Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP BOARD

DATE: **Friday, 28th October, 2022**

TIME: **1.00 pm – 2:30pm**

VENUE: **Council Chamber, Bury Town Hall, Knowsley Street, Bury BL9 0SW**

AGENDA

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.

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: Lee Teasdale

✉ lee.teasdale@greatermanchester-ca.gov.uk

This agenda was issued on 20th October 2022 on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority, Broadhurst House, 56 Oxford Street, Manchester M1 6EU

Declaration of 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
2. 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.

This page is intentionally left blank

MINUTES OF THE MEETING OF THE SHADOW GREATER MANCHESTER HEALTH AND CARE INTEGRATED CARE PARTNERSHIP HELD ON 20 SEPTEMBER 2022 VIA MS TEAMS

PRESENT:

Healthy Lives & Quality Care Portfolio Leader	Mayor Paul Dennett (Chair)
NHS GM Chair Designate	Sir Richard Leese
GM Mayor	Andy Burnham
Bolton	Cllr Andrew Morgan
Bury	Cllr Eamonn O'Brien
Stockport	Cllr Keith Holloway
Tameside	Cllr Gerald Cooney
Wigan	Cllr David Molyneux

OFFICERS IN ATTENDANCE:

Director of the Mayor's Office	Kevin Lee
Healthy Lives & Quality Care Chief Executive	Geoff Little
GMCA, Assistant Director, Governance & Scrutiny	Julie Connor
GMCA, Chief Executive	Eamonn Boylan
GMCA Deputy Chief Executive	Andrew Lightfoot
GMCA, Governance	Lindsay Dunn
GMCA. Monitoring Officer and Solicitor	Liz Tracey
GMCA, Treasurer	Steve Wilson
NHS GM IC, Chief Delivery Officer	Steve Dixon
NHS GM IC, Director of Communications and Engagement	Claire Norman
NHS GM IC, Deputy Chief Executive	Sarah Price
NHS GM IC, Chief Officer for Strategy & Innovation	Warren Heppolette

SICP 01/22 APOLOGIES

Apologies for absence were received and noted from:

Councillors Mark Hunter (Stockport), Andrew Western (Trafford), Mark Fisher (NHS GM IC, Chief Executive).

SICP 02/22 ESTABLISHMENT OF THE GM INTEGRATED CARE PARTNERSHIP BOARD

Liz Treacy, Monitoring Officer and Solicitor, GMCA introduced a report which set out the statutory minimum requirements along with guidance and recommendations of the Integrated Care Partnership Board, one of the two statutory components of an Integrated Care System, alongside the Integrated Care Board.

Engagement had taken place across the system regarding the proposed options for membership to fulfil the statutory requirements and responsibilities of the Integrated Care Partnership and Strategy.

The Shadow ICP were requested to determine proposed membership of the ICP and note that representatives would be invited to the inaugural formal meeting on 28 October 2022. Furthermore, work on the role and functions of the Joint Planning and Delivery Committee in discussion with the Shadow ICP and ICB would take place.

In welcoming the informative update which recognises the connections and the intentions of how the Board will interact with other parts of the system, it was suggested that the compromise option for membership detailed at point 5.4 of the report presented a balanced and manageable option.

In acknowledging the work undertaken by the GM Governance Group to develop an inclusive and workable approach, it was recognised that the proposals represented the Integrated Care Partnership Board and not the entirety of the Partnership. It was suggested that the engagement strategy being developed by the ICS should be considered imminently by the Board to demonstrate the scope and broad range of partners across various working groups along with the wide range of disciplines and specialisms.

It was advised that once agreed, the proposals would need formal approval by the ICB which was due to meet again ahead of the 28 October 2022. The statutory status of the ICP as a joint committee of the ICB and ten local authorities was welcomed, and it was suggested that the ICP should be jointly chaired by the GM Portfolio Lead and the GM ICB Chair Designate. It was agreed that further consideration and discussion regarding Chairing arrangements would be undertaken.

In discussion the Board considered the role of substitute members and whether voting rights would apply in the absence of the nominated individual. It was suggested and agreed that further consideration and clarity would be provided to the role of named substitute members.

RESOLVED/-

1. That the compromise option for membership of the Integrated Care Partnership detailed at 5.4 be approved and invitations for nominations from relevant organisations be requested.
2. That the joint committee of the ICB and ten local authorities be established noting that this would require the 10 local authorities to take a report through their governance and nominate to the ICP.
3. That it be noted that the authorities have previously provided nominations for the current HSCP and referred to those nominees as their ICP reps, not all nominations are Leaders.
4. That further consideration and clarity would be provided to the role of named substitute members and voting conditions.
5. That further consideration be provided to the joint Chairing arrangements of the ICP as a joint committee of the ICB and ten local authorities between the GM Portfolio Lead and the GM ICB Chair Designate.
6. That the first meeting of the ICP be held on Friday 28th October (same day and place as the GMCA meeting).
7. That at the first meeting of the ICP, the Chair and membership be appointed and the Terms of Reference be agreed (the Terms of Reference will consist of the statutory duties of the ICP and will be set out in the reports to the local authorities and the ICB which establishes the joint committee).
8. That the proposals be presented to the ICB for approval prior to the inaugural ICP Board meeting on 28 October 2022.

SICP 03/22 DEVELOPING THE GM ICP STRATEGY

Warren Heppolette, Chief Officer, Strategy & Innovation, NHS Greater Manchester Integrated Care, presented an update on the development of the ICP Strategy and requested that the Board review and approve the updated shared outcomes and shared commitments.

The Board were advised that the ICP strategy would be created and owned by the GM Integrated Care Partnership Board. It was reported that NHSE guidance states that ICPs have a statutory duty to create an integrated care strategy to address assessed needs, such as health and care of the population within the ICB's area, including determinants of health and wellbeing such as employment, environment, and housing.

It was advised that the strategy would be integrated covering health and social care and addressing the wider determinants of health and wellbeing. Furthermore, it would be aligned with the Greater Manchester Strategy (GMS) and the shared commitment in the GMS related to health.

The range of influences on the strategy which would inform its content and focus, in addition to national guidance were outlined. It was emphasised that engagement on the strategy is required and early engagement from March to May 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. A second phase of

engagement with communities and localities would take place in October and November with the presentation of a draft strategy for feedback and comment.

The encouraging progress in the development of the strategy was recognised and it was proposed that a systematic action plan would need to be built into planning process which embedded lived experience to emphasise real outcomes.

The critical connection to locality partnerships and plans to formulate the strategy was emphasised. It was suggested that an annual process of updating locality plans which reflect the requirements and opportunities at neighbourhood level be undertaken.

Furthermore, the encouraging progress that has been made across the city region regarding life expectancy data as captured in the Health Foundation Report should form the basis of lessons learnt to demonstrate improvement.

It was agreed that the Health Foundation Report would be circulated for consideration and utilised in the further development of the GM Integrated Care Partnership Strategy.

RESOLVED/-

1. That the update on the ICP Strategy development be noted.
2. That the updated draft shared outcomes and commitments be supported.
3. That the Health Foundation Report be circulated for consideration and be utilised in the further development of the GM Integrated Care Partnership Strategy.

SICP 04/22 DATE OF NEXT MEETING

RESOLVED/-

To agree that the inaugural meeting of the GM Integrated Care Partnership Board will take place on Friday 28th October 2022.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Integrated Care Partnership Board

Date: 28th October 2022

Subject: Establishment of the GM Integrated Care Partnership Board

Report of: Geoff Little, GMCA Chief Executive Portfolio Holder, Health and Social Care

---

PURPOSE OF REPORT

To note the establishment of the Greater Manchester Integrated Care Partnership (GM ICP) as a joint committee and to enable the GM ICP to agree its additional members, terms of reference and frequency of meetings.

RECOMMENDATIONS:

The GM ICP is requested:

a) To note that the ten Greater Manchester Local Authorities and the Greater Manchester Integrated Care Board (ICB) have agreed to establish the GM Integrated Care Partnership (ICP) as a joint committee of the ICB and ten local authorities.
b) To note the appointment of the local authority and ICB members and substitute members of the GM ICP.
c) To agree the proposed Terms of Reference of the Greater Manchester ICP.
d) To agree the membership and terms of office of the additional members of the Greater Manchester ICP.
e) To agree that the ICP will meet at least quarterly in public.

CONTACT OFFICERS:

Geoff Little, Chief Executive, Bury Council

Liz Treacy, Solicitor, GMCA

Gareth James, Head of People, Place & Regulation, Manchester City Council

BACKGROUND

Role of the ICP

1.1 An ICP is one of two statutory components of an Integrated Care System, alongside the Integrated Care Board (ICB). Section 26 Health and Care Act 2022 inserts s.116ZA into the Local Government and Public Involvement in Health Act 2007.

116ZAIntegrated care partnerships

(1) An integrated care board and each responsible local authority whose area coincides with or falls wholly or partly within the board's area must establish a joint committee for the board's area (an 'integrated care partnership')

(2) The integrated care partnership for an area is to consist of –

(a) one member appointed by the integrated care board

(b) one member appointed by each of the responsible local authorities

(c) any members appointed by the integrated care partnership

(3) An integrated care partnership may determine its own procedure (including quorum)

1.2 The minimum core membership of the ICP will consist of 10 representatives from the 10 districts and a member of ICB.

2. Purpose and function

2.1 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 within the ICB's area, including determinants of health and wellbeing such as employment, environment, and housing. In preparing the integrated care strategy each integrated care partnership must have regard to guidance issued by the Secretary of State.

2.2 Statutory guidance has now been issued by Government:

https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

2.3 The legal duties of an ICP are set out in Appendix A, references are to the guidance itself.

3. Further relevant guidance

3.1 Scrutiny

Further guidance issued by Government confirms that the ICP will be subject to local government Health Scrutiny arrangements and that the CQC will review Integrated Care systems including the functioning of the system as a whole which will include the role of the ICP. It is proposed that the GM ICS is scrutinised by the GM Joint Health Scrutiny Committee and at place level, as appropriate.

3.2 Health and Well Being Boards

3.2.1 It is expected that all HWB in an area will be involved in the preparation of the ICP Strategy. ICPs need to ensure that there are mechanisms in place to ensure collective input into their strategic priorities. Guidance also states that ICPs will need to be aware of the work already undertaken at Place and build upon it. They should not override or replace existing place-based plans.

3.3 Principles

3.3.1 This is more clearly delineated in the ICP engagement summary. Government has summarised responses to the ICP engagement document published in September 2021 and set out five expectations:

1. ICPs will drive the direction and policies of the ICS
2. ICPs will be rooted in the needs of people, communities and places
3. ICPs create a space to develop and oversee population health strategies to improve health outcomes and experiences
4. ICPs will support integrated approaches and subsidiarity
5. ICPs should take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights and develop plans

3.3.2 More recent guidance has referred to adopting a set of principles for all partners to develop good relationships including:

Building from the bottom up
Following the principles of subsidiarity
Having clear governance
Ensuring leadership is collaborative
Avoiding duplication of existing governance arrangements

3.3.3 Whilst not specified in the guidance it is anticipated in GM that Locality Boards will input into the GM Strategy.

4. Form of Integrated Care Partnership

4.1 A paper was circulated to local authorities and NHS Bodies on the role and potential makeup of the ICP earlier this year. There were a number of responses which included a concern to ensure that the ICP fully represented all areas of expertise and in particular mental health; that lessons were learnt from the operation of the Health and Care Partnership Board meetings, in that it should not develop into a large and unwieldy meeting; and that it needed to be inclusive and harness the passion and enthusiasm of a wide range of the public, private and voluntary sector on a regular basis without them necessarily being members of the ICP.

4.2 The paper was refined and the following issues on the form of the ICP have been further considered by the wider local authority and NHS system through a paper circulated to Place-Based Leads, NHS Provider Forum, NHS Primary Care Board and the ICB through their governance officers.

4.3 Responses to the paper were considered by a meeting of the Shadow ICP who have agreed the membership as set out below -

- ICB Chair
- ICB CEO
- 10x LA representatives (political)
- GMCA Mayor
- At least one Healthwatch rep
- One Director of Public Health (LA) as nominated by DPHs
- One DASS (LA) as nominated by DASSs
- One Director of Children's Services (LA) as nominated by DCSs
- One LA Chief Executive – Chief Executives health lead
- GMCA Chief Executive
- Two Provider Federation representatives: one mental health, one physical as nominated by PFB
- Four Primary Care representatives, one from each discipline
- Health Innovation Manchester representative
- One Trade Union representative
- One VCS representative
- One housing representative as nominated by GM Social Housing providers
- One Work and Skills representative.

This would result in an ICP of 30 members if it is possible to have one representative from the housing sector and work and skills, with others invited as required e.g. GMP

5. Membership

Core membership
All local authorities and the ICB either have confirmed membership or will have done so at the time of the meeting. A list of appointments will be circulated at the meeting.

Additional members
Organisations representing the proposed additional membership as set out in 4.3 above have confirmed the following nominations –

GM Healthwatch	Heather Fairfield
DPH	Katrina Stevens
DASS	Stephanie Butterworth
DCS	*To be confirmed*
Provider Federation	Kathy Cowell
	Evelyn Asantemensah
Primary Care	Darmish Patel
	Tracey Vell
	Don McGrath
	Luvjit Kandula
Health Innovation Manchester	*To be confirmed*

Trade Union	James Bull
VCSE	Lynne Stafford
Housing	Noel Sharpe
Work and Skills	*To be confirmed*

It is proposed that the nominating organisations may change their nominee at their discretion and in any event no nominee serves more than a three year term. Additional members will need to be formally appointed by the GM ICP itself.

6. Sub-committees and working groups

6.1 The engagement summary envisages that the ICP will convene and coordinate the activities of sub-committees, working groups or other forums as its role develops.

7. Frequency of meetings

7.1 This is not specified in the guidance but is has been suggested that it meets three or more times a year. It is suggested that it meets at least quarterly on the same day as the GMCA meeting.

8. Secretariat

8.1 The guidance says that no additional money will be available to local authorities. It is proposed that the ICP secretariat is provided by the GMCA governance team.

9. Recommendations

10. Members are requested:

a) To note that the ten Greater Manchester Local Authorities and the Greater Manchester Integrated Care Board (ICB) have agreed to establish the GM Integrated Care Partnership (ICP) as a joint committee of the ICB and ten local authorities.

b) To note the appointment of the local authority and ICB members and substitute members of the GM ICP.

c) To agree the proposed Terms of Reference of the Greater Manchester ICP.

d) To agree the membership and terms of office of the additional members of the Greater Manchester ICP.

e) To agree that the ICP will meet at least quarterly in public.

Appendix A

Legal duties and powers - where to find more information in this guidance

Statutory requirements	Further detail in this guidance
The integrated care strategy must set out how the ‘assessed needs’ from the joint strategic needs assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.	See ‘Evidence of need and the integrated care strategy’ for detail on evidence of need. See ‘Content of the integrated care strategy’ for a non-exhaustive selection of topics for the integrated care partnership to consider, including: shared outcomes; quality improvement, joint working and section 75 of the NHS Act 2006; personalised care; disparities in health and social care; population health and prevention; health protection; babies, children, young people, and their families, and health ageing; workforce; research an innovation; ‘health-related services’; data and information sharing.
In preparing the integrated care strategy, the integrated care partnership must, in particular, consider whether the needs could be more effectively met with an arrangement under section 75 of the NHS Act 2006.	See ‘Joint working and Section 75 of the NHS Act 2006’ in this document for further detail on this requirement.
The integrated care partnership may include a statement on better integration of health or social care services with ‘health-related’ services in the integrated care strategy.	See ‘Health-related services’ in this document for further detail on this power.

Statutory requirements	Further detail in this guidance
The integrated care partnership must have regard to the NHS mandate in preparing the integrated care strategy.	See the section in this document on the ‘NHS mandate’ for further detail on this requirement.
The integrated care partnership must involve in the preparation of the integrated care strategy: local Healthwatch organisations whose areas coincide with or fall wholly or partly within the integrated care partnership’s area; and people who live and work in the area.	See the section on ‘Involving people and organisations in the strategy’ for further detail on involving people and groups for the integrated care partnership to consider, including: local Healthwatch; people and communities; providers of health and social care services; the VCSE sector; local authority and integrated care board leaders; wider organisations; other partnerships and fora.
The integrated care partnership must publish the integrated care strategy and give a copy to each partner local authority and each integrated care board that is a partner to one of those local authorities.	See the section on ‘Publication and review’ for further detail on this requirement.
Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment.	See the section on ‘Publication and review’ for further detail on this requirement.

NHS mandate

The government sets objectives for NHSE through a statutory mandate. The integrated care partnership must have regard to the mandate, alongside the guidance from the Secretary of State, when preparing their integrated care strategy.

For integrated care partnerships, having regard to the mandate means following the mandate unless there are compelling or exceptional reasons not to do so. In practical terms, integrated care partnerships should ensure they act in accordance with the mandate, where its content is applicable to their context. The mandate will also be reflected in NHSE's own strategic documents and planning guidance

ICBs and LAs will be required by law to have regard to the integrated care strategy when exercising any of their functions. NHS England (NHSE) must have regard to the integrated care strategy when 'exercising any functions in arranging for the provision of health services in relation to the area of a responsible LA'.

The guidance goes on to set out the requirements of the Integrated Care Strategy and how it may be developed with partners and states that Healthwatch must be involved in its production.

Terms of Reference for GM ICP

The Greater Manchester Integrated Care Partnership is a joint committee created by the ten Greater Manchester local authorities ("the Constituent Authorities") and the Greater Manchester Integrated Care Board under s.116ZA into the Local Government and Public Involvement in Health Act 2007.

Membership of the Committee

The membership of the committee shall be

one member appointed by the integrated care board

one member appointed by each of the responsible local authorities

any members appointed by the integrated care partnership

The Constituent Authorities and the GMCA shall also each nominate a substitute executive member/assistant portfolio holder to attend and vote in their stead.

Role of the Committee

To enable the discharge of the ICP's functions under the Local Government and Public Involvement in Health Act 2007 and any related guidance concerning the role of integrated care partnerships.

Powers to be discharged by the Committee

The Committee shall have the power to discharge jointly the functions of the ICP.
The discharge of such functions includes the doing of anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of those functions

Operation of the ICP

- The ICP shall appoint a chair at its first meeting;
- The Quorum of the ICP shall be met where there are at least a third of the members appointed by the responsible local authorities present and the ICB appointee.
- Each member shall have one vote;
- The Chair shall not have a casting vote;
- Unless required by law, decisions shall be made by a simple majority.
- In relation to rights of access to information, including the publication/availability of agendas, reports, background documents and minutes, and public attendance at meetings, the ICP shall apply rules equivalent to those applying to local authority committees under Part VA of the Local Government Act 1972 ("the 1972 Act"). Such rights of access to information may be limited where the ICP considers "confidential information" or "exempt information", in a manner equivalent to that provided for by the 1972 Act.

This page is intentionally left blank

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Integrated Care Partnership Board

Date: 28 October 2022

Subject: The NHS Contribution to the GM Response to the Cost-of-Living Crisis

Report of: Sarah Price, Chief Officer for Population Health & Inequalities and Deputy Chief Executive – NHS Greater Manchester

SUMMARY OF REPORT:

- The cost-of-living crisis has the potential to exacerbate existing poverty in Greater Manchester and to adversely impact upon health outcomes, health inequalities and health and care services, particularly if the impact is sustained, inflation persists, and real term income reduces.

- The cost-of-living crisis will have a direct and indirect impact upon the health and care sector through multiple channels (consumption patterns / healthcare staff / affordability / public service sustainability / provider stability / policy interactions.

- The economy and health go hand in hand, as evidenced by the recent refresh of the GM Independent Prosperity Review, which found that "*tackling health inequalities is fundamental to achieving growth*". The likely differential health and wellbeing impacts of the cost-of-living crisis will adversely impact upon productivity, prosperity and growth.

- Whilst the underlying causes are complex and largely beyond the control of the health and care system, there are opportunities for the health and care system, as part of a coordinated whole system response, to take significant steps to mitigate the potential level of harm.

- This paper sets out the context to the issue, the system-level actions which are already taking place, and a series of proposed additional actions.

- This paper is also intended to serve as a catalyst for generating additional ideas of how the health and care system can mitigate harm, protect the health of GM residents, and maintain the financial and operational sustainability of our health and care services.

- This report does not consider the full range of long-term actions in relation to tackling poverty as a cause of ill health in Greater Manchester.

RECOMMENDATIONS:

The Greater Manchester Integrated Care Partnership Board is asked to:

- Note the content of this report and discuss the implications of the content for health and care in Greater Manchester.
- Agree the proposed actions set out in 5.4 and 5.5.
- Identify other opportunity for action to mitigate the impact of the cost-of-living crisis on health outcomes and health and care services in GM.

CONTACT OFFICERS:

Paul Lynch – Deputy Director: Strategy and Innovation, NHS GM, paul.lynch@nhs.net
Jane Pilkington – Director of Population Heath, NHS GM, jane.pilkington1@nhs.net
David Boulger - Head of Population Health, NHS GM, david.boulger@nhs.net

1. INTRODUCTION

1.1 This paper updates the GM Integrated Care Partnership Board on actions underway within GM to respond to the cost-of-living crisis, mitigate the adverse impact on the health of local citizens and minimise the impact on health and care services.

1.2 It recognises that a range of actions are already underway across localities and sectors including local government, NHS providers, the Voluntary, Community and Social Enterprise (VCSE) sector and in the GM Combined Authority.

1.3 The paper makes a series of additional recommendations where further action could be taken in the short and medium term.

1.4 This paper has been produced in collaboration with clinicians from within the GM system, colleagues from NHS GM (particularly those working within the medical directorate and strategic clinical network), and colleagues from within the wider GM system including localities and GMCA.

2. THE COST-OF-LIVING CRISIS AND IT'S IMPACT

2.1 What do we know about Poverty in Greater Manchester?

- Greater Manchester is a disproportionately deprived area within England and poverty is not a new challenge. The reasons for this are structural, and longstanding across multiple generations.

- According to the Indices of Multiple Deprivation (IMD), a quarter of GM residents (c.700,000 people) live in neighbourhoods that are amongst the 10% most deprived in England.

- According to the GM Poverty Monitor, GM Poverty Action estimate that at least 620,000 people are already living in relative poverty in GM and that almost 150,000 of these are children.

2.2 What do we know about the impact of poverty in health?

- Poverty is widely accepted as the single biggest driver of ill health and the relationship is bi-directional: Poverty causes ill health and ill health causes poverty.

- The impact of poverty on health is significant and wide-ranging and some illustrative examples include:

  - Chronic pain, heart and lung disease, alcohol problems, anxiety and depression, and diabetes are all 50% more prevalent in the most deprived 10% of neighbourhoods (within which 25% of GM residents live) than in the 10% least deprived neighbourhoods.

  - People between 45 and 64 who earn below-average income are twice as likely to have

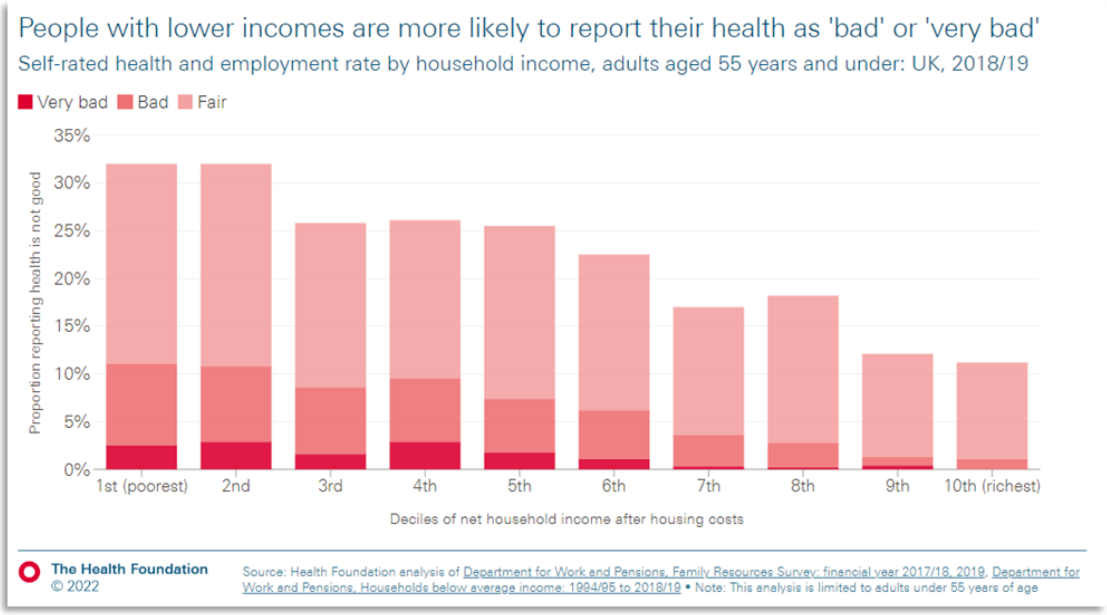
a work-limiting disability.

- Children living in low-income households are more than three times as likely to have a mental health condition than those in high-income households.

- Recent research by the Health Foundation has indicated that ill health is the primary reason for economic inactivity in the UK.

- According to the Joseph Rowntree Foundation, the Public Service costs linked to dealing with poverty and its consequences are around £78billion a year in the UK.

- According to DWP data, analysed by the Health Foundation, people with lower incomes are more likely to report their health as being “bad” or “very bad”.



- An average 60-year-old in the most deprived tenth of the country (within which 25% of GM residents live) is about as unhealthy as a 76-year-old in the least deprived tenth.

2.3 What is the Cost-of-Living Crisis?

- Annual price inflation (CPI) in the UK is at a 40 year high. This is driven by rising costs, as opposed to demand pressures. This form of inflation places a greater burden on standards of living as it is the result of supply difficulties, not higher incomes.

- The IMF expects UK inflation to be more persistent than elsewhere, partly due to labour market tightness and domestic wage pressures, meaning that the current pressures are unlikely to be a short-term issue.

- On a day-to-day basis this means that the prices of goods and services that are fundamental to good health (such as energy, food, transport / fuel, and housing) are increasing at a level that is significantly higher than any increases in income.

- The impact of this is greatest on those with the lowest income, whose routine expenditure on these core cost areas already represents a greater proportion of their overall income.

2.4 How is the Cost-of-Living crisis impacting upon the residents of Greater Manchester?

- There is currently a lack of quantitative data around the impact of cost-of-living crisis on the residents of Greater Manchester, although the iterative development of a GM Cost of Living dashboard, may address this gap over time.

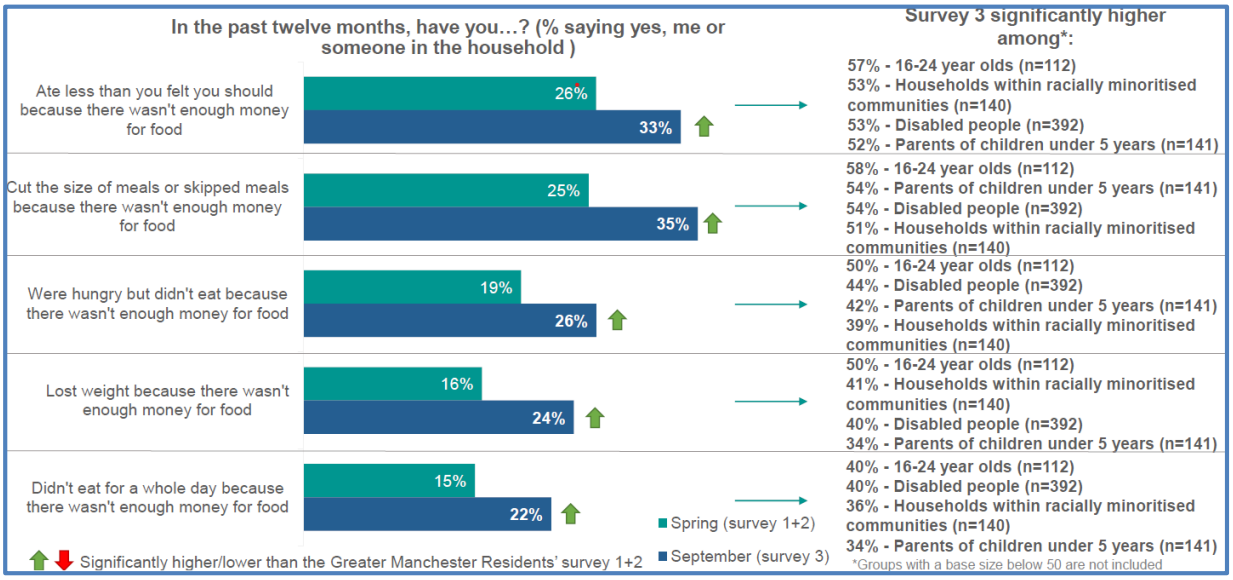
- However, the wide-ranging **GM Residents Survey** has been expanding to include a section on Cost of Living (alongside existing sections on Food Security and Digital Inclusion) which provides a window into the perceptions and lived experiences of residents of GM and offers up 2 headline findings from the fieldwork completed during September 2022:

  (1) There is a perception amongst local people that the situation is getting worse
  (2) The experiences and perceptions of GM residents are often worse than those held nationally.

- Some specific examples from the September survey are as follows:

  - 42% of GM residents were assessed as having low or very low food security compared to 35% in April 2022, with the figure increasing to 56% for households with children.

  - A deterioration of all key measures in relation to eating habits, which was disproportionately felt by 16–24-year-olds, households within racially minoritized communities, people with a disability, and parents of children aged under 5:



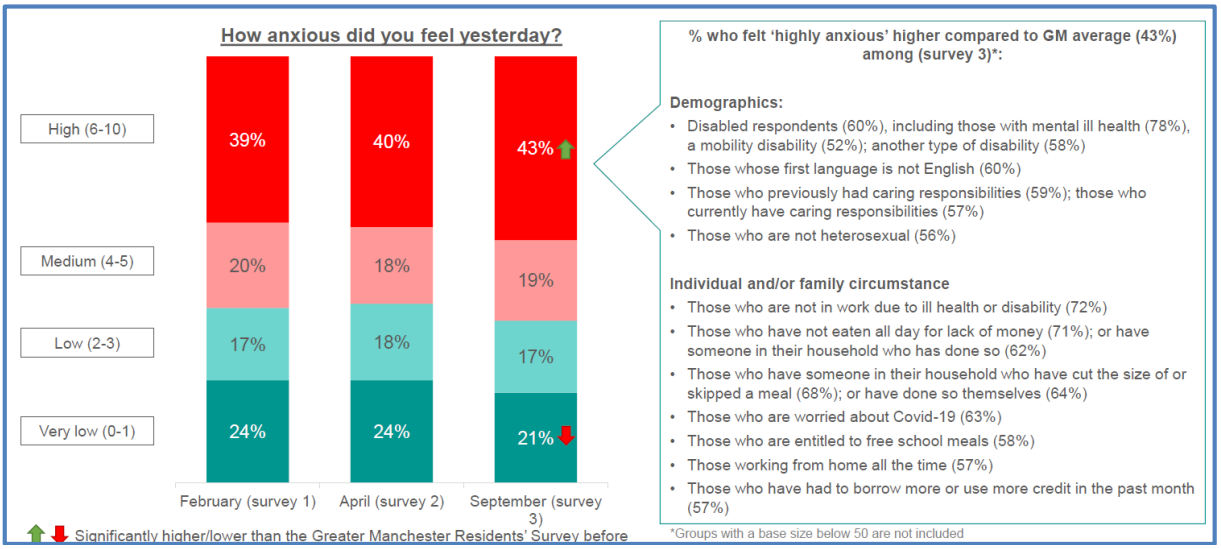
  - 84% of GM residents say their cost of living has increased over the past month and

81% are worried about the rising cost of living, suggesting that the impact is being felt beyond the 'disadvantaged' part of the population. Parents of children under 5 and people with a disability have the highest level of worry (88%)

- 35% of residents say they have had to borrow more money or use more credit than usual in the last month, compared to a national equivalent figure of 35%

- Only 17% of GM residents say that have very high life satisfaction, compared to 19% in April 2022, and 22% in February 2022.

- The cost-of-living crisis appear to be impacting on people's overall mental wellbeing with 43% of residents reporting high levels of anxiety, compared to 40% in April and a national equivalent figure of 36%. This figure increases significantly for some specific groups:



2.5 What are the potential impacts of the Cost-of-Living crisis on the health of citizens and the Health and Care System in GM?

- The potential impacts of the Cost-of-Living crisis on the health of citizens and the Health and Care system in GM are significant and wide-ranging and can be summarised as follows:

  a) **Inflationary impact on health and social care** including:

  - Increased costs of accessing care and support
  - Increased costs associated with providing services, and an increasing risk of the collapse of independent providers
  - Impact on the financial wellbeing of staff employed within the health and care workforce
  - Increased demand for health and care services driven by preventable ill health that is attributable to factors such as food, heat, and housing.
  - Affordability of co-payment services driving increased inequalities of access and

outcomes.
- Increased energy costs for vulnerable people with medical equipment within their home.

b) **Pressure on real incomes poses a risk to public health** including:

- Exacerbating the existing link between poverty and health outcomes.
- Fuel poverty and food poverty driving poor health.
- Impact on Mental Health and Wellbeing
- Increase in adverse childhood experience and childhood trauma because of increased disruption to living environment, poor parental mental health, and the impact of fuel and food poverty.
- Reduction in people accessing healthcare as a consequence of cost pressures – i.e. inability to pay for prescriptions; inability to pay for transport costs to attend appointments.

c) Long term impact on health and inequalities:

- There is a considerable risk that the impact of the cost-of-living crisis, and the exacerbation of pre-existing poverty, will have a long-term impact on health and health inequalities. This will adversely impact on health outcomes in GM, and on the future financial and operational sustainability of health and care services.

- The impact will not be equal and those already in or near poverty are likely to experience a greater impact, as are those who are already in relatively poor health.

3. THE ROLE OF THE NHS IN TACKLING POVERTY

3.1 "*One of the main drivers behind the creation of the NHS was to protect the poorest in society from being bankrupted by the need to pay for care. But the NHS can do more to mitigate, prevent and reduce poverty*." – Kings Fund (2021)

3.2 The role of the health and care system in tackling poverty is higher on the national agenda than it has ever been.

3.3 The NHS Confederation has published a new report (NHS Confederation Safety Net to Springboard Report) quantifying the positive relationship between increasing NHS spending and improved health outcomes, labour productivity and economic activity. The analysis suggests that every pound invested in the NHS gives £4 back to the economy through productivity gains and workforce participation, showing that the NHS both supports economic growth and is a security net for our local communities.

3.4 At national level, NHS GM is engaging with NHS England and the NHS Confederation to define how ICSs can deliver on their fourth core purpose: help the NHS support broader social and economic development. This includes setting out how ICSs can contribute to tackling poverty and deprivation.

3.5 In their 2021 publication – The NHS's Role in Tackling Poverty - the King's Fund set out a series of ways in which the NHS, as the largest economic institution in the country, can maximise its contribution to tackling poverty, within its resources and with its partners. A

summary of their proposals is set out below:

The NHS's role in tackling Poverty – The Kings Fund (2021)

NHS Greater Manchester Integrated Care

Awareness	Action
Build a stronger narrative about the NHS's role in tackling poverty	'Poverty proof' service pathways.
Enhance engagement with people who experience poverty and build upon models of care which are person-centred and draw upon the assets within local communities	Increase the number of NHS institutions recognising and using their anchor status, make better use of the Social Value Act, and the indirect economic effect of NHS spending in a place.
Ensure that NHS staff have access to training about poverty to influence their relationship with those at risk of or currently experiencing poverty	Ensure accessibility of universal services for all and develop targeted services for those experiencing poverty and use a personalised approach to providing access to care for different individuals.
Develop better ways to identify people experiencing poverty or at risk of poverty	Use digital innovation to widen access (whilst being mindful of the potential to further entrench inequalities)
Advocacy	Strengthen integration between health and social welfare services
Advocate for ICS's and NHSE/I to use their organisational power to speak out on a range of issues that impact upon poverty.	Develop metrics that are appropriate for identifying meaningful outcomes from work aiming to address poverty
Amplify the voice of the NHS workforce as advocates for anti-poverty action	Recognise and maximise the role of the NHS as a 'good' employer
Partnership and Leadership across Wider Systems	
Cross –sector partnerships for tackling poverty	

4. ACTION IN GM TO DATE

4.1 A great deal of action has already taken place within the GM Health and Care system. The health and care system is also providing support to a range of partners in tackling poverty and mitigating the impacts of the cost-of-living crisis.

4.2 Localities and VCSE colleagues have worked extensively on developing joined up responses at a locality level and are already providing support to individuals adversely impacted by the cost-of-living crisis.

4.3 This has then been supported by activity that is taking place at a system level.

4.4 The following list is not exhaustive but provides examples of some of the activity that has taken place to date at system level, recognising that all localities are also deeply engaged on this agenda.

a) The **GM Population Health Board** carried out a deep dive into health, poverty and cost-of-living at its September meeting. The Board agreed a priority set of actions covering the short, medium, and long term. These included:

- Advocate for cost of living and poverty to be included as key considerations within the health and care winter planning process for 2022/23. With a key focus on maximising signposting opportunities to benefits and debt advice, improving uptake of free prescriptions, patient transport and action to address cold homes.

- Ensure that poverty and cost of living is a prominent feature of the emergent GM Integrated Care Partnership Strategy and the GM Build Back Fairer Framework

- Agree and disseminate a single shared narrative around the impact of poverty and health in Greater Manchester

- Assess the feasibility and desirability of voluntarily adopting the socio-economic duty across NHS GM, GMCA and Local Authorities in GM (including engaging with colleagues from Wales and Scotland who have already made this a statutory requirement, and with localities who have already adopted the duty on a voluntary basis)
- Systematically review the GM health and care approach to poverty through the lens of the recommendations made by the Kings Fund in their publication – '*The NHS's Role in Tackling Poverty*' - and explore the feasibility and desirability of NHS GM developing an anti-poverty strategy

- Continue to advocate for NHS GM becoming a Real Living Wage employer, and for the NHS to require this of its supply chain

- Strengthen the way in which health and care organisation work together to optimize and expand their role as anchor organisations, and to maximise the social value that can be elicited from the health and care sector

- Continue to engage with central government on opportunities to tackling the structural causes of poverty and inequality in Greater Manchester

- Explore the feasibility of implementing policies approaches which will deliver significant population level impact on health outcomes, such as water fluoridation

b) NHS GM is represented in the **GM Cost of Living Group** through the Population Health and Strategy / Innovation function, alongside localities, VCSE partners, and the Growth Company. The primary purpose of the group for stakeholders to come together to share good practice, consider trends and escalate common issues related to the cost-of-living crisis. The Group has developed a **GM Cost of Living Dashboard** although this does not currently contain any Health and Care measures. Cost of Living is now a standing item at the monthly GM Combined Authority meeting.

c) A single point of information – **Helping Hand** - has been established to support residents and professionals to access accurate and timely advice and guidance. There is an opportunity to expand NHS GM representation at this group, particularly in relation to the clinical voice, equality / diversity / inclusion, people and culture, and social care transformation.

d) The **GM System Operational Response Taskforce (SORT)** group has coordinated a mapping exercise with localities on responses to the cost-of-living crisis. As part of this process, localities requested a GM level analysis of medical devices used at home that may be impacted by rising energy prices along with the average costs of running these.

Localities described a range of work underway to enable residents to access all direct financial support available to support their health and well-being.

e) The **PFB Directors of Strategy Group** is drawing on research and analysis from the King's Fund (see framework above) and Health Foundation on poverty and the cost of living to develop a framework to capture the contribution of trusts to this agenda. **The PFB Chief Operating Officers Group** is working on the impact of energy costs on patients and medical devices in people's homes and PFB is also looking at patient transport costs for elective care.

f) The **GM Directors of Adult Social Care** are focusing on ensuring a sustainable workforce and care market as well as supporting carers, and actions are being taken forward as part of integrated locality plans. In addition, significant action at GM level is underway as part of the Adult Social Care Transformation programme.

g) The **GM People Board for Health and Care** has key commitments in its upcoming strategy on good employment, attraction and retention of a health and care workforce, workforce wellbeing and paying the minimum of a real living wage. NHS GM's People and Culture team have representatives who sit on the GM Good Employment Charter Board and the Real Living Wage Board and funding has been secured to establish a Community of Practice of health and care employers to support them to become members of the Charter and pay the real living wage, as well as other employment standards such as secure and flexible work with a commitment to looking after staff health and wellbeing.

h) **The GM Workforce Wellbeing Programme** delivers a programme of workshops and masterclass sessions to support individual financial wellbeing, as well as promoting financial wellbeing resources which collates practical support and links to support colleagues with the cost of living, by focusing on financial housekeeping: food use, debt management and fuel costs. Individual organisations also have their own support packages available and are promoting local provisions. The GM People Board will continue to look at supporting best practice in this area.

i) The **GM Ageing Hub**, in partnership with GM Housing Providers, have been leading a proactive campaign to ensure that as many older adults as possible are applying for **Pension Credit**, as it is estimated that 36,000 eligible households are not currently claiming this in GM (a third of those who are eligible), equating to £70million per year of unclaimed credit across the city-region.

j) The NHS GM Population Team is supporting a GMCA-led piece of work which is using **modelled postcode level income and expenditure data** to highlight geographic areas that are at greatest risk from the predicted increases in household expenditure. This will enable the effective targeting of enhanced support to the areas that are likely to need it the most.

k) The NHS GM Population Health Team has also collaborated with GM Poverty Action on the refresh and enhancement of the **GM Poverty Monitor**

l) NHS GM has co-invested in the production of a GM "**Winter Wise**" guide aimed at providing advice and guidance to older adults and those who support them around staying

well, staying warm and staying safe. This includes a significant amount of advice and guidance around the cost-of-living impacts. 50,000 copies have been earmarked for NWAS to distribute via patient transport service, but there are opportunities to consider additional health and care distribution opportunities.

m) Local systems have sought to identify and establish community **"Warm Spaces"** to provide support to vulnerable people living within deprived neighbourhoods, but it is not clear whether any of these are within the health and care system estate.

5. OPPORTUNITIES FOR FURTHER ACTION

5.1 The ongoing actions described in (4) will all contribute to easing the pressures faced by our residents. However, given the severity of the crisis, there will be additional actions that we need to pursue.

5.2 Some potential options, based upon engagement within the Health and Care system (including senior clinicians), and with key stakeholders who sit outside it, are outlined below, and are separated into steps that can and should be taken immediately and steps which can be commenced immediately, but will take longer to realise and which require wider system change.

5.3 This report does not consider the full range of long-term actions in relation to tackling poverty as a cause of ill health in Greater Manchester.

5.4 Immediate Actions:

a) NHS GM to broaden representation (including from clinicians) at the GM Cost of Living response Group as part of ensuring a whole system response to the Cost-of-Living crisis.

b) NHS GM and the wider health and care system to contribute to the monthly Cost of Living update that is being produced for the GM Combined Authority, to bring the same monthly update to ICP Board and ICB, and to ensure it is cascaded through other significant parts of the GM health and care system such as place based leads and provider collaboratives.

c) NHS GM and the wider health care system to work with the GMCA to strengthen the current Helping Hand online platform and to increase awareness if it across to entire health and care system.

d) NHS GM to work with GMCA to incorporate appropriate health and care measures into the GM Cost of Living Dashboard.

e) NHS GM Place Based leads to engage with provider trusts to explore whether any further action can be taken to increase awareness of, and utilisation of, hospital transport offers to ensure people do not miss appointments because of travel costs.

f) NHS GM to write to NHS England to advocate for a monthly payment plan to be introduced for the pre-payment prescription scheme to increase affordability. This will support the "*squeezed middle*" who pay for prescriptions and where the only option at present is a 3

month or 12month pre-payment certificate for which payment is due as a single lump sum.

g) NHS GM to assess the feasibility of 'topping up' electricity payments for vulnerable people who have medical devices in their homes.

h) NHS GM Place Based leads to continue to engage with local partners in relation to patients at increased risk of deterioration, or hospital admission / readmission due to a cold home or the inability to afford to maintain a healthy diet.

i) NHS GM to utilise its channels and networks to amplify ongoing work aimed at connecting people to additional support that they are eligible for with a particular focus on Pension Top Up and Healthy Start vouchers and ensuring that practitioners working with the eligible cohorts are systematically seeking to support people to maximise their income.

j) As part of ongoing winter planning at GM and locality level, NHS GM to explore options for non-recurrently bolstering VCSE capacity and capability to support vulnerable people during Q3 and Q4 2022/23.

k) Once the data is available, health and care colleagues should seek to develop enhanced or targeted approaches in those geographic areas that are at greatest risk from the predicted increases in household expenditure.

l) GM health and care stakeholders to consider opportunities for distribute the GM Winter Wise guide for older adults and advise the GM Ageing Hub of requirements.

m) NHS GM Place Based leads to review the opportunities for local health and care facilities to be used as designated "warm spaces".

5.5 Ambitions for wider system change:

a) NHS GM to self-assess the extent to which it is a 'good employer' as set out in the GM Good Employment Charter, including progressing ongoing work around becoming a Real Living Wage employer and applying this standard to its supply chain.

b) NHS GM to consistently consider Social Value within procurement and contracting in order to maximise the potentially positive impact of health and care spend within local communities, and in a way which is aligned to the ambitions of the GM Social Value Framework.

c) "*Poverty proof*" health and care in Greater Manchester including:

- Reviewing health and care pathways to consider the extent to which they disadvantage people living in poverty, and/or the extent to which they seek to alleviate poverty, and/or the extent to which they take an approach which mirrors to principle of "proportionate universalism".

- Build a 'cost of living enquiry' into each long-term condition review

d) Ensure that VCSE investment and development is a consideration within the NHS GM

Functional Review and budget planning for 2023/24.

5.6 Board members should also use their experience and expertise to identify additional actions and ambitions.

6. NEXT STEPS AND RECOMMENDATIONS

6.1 The Greater Manchester Integrated Care Partnership Board is asked to:

- Note the content of this report and discuss the implications of the content for health and care in Greater Manchester.
- Agree the proposed actions set out in 5.4 and 5.5.
- Identify other opportunity for action to mitigate the impact of the cost-of-living crisis on health outcomes and health and care services in GM.

This page is intentionally left blank

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester
Integrated Care Partnership Board

Date: 28th October 2022

Subject: Developing the GM ICP Strategy

Report of: Warren Heppolette – Chief Officer – Strategy and Innovation

---

PURPOSE OF REPORT:

- To update the Integrated Care Partnership Board on the development of the ICP Strategy and to confirm support for the next steps.

KEY ISSUES TO BE DISCUSSED:

- The involvement of the ICP Board in the continued development of the ICP strategy

RECOMMENDATIONS:

GM ICP Board is asked to:

- Note the update on the ICP Strategy development
- Review and support the plans for the next steps

THE GM ICP STRATEGY

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[1] as setting "*the direction of the system … setting out how commissioners in 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*". 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*"

1.2. 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.

1.3. The ICP 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[2]), seeking to develop GM as "*a greener, fairer and more prosperous city-region*".

1.4. 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.*

1.5. 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[3] as part of the devolution of health and care funding to GM - and is anticipated to be of a similar length and level of detail at about 40-50 pages.

1.6. 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 will align with:

---

1 https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies
2 https://aboutgreatermanchester.com/
3 https://www.greatermanchester-ca.gov.uk/media/1120/taking-charge-of-our-health-and-social-care-plan.pdf

- The four objectives for Integrated Care Systems specified by NHS England[4].
- 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.

1.7. The health and care system (the ICS) both contributes to a range of commitments within the GMS, as well as benefitting from others e.g., the commitment to "*delivery of resilient, safe, and vibrant communities*" which benefit the population and those working in the health and care sector, including provider organisations.

1.8. The scale and scope of activity to improve the health and wellbeing of the population across the NHS, its partners and the wider public sector in GM is vast. It is therefore crucial that we are clear on the scope of the ICP strategy

1.9. The shared outcomes, commitments, and ways of working in the ICP Strategy will be a common framework for reference for all plans and strategies. It will not describe in detail the full range of the ICP's activities over the next five years, but will confirm, through its development and prioritisation, a small set of 'grand challenges', central to our vision and to making a difference so that people in GM can live a good life

1.10. 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*"[5].

2.0 STRATEGY FRAMEWORK

2.1. A framework for the ICP strategy has been agreed as framing for the discussion and analysis needed across the system. The strategy will comprise a set of shared outcomes: "*the Greater Manchester we want to see*" and a set of shared commitments "*Together we will …*", 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

---

[4] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

[5] https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

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 shared outcomes – "*the Greater Manchester we want to see*" – are:

A GM where everyone …

- Has a fair opportunity to live a good life
- Experiences high quality care and support where and when they need it
- Has improved health and wellbeing
- Works together to make a difference now and for the future

2.4. These outcomes are inter-related, and no one outcome can be achieved without the others.

2.5. Enabling everyone in GM to have a fair opportunity to live a good life will require system partnership across all the things that determine health and good lives, with a focus on equity and equality. The commitments made by the GM system within the GMS are important here – for example in relation to transport and employment.

2.6. Enabling everyone to experience high quality care and support when and where they need it can only be achieved through consideration of service provision, and the elimination of unwarranted variation, from hospital to general practice, and the wider care system. Much of this will be the responsibility of the GM Integrated Care Board (ICB), the statutory NHS organisation for GM, working with its system partners including local authorities and VCSE organisations.

2.7. Improving health and wellbeing will be achieved through good lives and high quality services, but also through preventing people becoming unwell, and supporting them to live well in their communities. The role of people in their own health and wellbeing is also a factor in this outcome.

2.8. Working together is a fundamental objective of any integrated care system, and the experience of partnership working within GM before and since devolution is a strong basis for further development. The rationale for working together is to make a difference for all, with a future focus on using all our resources effectively.

2.9. For each of these outcomes, a series of shared commitments have been developed - "*Together we will …*" – things that can only be achieved by the system working in partnership.

2.10. A GM where everyone … has fair opportunity to live a good life

Together we will …

- Ensure our children and young people have a good start in life
- Support good work and employment

- Enable local environments which support good health for everyone
- Play a full part in tackling poverty and long-standing inequalities

2.11. A GM where everyone … experiences high quality care and support where and when they need it

Together we will …

- Ensure that health and care services are accessible
- Reduce unwarranted variation in access and experience of care
- Use technology to improve care for everyone
- Drive continuous improvements in the availability and quality of care
- Ensure we have a sustainable workforce that is supported to provide the best possible care

2.12. A GM where everyone …has improved health and wellbeing

Together we will …

- Enable everyone to have a healthy lifestyle
- Use the strengths of communities to enable wellbeing

2.13. A GM where everyone … makes a difference now and for the future by working together

Together we will …

- Build trust and collaboration between partners to ensure co-ordinated services
- Ensure that all our services recover from the effects of the pandemic as effectively and fairly as possible
- Secure a greener Greater Manchester
- Ensure that health and care organisations play their part in social and economic development
- Manage public money well to achieve our objectives and ensure value for money
- Be at the forefront of innovation and discovery in health and care

2.14. We are currently identifying how we will work together as a system to achieve these outcomes and commitments, and discussion of the 'ways of working' within the ICP Board will be vital in achieving our ambitions for GM.

2.15. We will be explicit about 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, will be articulated in the strategy.

2.16. We will also, as a system, describe and affirm the 'grand challenges' that we will prioritise to enable people in GM to live good lives. A process for identifying

these, so that they can be included in the Engagement draft (see section 5.1) for system consideration, is under way.

3.0 PROCESS OF DEVELOPMENT

3.1. We have already established a strategy working group comprising a range of stakeholders from across the system, including localities, which has met monthly since March this year, to support this strategy development work.

3.2. This group developed the outcomes and commitments (see section 2.0) and is now considering on the ways of working as well as the prioritisation of key activities prior to producing a draft of the strategy for system consideration (see section 5.1). The process of prioritisation will include consideration of what has been learned from the last 7 years as well as the current challenges facing the ICS and the population at large.

3.3. The development process also includes analysis of data which identifies the needs of the population, as required in national guidance, engagement with stakeholders across the system, including the public, and links to the latest plans for the constituent parts of the system.

3.4. Initial analysis of locality plans and data on population need within localities reinforces the shared commitments as a description of the system activities needed to address the overall outcomes.

4.0 CURRENT ENGAGEMENT ON THE STRATEGY

4.1. 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.*".

4.2. Early engagement from March to May this 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.

4.3. A second phase of engagement with communities and localities is currently taking place (due to be complete in mid-November) supported by the VCSE and Healthwatch. A set of questions being used in this engagement have been co-produced:

1. *FOR COMMUNITY GROUPS: What would make the biggest difference for communities you serve in relation to being healthier, happier, and better?*

   FOR INDIVIDUALS: What would make the biggest difference to your life in relation to being healthier, happier, and better?

2. *What's stopping this?*

3. *What would help this?*

4. What's the most important thing health and care services need to improve?

4.4. Engagement will include conversations with at least sixteen community/voluntary/charity/social enterprise organisations in each locality, a series of conversations within each locality targeting people currently engaged with the health and care system, conversations with pan-GM communities of identity organisations and networks, not all of whom are engaged with services, and focus groups convened in each locality by the local Healthwatch organisations.

4.5. The results of this engagement will be available in late November and will be considered alongside feedback from the Engagement Draft (see section 5.1) to inform the final strategy document.

5.0 THE NEXT STEPS

5.1. We are working to produce an 'Engagement Draft' of the strategy in November for formal consideration by partners across the GM system.

5.2. The partners in the ICP, including the VCSE, Local Authorities, Trusts, Health Innovation Manchester, the GMCA, Primary Care, Social Care etc. will have the opportunity to influence the strategy through consideration of the Engagement draft in their own organisations and sectors. Plans for staff engagement over the same period are being developed with the GM Workforce Engagement Forum

5.3. The plan is to issue the draft to all ICP partners in late November, inviting consideration and comments during December and early January, with a mid-January deadline for feedback. A final version with then be presented for formal approval by the ICP Board in February. At present these is no date confirmed for submission of the strategy to NHSE.

5.4. The Engagement draft will comprise the shared outcomes: "*the Greater Manchester we want to see*" , the shared commitments "*Together we will …*", supported by a description of how we will work together ("*Ways of Working*") and a set of key priorities and high-level progress measures. It will also summarise the key challenges facing the GM ICP and how the strategy will seek to address them.

This page is intentionally left blank