step is to address each of the principal reasons for the financial, efficiency and productivity challenges in the Greater Manchester integrated care system, in order that the Greater Manchester system leadership can collectively own the outputs and agree to the actions necessary to address the challenges.

This will include action to:

- Confirm and address the most significant demand drivers in across the Greater Manchester integrated care system
- Develop a comprehensive system wide programme spanning cost improvement, productivity, demand reduction and service transformation. Specifically, to:
  - Confirm the assessment of in-year cost improvement opportunities
  - Maximise patient flow and theatre productivity approaches
  - Incentivise Provider Collaboratives to optimise their collective sites and workforce and reduce structural costs
  - Balance incentives and funding to support the management of new demand in primary and social care and reduce demand elsewhere in the system
  - Scale social support and prevention to reduce demand for formal health and social care
- Identify factors from successful system-working to take forward the outputs, including the behaviours and incentives for system working.

8. Monitoring Our Progress

We are committed to reporting on how successful we are in achieving the ambitions set out in this Strategy and developed an accompanying Performance Framework to track progress against the commitments and missions set out.

The Performance Framework includes a set of shared outcome indicators – these are higher-level, contextual measures, on which we expect to see change in the medium to longer-term.

We are committed to generating intelligence that gives us a better understanding of inequality across the city-region, in terms of both spatial and demographic variation. We also want to understand how outcomes vary for our diverse communities, including variance by age, sex, ethnicity, disability, sexual orientation and trans status, and religious affiliation. In particular, we want the Framework to give us intelligence on the disproportionately poor outcomes experienced by some of our communities and have included indicators that can give us insight into performance 'gaps' with the wider population and how these gaps are changing over time.

We propose to develop and publish a Joint Forward Plan (JFP) by the end of June 2023 as a delivery plan for the ambitions in our Integrated Care Partnership Strategy.

Greater Manchester Joint Health Scrutiny Committee

Date: 8 March 2023

Subject: Addressing the Increased Presentation of Young People Experiencing Mental Health Issues

Report of: Sandeep Ranote, Medical Executive Lead - Mental Health, NHS GM Integrated Care and Xanthe Townend, Greater Manchester Programme Director for Mental Health

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Purpose of Report:

At the July 2022 meeting of the Joint Health Scrutiny Committee, the Greater Manchester (GM) Recovery Strategy was presented to give a broad view of the challenges associated with recovering our services and the main themes for action over the next three years. As a follow up to this, we were asked to come back to the committee to describe how GM is addressing the significant increase in people experiencing mental health issues, particularly in young people.

Recommendations:

The Joint Health Scrutiny Committee is requested to:

1. Note the report on how GM is addressing increases in prevalence of Mental Health (MH) conditions for young people.
2. Discuss the report and comment on the actions being taken, with a view to identifying any additional actions that might be necessary.
3. Discuss our ask of the GMCA.

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1. Introduction

The GM Recovery Strategy, presented at the July committee, highlighted how the pandemic has created significant additional demand for mental health services, particularly from younger people.

2. Prevalence and demand

The pandemic has had a profound impact on people's mental health, with an estimated 25% increase in the prevalence of anxiety and depression worldwide[1].

An increase in the prevalence of mental health conditions amongst younger people has been seen over the last 2 decades. Between 1999 and 2004 there was no observed increase in prevalence but from 2004 to 2017 there was steady growth, from 1 in 10 children having a mental health disorder in 2004 to 1 in 8 by 2017. Post-pandemic this has increased at a much faster rate from 16% of young people having a mental health disorder in 2020 to 18% in 2022. For 17–19-year-olds the increase is even more dramatic, from 10.1% in 2017 to 17.7% in 2020 and increasing again to 25.7% in 2022[2], making this now 1 in 4. In this age group, the rise has been particularly significant in females. There has also been a twofold increase seen in eating problems across young people, again particularly in females. The use of social media has risen, possibly the single most significant sociocultural change seen over this last 2 decades with a concomitant rise in cyber bullying reported. In young people with a mental health condition, 1 in 4 report cyber bullying[2].

Within GM, demand for Children and Young People's (CYP) mental health services has increased dramatically since the pandemic as illustrated in Annex 1 for a range of services. However, note that the increase in crisis line demand is likely due to increased publicity of this service following a campaign to raise awareness. Community eating disorders in particular has experiences a significant increase in demand (see Figure 3 in Annex 1).

BeeWell data at year 1 shows that the average overall life satisfaction and wellbeing scores for young people in GM is lower than the national averages with variation seen across GM. There were significant wellbeing inequalities from year one data seen in

[1] COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide (who.int)
[2] Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey - NDRS (digital.nhs.uk)

gender and gender identity with females and non-binary groups reporting greater problems with emotional well-being. Wellbeing inequalities were also found in ethnicity, young people eligible for free school meals, special educational needs and disability, and those having carer responsibilities, albeit it smaller.[3]

In addition, figures from the County Councils Network reveal that in 2015, 69,000 children in England were looked after by councils - but by March 2020, the figure was 80,080. It is well established that young people in care have a higher risk of mental health problems. Those in care are at a record high level, set to rise further. There is now an important opportunity for the new integrated care systems to address this as a whole.

3. CYP Mental Health Actions

The GM Recovery Strategy included five actions specific to CYP mental health, which are noted below along with updates on progress.

3.1.Funding Core Services

Action	Work with commissioners to review funding proposals for core Child & Adolescent MH Services (CAMHS) services for 2023/24.
Progress	Since July 2022, the Integrated Care Board (ICB) has been responsible for commissioning across GM rather than having 10 localities deciding on their own local commissioning priorities. Historic locality-based commissioning decisions have created gaps in core service provision for CAMHS in some areas. The ICB is committed to filling these gaps to end the postcode lottery of service provision for this cohort. Negotiations are currently underway as part of the 2023/24 operational planning process to ensure that core CAMHS services are levelled up across GM.

[3] https://gmbeewell.org/wp-content/uploads/2022/09/BeeWell-overview-briefing.pdf

3.2.Long-term Plan commitments

Action	Implement Long Term Plan for mental health agreed trajectories for 2022/23 including expanding crisis alternatives and exploring options for a single GM helpline, enhancing community-based support and support for children and young people.
Progress	**Rapid Response Teams (RTT)** are a community-based crisis response offer undertaking risk assessment and management, de-escalation, safety planning and brief intervention with up to 72 hours of intensive support. Their aim is to reduce A&E attendance and avoid unnecessary admissions to pediatrics and Tier 4. **GM Assessment & In-reach Centre** is a point of access for referrals into CAMHS inpatient services across GM. It provides an access assessment to determine whether an admission is indicated. Team is being expanded to offer 7 days working with on-call offer between 8pm and 8am. **Home Intensive Treatment** provides intensive support in the community for young people at risk of hospital admission or to support discharge from a CAMHS inpatient unit. **Thrive navigators** are co-located with CAMHS in each locality to provide psychosocial support pre and post discharge. Service is operational in most localities, with the remainder due to start in 23/24. Additionally, digital tools such as Kooth have been rolled out across GM to ensure young people (10-25 yrs) have access to immediate support for MH issues. A review of the CYP MH Crisis programme is underway to determine the priorities for development in 2023/24. This has captured the views of front-line clinicians, young people, and other stakeholders across the CYP urgent and emergency

	care system. Consultation on the proposals resulting from this are now underway.

3.3.Eating disorders

Action	To improve the whole system pathway for eating disorders including prevention, early intervention, alternatives to admission and the management of medical emergencies in eating disorders in line with the Medical Emergencies in Eating Disorders (MEED) guidance.
Progress	Demand for eating disorder services has increased dramatically since the pandemic (see Figure 3 in Annex 1). This increased demand combined with continuing workforce challenges mean waiting times are increasing (Tables 2&3 in Annex 2). Early intervention and speedy nutritional support remain a priority, but the psycho-social aspect of care is essential for this cohort of individuals. The availability of nasogastric feeding tubes within general adolescent units is mixed. Guidance is that all providers have the ability and capacity to offer this. As an example of good practice, Manchester Foundation Trust piloted a community nasogastric feeding clinic for young people which saw 5 people access support over an 8-week period with the option to have supported feeding or nasogastric tube feeding. This aligned to the intensive support offer within community eating disorder services and helped 2 people avoid pediatric admissions, thereby reducing pressure on acute settings. Service users experienced positive weight gain outcomes and this contributes to the prevention of further deteriorations in physical health. Community eating disorders leads set up a working group to discuss the implementation of MEED, launched in May 2022

	as per NICE guidance to reduce unwarranted variation and reduce risks associated with acute emergencies. Work is now underway to roll this out across GM.

3.4.Mental Health Support Teams

Action	To improve early intervention and prevention pathway for CAMHS in line with the NHS Long Term Plan ambition to mobilise Mental Health Support Teams (MHST) working in schools and colleges, building on the support already available, which will reach 30% of GM's 5-18 age population.
Progress	MHSTs are an early intervention and prevention service designed to support 5-18 age CYP. The three core functions of MHSTS are one to one and group psycho-social support for CYP with mild to moderate mental health needs delivered in or around education settings, working with the MH lead in the setting to deliver a Whole School Approach to MH and Wellbeing and lastly supporting the MH lead in the setting to navigate and link effectively with the wider system. The GM model of MHST is a blended model of NHS led teams with VCSE psycho-social capacity effectively broadening the therapeutic and community offers available to the teams. A phased approach has been taken to mobilising MHSTs across all 10 GM localities, with new localities coming on board each year and by the end of 2022/23 we will have 22 core locality teams and two provider footprint teams specialising in Emotionally Based School Avoidance, Colleges and ASD. Funding for a further 8 MHST is available in 2023/24 which will be allocated across the three provider footprints based on CYP population with the majority of the capacity focused on core delivery and the remaining capacity on locality needs and footprint level specialist college teams in

	recognition that the CYP cohort most impacted by COVID has been adolescents and that colleges support young people over an important developmental two year period of their lives that have significant transition points into and out of college, also colleges have undergone a shift in recent years that have seen smaller organization amalgamate into multi-site settings with in some cases 5-6000 students. Data flows for MHST activity are still being established (see Figure 6 in Annex 2) but early feedback from schools indicates a reduction in the number of anxiety-based referrals needing to be handled by out of school mental health services and analysis of the year 2 BeeWell data in relation to comparison of MHST supported schools with their statistical neighbors is underway.

3.5.System response for CYP with complex needs

Action	To improve the whole system integrated response to children and young people presenting with high risk, complex social care and mental health needs including the development of a shared accountability framework and alternatives to hospital admissions. To improve Tier 4 interfaces with the whole system including admission, alternatives to admission and discharge
Progress	Challenges caused by fragmented commissioning across Lead Provider Collaboratives (LPC) and ICB have been mitigated through shared roles and cross-GM whole pathway service development. Although LPCs have their own governance structures, they also report up through the MH system board for oversight. Crisis support services, as detailed in section 3.2, are in place to help reduce unnecessary admissions. Where admission is

	required, we are working to embed clear stepped care pathways and to increase the consistency between providers by defining shared outcomes and expectations, focusing initially on acute general adolescent. We are working collaboratively across GM to enhance, develop, and support the CAMHS inpatient workforce, noting the particular impact the pandemic has had on frontline staff A jointly owned framework and policy developed and agreed across health and social care which aims to: • Set out a framework to promote CYP safety when they present in crisis • Set out the process for system partnership work (when a CYP in crisis is admitted to an acute hospital bed without a physical or mental health need) to safely discharge the CYP to the appropriate placement • Set out the escalation process This is being rolled out across the system with webinars for each locality. A MH-funded parachute team model was developed to meet the needs of these CYP presenting to acute general hospitals better in the crisis period by providing a joint package of care by the system - which could include a placement or may be providing the right care to support them in the current placement or home environment. This model was piloted in Salford but further rollout across other localities has been paused pending a review to incorporate lessons learned from the pilot. The pilot has diverged from its original aims due to challenges in accessing social care pop-up beds but we continue to work with our social care partners to optimise these.

4. Support needed from GMCA

Since July 2022, the NHS has been part of an Integrated Care System (ICS) along with partner organisations such as GMCA and Local Authorities. The move to create ICSs was intended to break down the organisational barriers that previously existed to ensure the public receive a better standard of care.

Patient voice is a key part of our work. An exercise is underway with the BeeHeard group looking at community eating disorder services, crisis and Tier 4 which will culminate in a round table with service leads from CAMHS and MHSTs. The findings of the BeeHeard group will be presented at a youth-led combined CYP Community and Crisis Programme Board. Further co-production is taking place though our work with Youth Focus North West and lead providers to profile a programme of Young Inspector activity for 2023/24.

Within the 2023/24 funding for MHSTs we have stipulated 1 WTE post per locality to coordinate and manage the culture change and early intervention work in the Whole School Approach to MH and Wellbeing roll out and ongoing management. This work has the potential to reach 100% of schools and colleges and form a community of practice raising standards and sharing best practice across GM. This could result in an ask to education colleagues to support this work and GMCA's championing of this would be welcomed.

The action updates above highlight how collaboration and partnership working still needs to improve to deliver better care, with, for example, some NHS schemes being unable to fulfil their potential due to social care facilities not being available. Whilst these partnerships have undoubtably improved over time, social care is still our biggest challenge and risk and, as such, we need more joint policies and workforce solutions.

Our ask to the GMCA is to consider how it can encourage this collaboration, at both locality and GM level, to ensure we have a joined-up approach with Local Authorities.

5. Annex 1

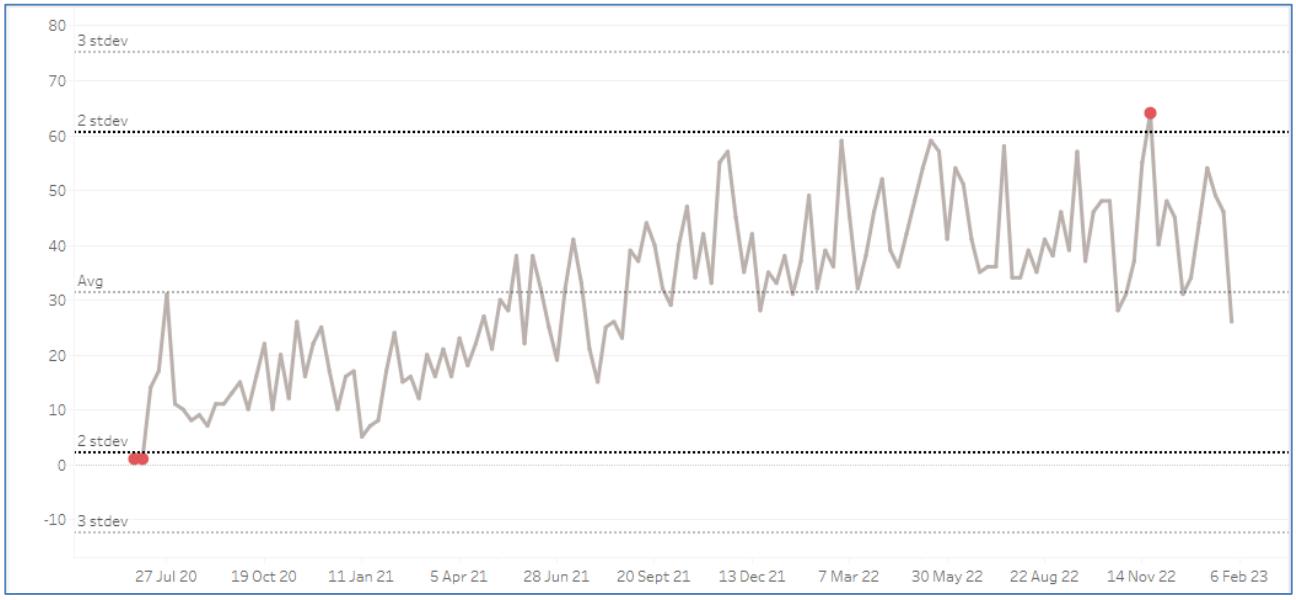

Figure 1Number of CYP calls to the GM Mental health crisis line

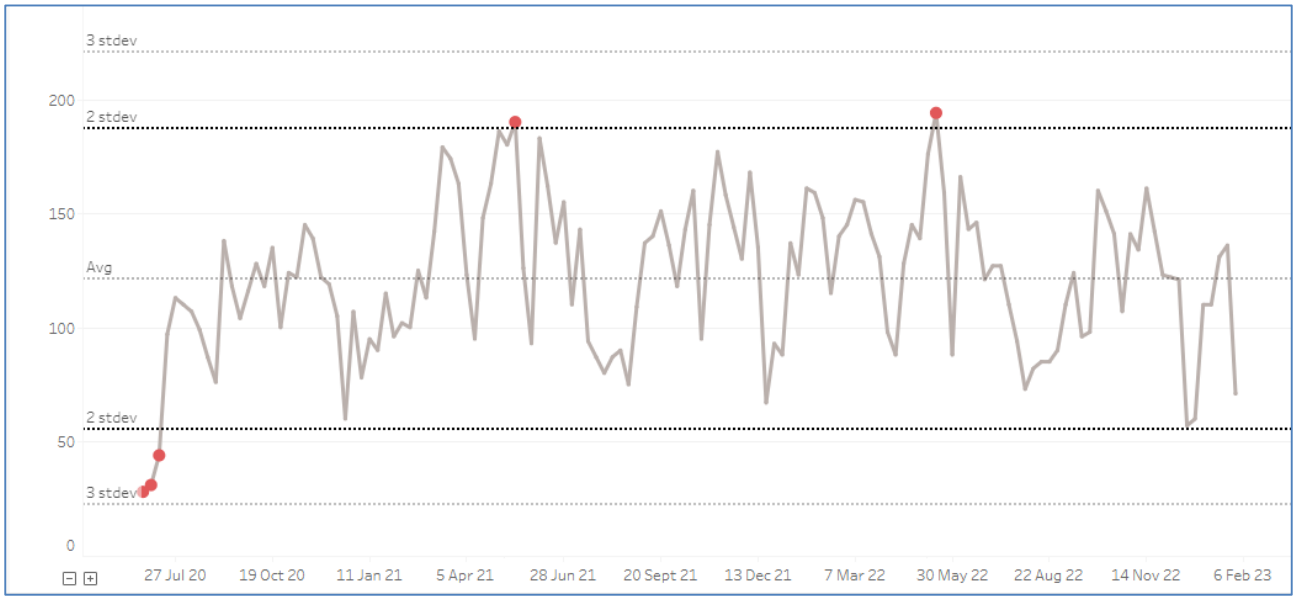

Figure 2 CYP Mental Health Liaison referrals in A&E

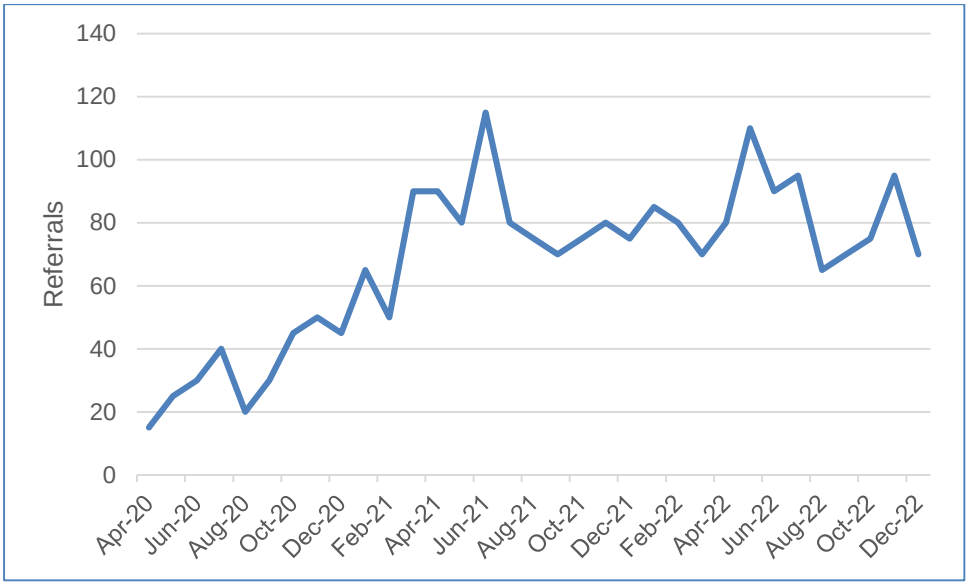

Figure 3 Community eating disorder referrals

6. Annex 2

The source for all data reported in this annex is NHS Digital's Mental Health Minimum Data Service dataset (MHSDS). Due to a cyber-attack, mental health data for July to September was not published and data for October and November (the latest available) is known to be affected, with counts likely not reflecting the true levels of activity.

The CYP access target for Greater Manchester is to reach 45,370 people by March 2023. Table 1 shows the data to June 2022 but the figure from November, although less reliable, has GM exceeding its target for the year already.

Table 1 CYP access as at June 2022

	Actual number of CYP receiving treatment in last 12 months (1+ contact)	Total number of CYP with a diagnosable MH condition	Percentage access rate last 12 months (1+ contact)
England	691,935	1,060,949	65.2%
North West	94,275	146,064	64.5%
Greater Manchester	43,265	59,099	73.2%
Bolton	4,150	6,484	64.0%
Bury	2,490	3,877	64.2%
Heywood, Middleton & Rochdale	4,865	5,086	95.7%
Manchester	10,900	12,364	88.2%
Oldham	3,070	3,965	77.4%
Salford	3,980	5,445	73.1%
Stockport	3,120	5,400	57.8%
Tameside	4,030	5,485	73.5%
Trafford	3,060	4,593	66.6%
Wigan	3,600	6,400	56.3%

The waiting time target for CYP eating disorders services is for 95% of people to be seen within 1 week for urgent cases and 4 weeks for routine cases. Tables 2 & 3 show that although GM is not quite meeting those targets, we are performing better than the national average.

Table 2 CYP eating disorders waiting times - Urgent

	Dec 2021	Mar 2022	Jun 2022	Nov 2022
England	59.0%	61.9%	68.1%	77.5%
North West	85.0%	90.9%	84.6%	86.8%
Greater Manchester	84.4%	85.9%	83.7%	81.7%

Table 3 CYP eating disorders waiting times - Routine

	Dec 2021	Mar 2022	Jun 2022	Nov 2022
England	66.4%	64.1%	68.9%	80.7%
North West	76.6%	76.3%	70.6%	87.7%
Greater Manchester	92.4%	93.9%	93.6%	93.8%

Figure 4 shows the GM dashboard for CYP outcomes, which reports the proportion of cases that showed a measurable improvement in symptoms and functioning in the period between at least two care contacts. For the latest reporting period, October 2022, nearly 35% of closed cases across GM reported an improvement.

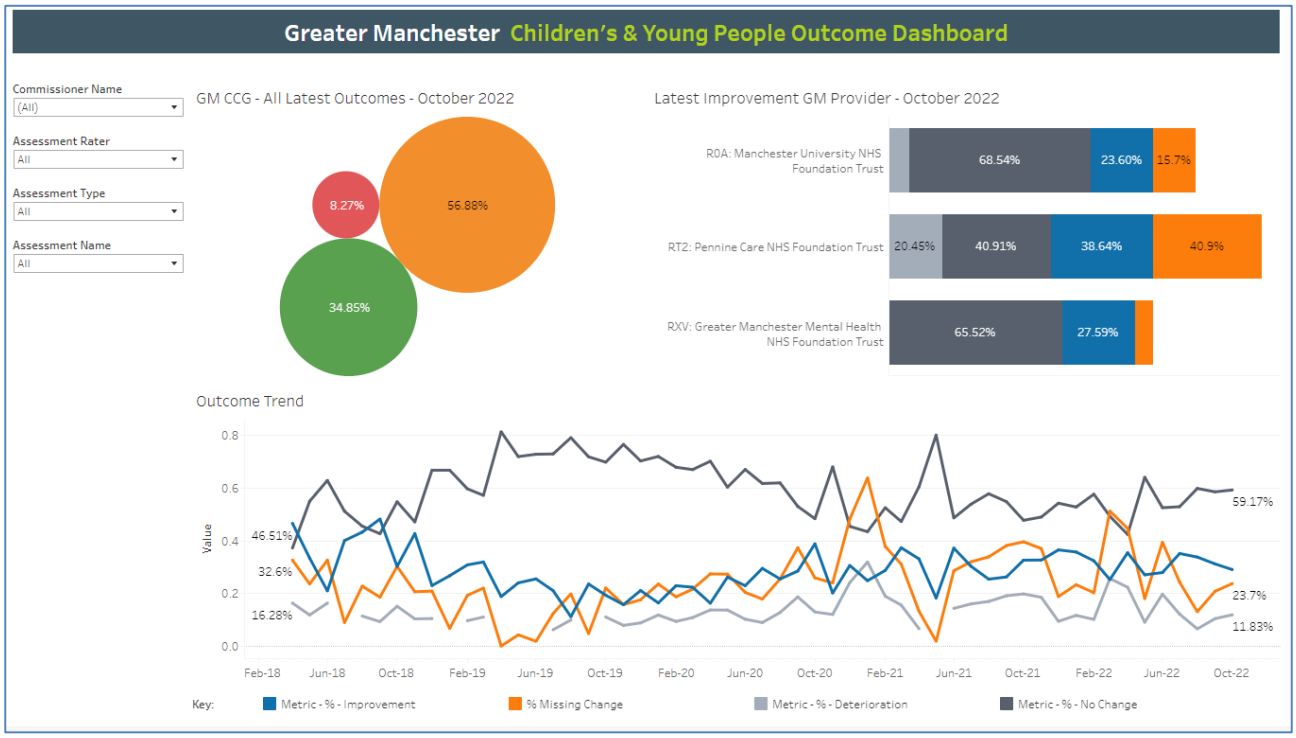

Figure 4 CYP outcomes by provider

Figure 5 shows the proportion of closed cases that reported an improvement split by age, waiting times, service type and number of contacts.

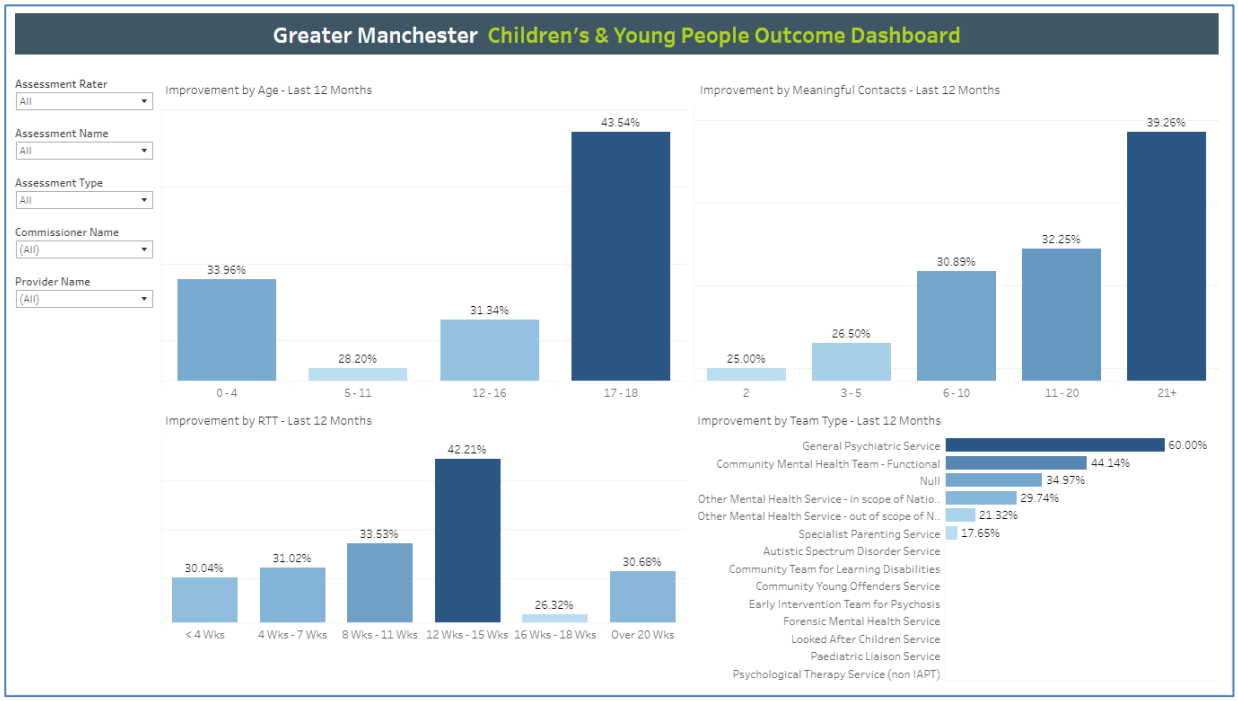

Figure 5 CYP outcomes by dimension

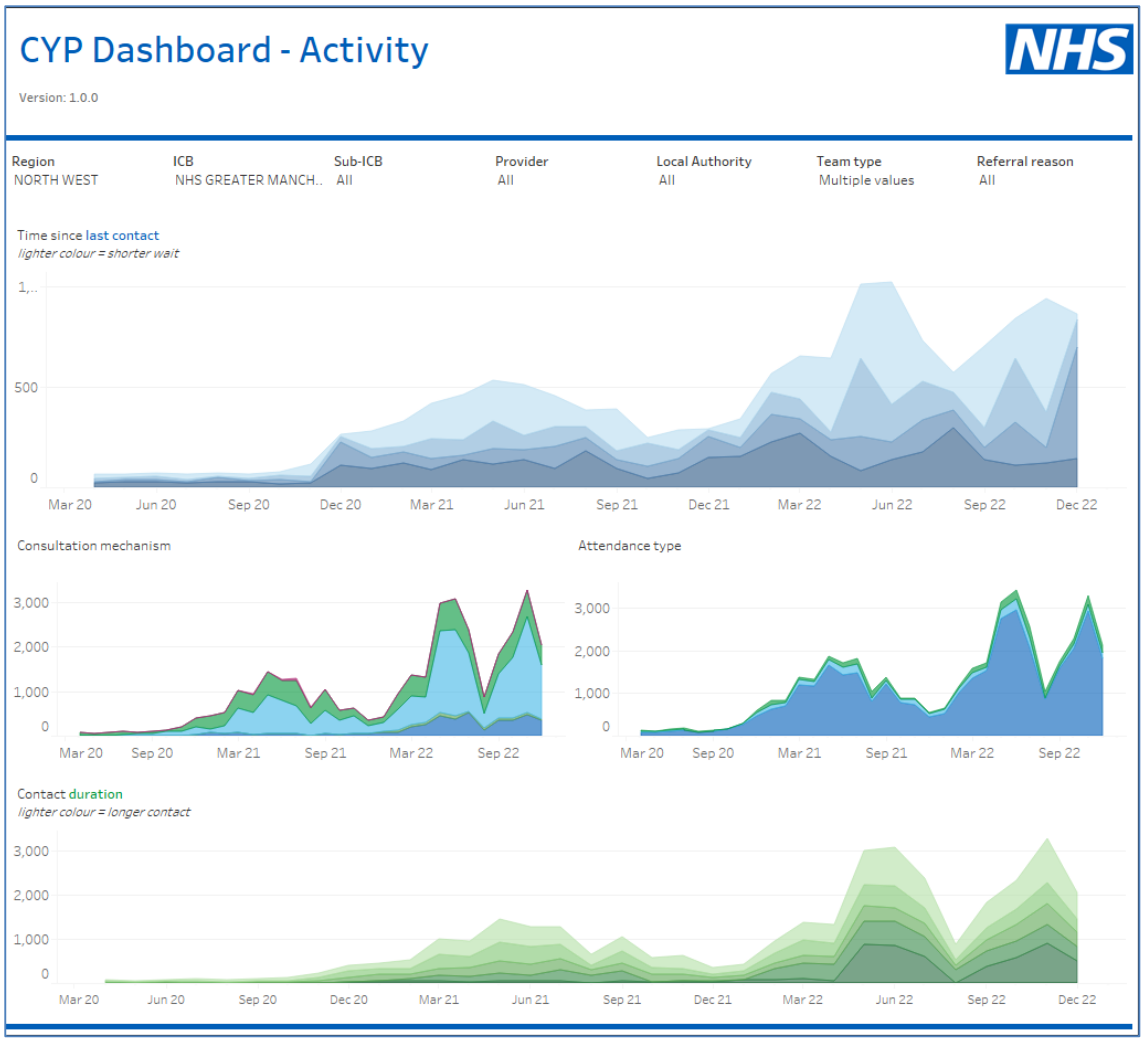

Figure 6 MHST activity

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NHS
Greater Manchester
Integrated Care

Addressing increased demand for MH services from children & young people

Part of Greater Manchester
Integrated Care Partnership

Key Findings

NHS
Greater Manchester
Integrated Care

In 2022, 18.0% of children aged 7 to 16 years and 22.0% of young people aged 17 to 24 years had a probable mental disorder.

In children aged 7 to 16 years, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020. Rates of probable mental disorder then remained stable between 2020, 2021 and 2022.

1 in 8 (12.6%) 11 to 16 year old social media users reported that they had been bullied online. This was more than 1 in 4 (29.4%) among those with a probable mental disorder.

In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020. Rates were stable between 2020 and 2021, but then increased from 1 in 6 (17.4%) in 2021 to 1 in 4 (25.7%) in 2022.

Videos

Greater Manchester universities mental health service - Mental Health (gmintegratedcare.org.uk)

Greater Manchester Mentally Healthy Schools and Colleges programme - YouTube

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Greater Manchester Joint Health Scrutiny Committee

Date: 8 March 2023

Subject: Greater Manchester People and Culture Strategy

Report of: Janet Wilkinson, Chief People Officer, NHS Greater Manchester

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Purpose of Report:

To provide Members with a draft of the Greater Manchester People and Culture Strategy ahead of its launch next week.

Recommendation:

That Members consider and provide comments on the draft Greater Manchester People and Culture Strategy ahead of its launch next week.

Contact Officers:

Janet Wilkinson, Chief People Officer, NHS Greater Manchester

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Anna Cooper-Shepherd | Communications & Engagement Lead (Workforce), NHS Greater Manchester Integrated Care

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Greater Manchester People and Culture Strategy 2022-2025

Setting out a shared ambition for the health and care workforce

Greater Manchester Integrated Care Partnership

Contents

Foreword

Our workforce in Greater Manchester is made up of over one million people who work in in hospitals, GP practices, pharmacies, care homes, town halls and other people's homes, as well as community centres, and in many other locations and environments. These people are the beating heart of our health and care services. Everyday people go over and above to deliver world class care. We could not deliver our health and care services without those who work so tirelessly in service of our communities. They are caring, and compassionate, and bold and innovative too. Our people are diverse in every sense of the word –and we want to make sure we value the unique contribution of all of our workforce. This is a strategy for every member of our health and care workforce –and it is our vision that we approach everything as **one workforce**.

As a system we recognise the important role of improving employment standards across health and care and the connection this has on improving the health and wellbeing of the local population. The majority of our workforce is our local population too. As the biggest collective employer in Greater Manchester, getting it right for our people (improving employment standards, including pay and conditions), will have a significant impact on the wellbeing of the Greater Manchester population. Therefore, this strategy has supporting our commitment to building back fairer, through good employment, health and wellbeing and addressing inequalities, at its core.

There is no denying that these are extremely challenging times for our health and care services as we face significant financial pressures and a workforce crisis. We have spiralling sickness absence rates, recruitment and retention challenges and a workforce that feels overstretched and often under valued. As an integrated care system (ICS) we need to take action now –to create the conditions to allow our people to provide the best possible care, within the financial envelope. It is important that the action taken is effective, coordinated and sustainable –so that the changes we make can support our workforce and our services in the years to come. That is the focus of this People and Culture Strategy.

We understand the scale of the challenges we are facing, but we value the power of our people and as a system we aren't afraid of being ambitious. Our five priority areas take a holistic approach to improving the way we work. They promote integration, better partnership working and good employment practices. They look at tackling the causes of sickness to keep our workforce well and addressing the inequalities we know people face in the workplace. They also look to ensure we have more people choosing health and care as a career of choice, and that they feel supported to develop and stay in the sector. Weaved throughout these priority areas is cultural change. A cultural shift is vital to delivering this strategy and our broader ambitions as an ICS. We are committed to creating a more compassionate and inclusive leadership culture, bolstering a culture of collaboration and a broader culture of inclusivity where wellbeing matters.

Foreword (continued)

This strategy is a platform for working together to deliver change at a system, sector, locality and organisational level, as well as in partnership with our workforce and trade union colleagues. It creates the shared ambition, aims, priorities and values by which we can all work together to deliver for our health and care workforce, and ultimately improve the care and services we provide. It will remain a live document, which is regularly reviewed to ensure our priorities continue to be the right ones.

We look forward to working together with you to deliver this strategy.

Karen James, Chair of the Greater Manchester Health and Care People Board, Chief Executive for Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust and Chair of Provider Federation Board

Janet Wilkinson, Chief People Officer, NHS Greater Manchester Integrated Care

Shazad Sarwar, Chair of People Sub-committee and NHS Greater Manchester Integrated Care Board Non-Executive Member

Our strategy on a page

Greater Manchester Integrated Care Partnership

Ambition

One sustainable health and care workforce for Greater Manchester, supported to deliver the best possible care

Shared values

Collaboration Sharing Supportive Trust Inclusive

Priorities

Aims

Workforce integration

To ensure our people in social care feel recognised and valued for their important contribution to our system as part of our commitment to greater integration. To develop an effective system culture that promotes collaboration and empowers our people to work across organisational and geographical boundaries and move more easily between services.

Good employment

To improve employment practices within health and care to help drive economic and social recovery and growth in our communities. To enable more people to work flexibly to support a good work/life balance.

Workforce wellbeing

To support better wellbeing cultures and provide everyone with access to good wellbeing support regardless of their employer to reduce sickness levels and improve overall wellbeing.

Addressing inequalities

To improve the experience of all of our diverse people so they feel represented, heard and treated with respect. To develop effective, compassionate and inclusive leaders that are representative of our communities and support our people to be their best.

Growing and developing our workforce

To attract the best people to work in health and care from within our communities and further afield to grow a sustainable workforce. To develop career pathways across health and care by providing access to the best education and training, supporting progression and promotion from entry level to board level. To improve how we plan for the future together in a truly integrated way.

Delivery

Co-delivery at Greater Manchester, sector, locality and system level

Introduction

Our journey so far

This strategy builds on the progress of previous workforce strategies to set out our renewed vision for our health and care workforce in Greater Manchester.

Our first Greater Manchester-wide workforce strategy was developed in 2017 to support ‘Taking Charge’. The strategy was delivered by our Greater Manchester Workforce Collaborative, with dedicated resource from Greater Manchester Health and Social Care Partnership. Key initiatives and successes include:

- Establishment of the Greater Manchester nursing, midwifery and Allied Health Professions programme team with targeted actions to improve the workforce pipeline, placement opportunities and retention
- Introduction of a continuous service commitment to support movement between council and NHS organisations
- Good progress made to establish baseline data for workforce race equality across health and social care, along with targeted actions to begin to address inequalities
- Step into Care, a a pre-employment programme that supports people into employment in social care.
- Delivery of the Greater Manchester Health and Care Champion Awards to recognise collaboration and good practice across the system

The Workforce Strategy was reviewed in 2020 and much of the work was paused to support our Covid response and recovery. The majority of the work restarted in 2021 and initiatives developed during the pandemic were scaled up and shared – such as the Greater Manchester Wellbeing Toolkit and the Workforce Bureau. The latter was established to support the workforce supply for the Covid vaccination programme .

Development of this strategy

This strategy has been developed within the context of changes both nationally and within Greater Manchester. These include the establishment of statutory integrated care systems, including NHS Greater Manchester Integrated Care (NHS GM) in July 2022. These new arrangements mark the latest stage in our city region’s journey to more joined up working, which has developed since our health and social care devolution deal in February 2015. This strategy has been developed at the same time and in close alignment with the Greater Manchester Integrated Care System’s Health and Care Strategy for the next five years, following on from 'Taking Charge’.

The creation of NHS GM has established a People and Culture Function, with a Chief People Officer responsible for the delivery of the NHS People Plan for Greater Manchester.

This strategy sets out a shared ambition for our people working in health and care in Greater Manchester for the next three years; to support the delivery of the NHS People Plan, the Adult Social Care White Paper, the Integration White Paper and the Greater Manchester Integrated Care Partnership Strategy. Delivery of the strategy will be supported by other targeted strategies and plans such as primary care, community and social care, as well as work at a local and organisation level.

Throughout August and September 2022 over 200 stakeholders attended our strategy development sessions to have their say on what they wanted to see in our strategy. We had good conversations on the ambition, aims and priorities of our strategy and what success would look like in reality. We also had valuable discussions at our People Board, Workforce Collaborative Steering Group, Workforce Engagement Forum and our Integrated Care Board, as well as two events with our wider workforce to listen and learn from their experience. We also completed an equality impact assessment to understand the impact of the delivery of this strategy – to identify and mitigate adverse impacts on people with protected characteristics, as well as ensuring addressing inequalities runs throughout the strategy.

This strategy is the output from this extensive engagement activity.

This strategy will continue to be closely aligned with the Greater Manchester Integrated Care Strategy and the broader Greater Manchester Strategy, which is overseen by the Greater Manchester Combined Authority.

Scope of this strategy

It is important from the outset that we are clear about what is within the scope of this strategy and what is not.

This strategy creates a shared vision for what we want to achieve together for our Greater Manchester workforce as an integrated care partnership. It provides **a blueprint for why, where and how we work together to deliver maximum impact**. It does not seek to replace or override local or organisation plans.

While the national NHS People Plan and the People Promise have informed and helped shape this strategy, our ambitions for our Greater Manchester people go much further. This is a strategy for health **and care,** and it has a strong focus on greater integration; through a one workforce approach and partnership working.

Greater Manchester will continue to work to support the delivery of the national People Plan and the Adult Social Care White Paper and Integration White Paper. The national People Plan pillars align to our five priority areas to support reporting process for all partners.

This is a strategy for every member of our health and care workforce and a 'One Workforce' approach is a key theme throughout this strategy. This approach will drive meaningful integration that not only looks at how we deliver better services within the current parameters, but how we as a system can influence the national agenda.

Our 'One Workforce' approach looks at how our people work together in delivery of our shared goals in health and care, starting with behaviours and the way we work at a system level, as well as how every member of our health and care workforce feels that they belong and are treated fairly.

We recognise that there are areas that are out of our sphere of control, for example implementing the real living wage in the independent care sector. However, in these areas we must make the most of the opportunity to influence local partners as well as the national agenda.

Our One Workforce includes all of those working in health, care, the VCSE sector, volunteers and unwaged carers and this is a strategy for every member of our One Workforce.

Our people picture in Greater Manchester

Our workforce in numbers
NHS 88,995
Primary care 22,000
Adult social care 63,000
Paid employees in VCSE sector - 75,610

Total of 249,605 Plus 496,609 volunteers and 280,000 unwaged carers.

Primary care
416 GP Practices
382 Dental Practices
658 Community Pharmacies
303 Optometry Practices

Secondary care
In secondary care, support to nursing staff has the greatest vacancy rate at 14%. Nursing, Midwifery and Health Visitors has 8% vacancy rate equivalent to 1,839 FTE posts, with Mental Health nurse vacancy rate at 22% and adult nurse vacancy rate at 9%.

Sickness in secondary care - Over the last 12 months over **1.5 million days were lost** due to sickness absence. The main reason for absence attributed to **Mental Health** with **30%** of all absence.

Social care
Out of 64,000 work in adult social care, 57,000 employed by the independent sector

Approximately 1,000 CQC registered establishments across GM

6225 Personal Assistants in care

VCSE sector
17,494 Voluntary organisations, community groups, charities, social enterprises

Gender

Sector	Male	Female
NHS[1]	22%	78%
Primary care[2]	17%	83%
Adult Social care[3]	18%	82%

Age

Sector	Age 55+	Under 55
NHS[1]	21%	79%
Primary care[2]	27%	74%
Adult Social care[3]	25%	75%

Ethnicity

Sector	BAME	White British
NHS[1]	21%	76%
Primary care[2]	NA	NA
Adult Social care[3]	17%	83%

[1] NHS Trust and non – trust providers, source ESR June 2022
[2] Primary Care – GP practices source NHS D July 2022 and Primary care networks Source NHS D June 2022
[3] Adult social care – Source Skills for Care 2020/21

In Greater Manchester (2)

Vacancy rate

Sector	Vacancy Rate
NHS[1]	7%
Primary care[2]	Not known
Adult Social care[3]	8.5%

Turnover rate

Sector	Turnover Rate
NHS[1]	14%
Primary care[2]	Not known
Adult Social care[3]	31%

Sickness absence

Sector	Sickness / Absence Rate
NHS[1]	6%
Primary care[2]	Not known
Adult Social care[3]	3%

Student pipeline

Total students qualifying each year across greater Manchester has increased by 92% during between 2012 and 2022.

- Adult nursing increased by 53%
- Mental health nursing by 56%
- Midwives by 32%

Even given these increases in the number of students qualifying there will still be a gap between those in post and numbers required for qualified nurses, midwives and MH nurses

[1] NHS Trust and non – trust providers, source ESR June 2022
[2] Primary Care – GP practices source NHS D July 2022 and Primary care networks Source NHS D June 2022
[3] Adult social care – Source Skills for Care 2020/21

Current challenges

This strategy has been developed against the backdrop of an unprecedented workforce crisis. Addressing our workforce challenges is the biggest barrier to improving the way we provide health and care in our communities. It is vital that we get it right for our workforce so we can provide the best possible care for the people of Greater Manchester.

Key workforce challenges include:

Recruitment and retention

Recruitment and retention are challenges that are being faced across health and care – but particular areas include nursing and midwifery, dental nursing, care workers and within the VCSE sector. As a result pressures are being felt across the health and care system. We also know that we have a ageing workforce and a high turnover of people within adult social care. We need a coordinated approach at system level to attract more people to work in the sector, with clear career pathways and a commitment to being good employers to become an employer of choice. We also need to review how we work together to retain our people – by supporting them to develop and helping them to move more easily across our system.

Health and wellbeing

The pandemic and subsequent recovery has been really challenging for our workforce. People have worked tirelessly to provide care when demand has been high and staff sickness levels significant. There has subsequently been no recovery period and we know that many of our people are facing, or already experiencing, burnout. As a result sickness absence levels remain extremely high, putting further strain on our workforce and our finances. We have worked well as a system to bring our wellbeing offers together and help improve access, particularly in primary and social care. But we must take more action to help keep our workforce well; focusing on sustainable workplace wellbeing cultures that address the causes of staff sickness in the first place.

Lack of diversity amongst our workforce

We need diversity in our workforce at all levels to ensure decisions are being made and care is being provided that meets the needs of everyone. We have a long way to go to ensure we have a workforce that represents the people we are serving, particularly at senior levels. To do this requires positive action at a system level and addressing inequalities is a key priority within this strategy.

Lack of parity across the system

The pandemic further reinforced the lack of parity between our NHS and social care workforce. Our social care workforce worked tirelessly to care for many of the most vulnerable people in our communities at the most challenging time. They did this while often not receiving the living wage, without access to occupational sick pay or without a suite of wellbeing support to get them through. We have so much more to do as a system to improve the experience of colleagues in social care, to use our collective power and influence to share many of the benefits enjoyed by NHS colleagues. Much of this is also the case for our primary care and VCSE workforce too.

Current challenges (2)

Cost of living crisis

It is important to recognise that many in our workforce and the people we care for will be worrying about how they make ends meet as we face a cost of living crisis with increasing fuel and food costs. In areas of primary care and social care we know that turnover is impacted by people finding better pay in the retail sector. As the biggest collective employer in Greater Manchester, we have an important role to play as an anchor institution to support our workforce and wider communities through economic growth and recovery.

Culture change

While we have a strong history of working together as a system to deliver health and care services, we still have more work to do to undertake the culture change needed to truly transform the way we deliver care. We need to challenge behaviours and perceived ways of working to promote a culture shift where collaboration, trust and openness are at the heart of everything we do. This culture change needs to start at the very top and filter through our entire system. We must work with our workforce across all organisations and all levels to design the culture and ways of working we want to see.

Financial challenges

All our health and care services are facing unprecedented financial pressures. The workforce crisis is contributing to this – with high sickness absence rates, agency and locum spend and reduced workforce productivity. It is absolutely vital that we take action to resolve our workforce crisis in a sustainable way – which won't necessarily be about adding to our overall headcount, but focusing on retention, as well as thinking about working in a different way, embracing digital advancements and reducing costly agency and locum spend.

Our ambition

Building on our people journey over the last six years we will continue to support the development of a resilient and sustainable workforce in health and care. We want our people to work together as **one workforce.** We want them to feel **valued** and **supported**, to **feel safe** and that their **wellbeing matters**, as well as enjoying a sense of **empowerment over their professional and personal growth**.

"We want our workforce to be **representative of the communities we serve**, at all levels and we want our people to be supported by **compassionate leaders** to work **flexibly** and to reach their potential.

"We want Greater Manchester to be the best place to work in health and care and as a system we want to work with our partners to act as exemplars of truly **'good employment'**. We want our people to be their best, to meet the future needs of our integrated care system and to continue to provide our population with the best possible care."

Our aims

These are the ten areas we want to achieve in order to reach our overall ambition.

1. To attract the best people to work in health and care from within our communities and further afield to grow a sustainable workforce
2. To develop career pathways across health and care by providing access to the best education and training, supporting progression and promotion from entry level to board level
3. To improve employment practices within health and care to help drive economic and social recovery and growth in our communities
4. To support better wellbeing cultures and provide everyone with access to good wellbeing support regardless of their employer to reduce sickness levels and improve overall wellbeing
5. To enable more people to work flexibly to support a good work / life balance
6. To improve the experience of all of our diverse people so they are represented, heard, treated with respect and have equal opportunity to develop
7. To ensure our people in social care feel recognised and valued for their important contribution to our system as part of our commitment to greater integration
8. To develop effective, compassionate and inclusive leaders that are representative of our diverse communities and support our people to be their best
9. To develop an effective system culture that promotes collaboration and empowers our people to work across organisational and geographical boundaries and move more easily between services
10. To improve how we plan for the future together in a truly integrated way

Our people and culture priorities

In order to deliver our ambition and aims, these are the five priority areas we will be focusing on.

Workforce integration

We continue to improve the way we work together across health and care to achieve our shared goals.

Good employment

We look after our people and use our influence to improve employment standards for others, as part of our commitment to addressing broader health inequalities.

Workforce wellbeing

We provide the support and space for our people to maintain good health and wellbeing and make sure help is on hand when it's needed.

Addressing inequalities

We are committed to having a workforce that represents the communities we serve at every level and where our people are treated fairly and with respect.

Growing and developing our workforce

We support our people to develop and are always finding new ways to plan, grow and retain our workforce for the future together.

Our people and culture priorities

These five priority areas are closely interlinked and equally important to delivering on our ambition. We will work together across all spatial levels to deliver against these priorities. There are some areas where it makes sense to take action once at a Greater Manchester level, and this next section outlines work that has been identified as priority actions at a Greater Manchester level. These actions will be delivered through a variety of routes - the NHS GM People and Culture Team, through allocation of HEE Workforce Development money, primary care, secondary care and social care workforce plans and collaborative working with system partners.

Workforce integration

Our health and care system works best when we work together. Having a workforce that understands its part in the whole ultimately leads to better care. It is our priority to improve the way we work together and support our workforce to have a wider understanding of how our system operates. A system that is truly integrated will result in less hospital admissions, better discharges and ultimately keep more people well at home. Workforce integration is a vital component for this and our work in this area starts with creating a more integrated culture and ways of working, and includes better opportunities to work across the system, more consistent inductions, development opportunities and shared networks.

Priority areas for Greater Manchester action:

- *Co-create a culture of collaboration, including development of ways of working which are adopted at all levels, such as our system Boards and wider leadership development*
- *Enable leaders to work across traditional boundaries to support service integration*
- *Develop a plan for cross system mentoring and coaching*
- *Promote the development of neighbourhood based integrated health and social care roles, including the expansion of the blended roles programme*
- *Make it easier for our workforce to move across different settings, including the expansion of the GM passport across health and care settings*
- *Work with our regulators to develop standards around integration*
- *Establish a system induction toolkit that can be incorporated into place and organisation inductions to provide useful context around how our system works and supports the development of a system culture.*
- *Establish a system staff survey to improve our understanding of our workforce experience across the sector*
- *Continue to share best practice and ways of working to support integration and collaboration, through toolkits and events such as the Workforce Collaborative Summit*

Good employment

It is our priority to ensure all health and care organisations provide our workforce with good employment. There is currently significant disparity in experience of good employment across our workforce. While we recognise that there are some areas that are outside our control as an Integrated Care Partnership, we not only want to improve the employment of those directly employed by the NHS and local authority organisations but use our influence to drive improvements in primary care, social care and the voluntary sector. Fair pay and working conditions are fundamental to good employment. It is more important now than ever as we are entering a cost of living crisis which is likely to affect our people for the duration of this strategy.

Priority areas for Greater Manchester action:

- *Increase in Good Employment Charter membership and payment of the Real Living Wage. Supporting organisations to achieve Charter membership will also improve employment standards across all areas covered by the Charter, including security, flexible working, employee engagement, recruitment, people management wellbeing provision and inclusion.*
- *Establish a Good Employment Charter definition for good leadership – piloting in NHS Greater Manchester and sharing best practice with the system*
- *Work with partners to help embed good employment practices in our commissioning and contracting of services*
- *Improve access to staff benefits, starting with the Blue Light Card*
- *Share best practice and resources to support managers to be the best they can be and explore a core development programme for managers – including line management and clinical supervision*
- *Coordinate action to tackle violence and bullying experienced by our workforce in their place of work*
- *Improve workforce engagement and access to flexible working by sharing good practice*
- *Support our net zero ambitions by promoting active travel and improving access to electric cars and cycle schemes*
- *Establish a HR support centre for primary care to develop more consistent employment practices*
- *Deliver the Greater Manchester Champion Awards to celebrate collaboration and good practices*
- *Continue to work in close partnership with trade unions, supporting ongoing engagement between unions and employers in the event of industrial disputes.*

Workforce wellbeing

The need for a Greater Manchester approach to workforce wellbeing emerged as a response to the pandemic which exposed the lack of access to good wellbeing support, particularly in areas where the people are non-NHS employed, such as primary care, social care and the VCSE sector. Since 2020, this approach has developed and evolved to include psychological, physical and practical support. However, sickness absence levels in Greater Manchester are some of the highest in the country. More needs to be done as a system to tackle this in a sustainable way to ensure we don't reach this point again. The focus at a Greater Manchester level is on prevention and that looks at how we tackle the causes of staff sickness to keep our people well and reduce sickness related absence .

Priority areas for Greater Manchester action:

- *Take action on the causes of staff sickness which include stress, busy workloads and burnout*
- *Improve access to existing resources so that all our people can get the support they need for maintaining good wellbeing and getting the help when they need it*
- *Establish occupational health and Employee Assistance provision for NHS Greater Manchester and look to extend this where possible in primary care, social care and the VCSE sector*
- *Take a more standardised approach to occupational health in secondary care*
- *Support organisations and networks to embed good wellbeing cultures and practices to enable people to maintain good wellbeing in the workplace*
- *Identify wellbeing needs/gaps and working with partners to address them together at a Greater Manchester level*
- *Supporting workplaces to keep people well in order to reduce workforce sickness levels and agency/locum spend*
- *Improve infrastructure and systems for absence management to support effective workforce planning*
- *Greater strengthen the workforce wellbeing oversight group – with the power to act on system themes*

Addressing inequalities

We are proud of the diversity of our workforce across Greater Manchester and want it to be something that we celebrate. But before we can do that, we have a long way to go to ensure there is equal access to opportunity so that we see diversity at all levels – from the front line to board level. We also need to make big changes so that all our colleagues are treated fairly and without discrimination. It is only by making our workforce more diverse and inclusive, that we are better able to not only have a workforce that represents the communities it serves, but better understands the needs of those communities to provide the best possible care.

Over recent years some progress has been made in tackling workforce race inequality, through the collection of baseline data and targeted programmes such as Building Leadership for Inclusion and the Race Equality Change Agents Programme (RECAP). But there is much more to be done to address race inequalities and wider discrimination experienced by colleagues with any of the protected characteristics identified in the Equality Act 2010.

Priority areas for Greater Manchester action:

- *Building a leadership culture that is committed to addressing our city-region's health inequalities*
- *Develop and implement a Greater Manchester Workforce Disability Equality Scheme*
- *Develop a Equality, Diversity and Inclusion Framework for inclusive leadership*
- *Adapt the recruitment process to provide alternative entry routes for diverse talent*
- *Delivery of the national Stepping Up programme at scale.*
- *Implement the #InclusiveHR initiative to create more representative and inclusive People and Culture services across Greater Manchester*
- *Addressing wellbeing inequalities experienced by specific groups*

Growing and developing our workforce

Growing our workforce is vital to addressing the immediate workforce crisis. But ensuring this is done in a coordinated, informed and sustainable way is just as important. Therefore, our priority is both growing and developing our workforce. This includes reaching out into our communities, developing attractive career pathways, understanding where our gaps and challenges lie, thinking innovatively around how we fill those gaps and how we continue to develop our people so they want to stay.

The following areas have been identified for Greater Manchester action:

- *Work together to focus on our educational offer and future planning*
- *Develop our Greater Manchester careers approach to reach into our communities and engage with school leavers as well as those looking for a new career*
- *Use the work within this strategy to build a strong narrative on why people should want to work in health and care in Greater Manchester*
- *Develop our talent pool to ensure it is diverse and meets the needs of our system*
- *Develop the Social Care Careers Academy to support growth, retention and development of the social care workforce*
- *Develop and deliver the Greater Manchester retention plan: focusing on the experience of our health and care people and integrated roles*
- *Provide a single point of contact for matching workforce and employers through a GM platform*
- *Embrace digital innovation to improve the way work in a more efficient way, with a focus on digital literacy and exploring different ways of working*
- *Building on the findings from research into the workforce development needs of the VCSE sector in Greater Manchester, the VCSE sector's Local Infrastructure Organisations will establish a collective workforce development hub for the sector focusing on key priorities (including supply, wellbeing, leadership and new ways of working/collaboration).*
- *A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on community services, the social care workforce and unwaged carers*

Growing and developing our workforce (continued)

- *Work closely with HEE to create more development opportunities and help enable people to have the protected time to participate*
- *Support primary care employers to utilise Additional Roles Reimbursement Scheme (ARRS) funding and strengthen the multi-disciplinary approach in primary care*
- *Targeted action on nursing, midwifery and AHPs – including student recruitment, placement capacity and promotion of working in GM*
- *Targeted action to recruit and retain key primary care roles including GPs, nurses, community pharmacists, NHS dentists and dental nurses working in partnership with HEE*
- *Support providers with the delivery of the Sustainable Services programme – managing workforce shortages by developing new ways of working to support the system to continue to provide valuable services*
- *Support Greater Manchester People Teams to develop by creating a development plan for our HR and OD colleagues*
- *Ongoing delivery of our system approach to workforce planning and transformation – working across an integrated health and care system at place and neighbourhood to improve system-wide workforce insights and strategic workforce planning more broadly*
- *Improving workforce data in areas such as primary care to support better workforce planning*

Delivery

This is a strategy which sets out our ambition and aims as a system. Delivery of this strategy will be through a number of plans, being delivered at different spatial levels.

The Greater Manchester People Board will oversee delivery of the strategy.

System delivery will be led by the NHS Greater Manchester People and Culture function, working in collaboration with the Workforce Collaborative, system partners, our trade union colleagues and locality teams. This will include the development of a system delivery plan which will be reported to the Greater Manchester People Board.

This will be supported by the delivery of other targeted strategies and plans, as well as the work of Provider Collaboratives, localities, clinical pathways and networks, and individual organisations.

Many of the priority actions identified in this strategy will be delivered by system partners supported by our allocation of Health Education England workforce development funding. The Workforce Collaborative will ensure that ongoing bid proposals are closely aligned to the system priorities identified in this strategy, with a focus on identifying gaps in delivery. Key areas identified for priority funding include: workforce digitisation, workforce planning, greater development opportunities in primary care, social care, the VCSE sector and for unwaged carers, action to improve diversity at senior leadership levels, particularly for women and people of colour, and developing career pathways

The delivery of Greater Manchester-wide priority action areas may be dependent on the allocation of funding to the NHS GM People and Culture Function.

Our strategy in action

Greater Manchester Integrated Care Partnership

Greater Manchester Integrated Care Partnership Strategy

People and culture strategy for our Greater Manchester workforce

Shared ambition, aims and perspectives

- Sector workforce plans and strategies including primary care and social care
- Locality workforce plans
- Clinical pathway and workforce plans
- Organisation workforce plans

Delivering for our health and care workforce and providing joined-up care for our population

Shared values for delivering together

We all have a responsibility to support the delivery of this strategy, whether it's at Greater Manchester, sector, locality or organisational level. Working together to achieve our shared goals will be essential for successful delivery.

To support the delivery of this strategy and our broader commitment to cultural change, we will commit to delivery following these values:

Collaboration – actively seeking out opportunities to work together to deliver shared outcomes

Sharing – committing to sharing resources and best practice with others

Supportive – stepping up to offer support to others when they need it

Trust – we trust one another and our commitment to delivering this strategy

Inclusive – we involve others and recognise the different skills we all bring

**These values have been developed for the People and Culture Strategy and will remain under review to reflect the 'ways of working' in the forthcoming Integrated Care Partnership Strategy.*

Measuring success

The NHS Strategic Oversight Framework reporting process provides some useful measures of success which can be utilised for this strategy. They include NHS staff engagement, leaver rate and sickness absence rate, as well as CQC for well-led ratings. However, we recognise there are limitations with this data, such as being largely only representative of secondary care and limited to the NHS.

At a Greater Manchester-level we have an opportunity to shape the key indicators of success for this strategy. Below are five commitments for the change we would like to see at system level for each of our priority areas. A series of measures sit below each of these commitments to measure whether they have been achieved. These measures have been included as Appendix A.

Workforce Integration: We will increase the opportunities for sharing and partnership working across our system and organisational boundaries, and increase the number of people working in integrated roles.

Good Employment: We will see a significant improvement in the delivery of the Good Employment Charter across the seven characteristics of good employment and increase the number of employers paying the Real Living Wage.

Workforce Wellbeing: We will increase access to wellbeing and absence management resources, with the aim of improving wellbeing and reducing sickness to support better workforce planning and ensure safe staffing.

Addressing Inequalities: We will improve diversity at senior manager and executive level and improve the experience for our workforce with protected characteristics.

Growing and Developing our Workforce: We will increase recruitment to the sector from within our own communities, including key areas such as nursing, midwifery, social care and mental health. We will support more people to develop and stay, and improve our workforce planning system infrastructure.

Our measures – workforce integration

We will increase the opportunities for sharing best practice and partnership working across our system and organisational boundaries, and increase the number of people working in integrated roles

Measures

- Increase in number of integrated learning environments within nursing, AHP and medical education programmes
- Total number of senior leaders participating in system integration development programme
- Total number of organisations incorporating system induction piece into their induction programmes
- Increase in number of integrated health and social care roles, including blended roles programme
- Increase in number attending our Workforce summits and post event evaluation
- Total number of people accessing cross sector mentoring
- Survey measuring perceived integration/survey of leaders feeling able to work across boundaries
- Increase in number using the digital training passport

Our measures – good employment

We will drive a significant improvement in the delivery of the Good Employment Charter across the seven characteristics of good employment and increase number of employers paying the Real Living Wage/national living wage

Measures:

- Increase in Good Employment Charter membership
- Good Employment Charter Steering Group engagement on perceived change in the system
- Increase in the number of health and care employers paying the Real Living Wage and improvement of the wider employment standards included in the Good Employment Charter, such as increase in access to flexible working
- Increase HR provision within primary care
- Staff survey engagement theme score*
- Staff survey bullying and harassment score*

*Strategic Oversight Framework (SOF) measure

Our measures – workforce wellbeing

We will increase access to wellbeing and absence management resources, with the aim of improving wellbeing and reducing sickness to support better workforce planning and ensure safe staffing.

Measures:

- NHS staff survey results/consider introducing a wider workforce survey that is accessible in primary care, social care and the VCSE sector
- Increase in number of individuals accessing Greater Manchester wellbeing events and resources
- Improve provision of occupational health in primary care and the VCSE sector
- Sickness absence rate*
- Improve sickness absence rate reporting in primary care and social care
- Better absence management recording

*SOF measure

Our measures – addressing inequalities

We will improve diversity at senior manager and executive level and improve the opportunity and experience for all of our workforce with protected characteristics

Measures:

- Proportion of staff in senior leadership roles who are from a) a BME background or b) are women*
- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age*
- Increase representation of people with protected characteristics at all levels, within the NHS that will be particularly at entry levels at Band 2, Band 5 and Junior Medical Grades
- Number of organisations that have adapted their recruitment processes to attract diverse talent and impact this has had on those recruited
- Reduction in the disproportionality in disciplinary investigations by people with protected characteristics
- Number of individuals taking part in positive interventions, eg Ready Now
- NHS staff survey results/consider introducing a wider workforce survey that is accessible in primary care, social care and the VCSE sector

*SOF measure

Our measures – growing and developing

We will increase recruitment to the sector from within our own communities and beyond, including key areas such as nursing, midwifery, social care and mental health. We will support more people to develop and stay, and improve our workforce planning system infrastructure

Measures:

- Leaver rate* and vacancy rate
- Utilise data on why people leave and where they are going, to identify opportunities for retaining these staff
- Increase the number of people engaged through GM careers activity
- Increase in student numbers in nursing, midwifery and mental health
- Increase in the size and diversity of the GM talent pool
- Increase in perceived access to development opportunities through staff surveys
- Increase in utilisation of CPD funding to support development
- FTE doctors in General Practice per 10,000 weighted patients*
- Direct patient care staff in GP practices and PCNs per 10,000 weighted patients*
- Increase number of programmes supporting workforce digitisation

*SOF measure

Greater Manchester Joint Health Scrutiny Committee

Date: 8 March 2023

Subject: Greater Manchester Elective Care Recovery and Reform

Report of: Vicky Sharrock, Greater Manchester Programme Director for Elective Care, NHS Greater Manchester Integrated Care

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Purpose of Report:

On 14 September 2023 the Committee was provided with an update on the overall Greater Manchester approach to Elective Recovery, which included a summary of the agreed pillars of recovery:

- Integrated Elective Care
- Productivity and Efficiency
- Independent sector
- Surgical hubs
- Wait list management
- Children and young people

The purpose of this further report is to address Members request for a further update specifically focus on the 78 week wait position. The Greater Manchester ambition is to ensure there are no patients waiting over 78 weeks at end March 2023 aligned to the national target

Recommendation:

That Members consider and comment on the presentation.

Contact Officers:

Vicky Sharrock, Greater Manchester Programme Director for Elective Care, NHS Greater Manchester Integrated Care

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NHS
Greater Manchester
Integrated Care

Greater Manchester (GM) Elective Care Recovery and Reform

GM Joint Health Scrutiny Committee
8 March 2023

Part of Greater Manchester Integrated Care Partnership

GM Elective Recovery Strategy

NHS Greater Manchester Integrated Care

- On 14 September we provided GM Joint Health Scrutiny Committee with an update on the overall GM approach to Elective Recovery
- This included a summary of the agreed pillars of recovery:
  - Integrated Elective Care
  - Productivity and Efficiency
  - Independent sector
  - Surgical hubs
  - Wait list management
  - Children and young people
- Committee members requested a further update specifically focus on the 78 week wait position
- The GM ambition is to ensure we have no patients waiting over 78 weeks at end March 2023 aligned to the national target

Overall Context

- Through the first three quarters of this financial year, we saw week on week increases in the overall wait list
- As a result, the wait list increased from 467k to a peak on 25 December of approximately 539k
- The overall wait list position during the year has been affected by the ongoing pressures within the system including continued high levels of covid, wider respiratory conditions, urgent and emergency care demand and significant numbers of patients who are ready for discharge but remaining in hospital beds
- Through January and early February 2023, we have started to see steady decreases in the wait list which is now approximately 533k (week ending 19 February)
- The GM recovery has been impacted on by nursing strikes as nurses were moved from elective theatres and outpatients to cover wards and acute care
- We can't look at elective long wait recovery in isolation of other clinical priorities such as cancer recovery
- Both cancer and elective recovery are underpinned by the same diagnostics capacity. We have seen investment in this area which has supported the position in particular through the Community Diagnostics Centres (CDCs)

GM 78 Week Wait Cohort

- The total cohort of people waiting over 78 weeks between July 22 and March 23 was approximately 84,000

- This included those who were already over 78 weeks and those that would become over 78 weeks before the end March if not treated

- At the beginning of the financial year, we were predicting 2,135 patients that we did not have capacity to treat within the given timeframe

- This later increased to 2,576

Current position

- On 21 February we had 3,485 patients remaining in the overall cohort
- Of these 2,896 already had or would have dates for their treatment ahead of end March 2023
- This left 589 patients for whom capacity had not yet been identified
- The significant reduction in the overall cohort and the number of predicted residual patients was delivered through a combination of:
  - Increased productivity and efficiency
  - Transformation activity and learning from Covid to create additional capacity in secondary care for example through alternatives such as the Gynaecology Care Navigation Hub pilots and opportunities to treat people in primary care that previously would have been daycases in secondary care
  - Validation of the wait list
  - Support from within GM through the provision of mutual aid
  - Working with the independent sector
  - Insourcing to provide additional capacity on trust sites
  - Support from trusts outside GM

Ongoing work to support the remaining patients

NHS Greater Manchester Integrated Care

- The GM ambition continues to be no patients waiting longer than 78 weeks at the end of March 2023 (except for choice and complex patients)
- To support this, we continue to work across GM and with the national team to identify capacity
- This includes identifying further potential provision of mutual aid and the use of the national Digital Mutual Aid System (DMAS) which identifies capacity for patients who are prepared to travel
- Some patients are choosing to wait longer than the end of March as this fits their personal circumstances
- A small number of patients are awaiting corneal grafts for which there is a national shortage of graft material
- There will be other patients who for reasons of complexity or illness we are not able to treat before end March

High risk areas

- There are a number of risks to the delivery of the 78 week wait ambition including ongoing system pressures and the availability of capacity at independent sector sites

- The most significant current risk is the planned junior doctor strike which will impact our ability to undertake elective activity and potentially lead to over a thousand cancelled procedures to ensure we maintain safe services

- Two high risk specialty areas have been identified in particular: dermatology and gynaecology
  - We are currently projecting no dermatology patients waiting over 78 weeks at the end of March but there are risks to the achievement of this position
  - Over half the remaining patients are gynaecology with some requiring complex procedures that can only be undertaken at limited places across the country
  - Taskforces have been established in both these areas to identify options for how services can be made more sustainable in the medium to long-term
  - Links into the national process of mutual aid will continue

Summary

- The overall wait list has now started to reduce
- GM aligns with the national ambition to eliminate all long-wait patients (with the exception of those choosing to wait or who have complex requirements)
- The vast majority of the overall cohort of patients waiting over 78 weeks (84,000) has already or will be treated by the end of the financial year
- There remains 589 patients who we have not yet identified the capacity to support
- We continue to work across the GM system and more widely in the NW region and national to identify options for all remaining patients
- Some of the remaining cohort will fall into the choice or complex categories
- Ongoing pressures in the system creates risk to the delivery of the planned position. Mitigating actions will be put in place to ensure this is minimised
- The proposed junior doctor strike presents a significant risk to the delivery of elective activity and will impact on the 78 week wait position
- Long term sustainability is being addressed for those specialties particularly at risk

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Thank you
Any questions?

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