Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

JOINT MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE AND GMCA OVERVIEW & SCRUTINY COMMITTEE

DATE: **Wednesday, 8th November, 2023**

TIME: **10.00 am**

VENUE: **Boardroom, Greater Manchester Combined Authority, Tootal Buildings, 56 Oxford Street, M1 6EU**

AGENDA

1. APOLOGIES FOR ABSENCE

2. CHAIR'S ANNOUNCEMENTS AND URGENT BUSINESS

3. DECLARATIONS OF INTEREST 1 - 4

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.

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'S WORK TO TACKLE HEALTH INEQUALITIES 5 - 90

Presented by Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester and Jane Pilkington, Director of Population Health, (NHS GM).

5. DATES AND TIMES OF FUTURE MEETINGS

- Joint Health Scrutiny Committee – 17 January 2024 at 10.00 am, GMCA, Boardroom.
- Overview & Scrutiny Committee – 22 November 2023 at 1.00 pm, GMCA, Boardroom.

Greater Manchester Joint Health Scrutiny Committee Membership 2023/24		
Name	**Organisation**	**Political Party**
Councillor Andrew Morgan	Bolton Council	Conservative
Councillor Elizabeth FitzGerald	Bury Council	Labour
Councillor Zahid Hussain	Manchester City Council	Labour
Councillor Eddie Moores	Oldham Council	Labour
Councillor Patricia Dale	Rochdale Council	Labour
Councillor Samantha Bellamy	Salford City Council	Labour
Councillor David Sedgwick	Stockport Council	Labour
Councillor Naila Sharif	Tameside Council	Labour
Councillor Sophie Taylor	Trafford Council	Labour
Councillor Ron Conway	Wigan Council	Labour

GMCA Overview & Scrutiny Committee Membership 2023/24		
Name	**Organisation**	**Political Party**
Councillor Peter Wright	Bolton Council	Independent
Councillor Nadim Muslim	Bolton Council	Conservative
Councillor Russell Bernstein	Bury Council	Conservative
Councillor Imran Rizvi	Bury Council	Conservative
Councillor Basil Curley	Manchester City Council	Labour

Councillor John Leech	Manchester City Council	Liberal Democrat
Councillor Mandie Shilton-Godwin	Manchester City Council	Labour
Councillor Jenny Harrison	Oldham Council	Labour
Councillor Colin McLaren	Oldham Council	Labour
Councillor Patricia Dale	Rochdale Council	Labour
Councillor Tom Besford	Rochdale Council	Labour
Councillor Joshua Brooks	Salford City Council	Labour
Councillor Lewis Nelson	Salford City Council	Labour
Councillor Helen Hibbert	Stockport Council	Labour
Councillor Naila Sharif	Tameside Council	Labour
Councillor Jill Axford	Trafford Council	Labour
Councillor Shaun Ennis	Trafford Council	Liberal Democrat
Councillor Nathan Evans	Trafford Council	Conservative
Councillor Joanne Marshall	Wigan Council	Labour
Councillor Fred Walker	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 23 October 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 interest 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 (e.g., employment, trade, profession, contracts, or any company with which you are associated).
2. You and your partner's wider financial interests (e.g., 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 and Scrutiny 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 interest, you must:

1. Notify the Governance and Scrutiny 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.

Joint Meeting of the Greater Manchester Joint Health Scrutiny Committee and GMCA Overview & Scrutiny Committee

Date: 8 November 2023

Subject: Fairer Health for All: Our Co-ordinated Response as a City Region to Reducing Health Inequalities

Report of: Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester and Jane Pilkington, Director of Population Health (NHS GM)

Purpose of Report:

This meeting of the GM Joint Health Scrutiny Committee and GMCA Overview and Scrutiny Committee will focus on creating Fairer Health for All: our co-ordinated response as a city region to reducing health inequalities.

This paper outlines opportunities for partners to input and shape priorities for co-ordinated action on health inequalities across Greater Manchester, responding to the proposed principles, priorities, targets, and metrics in the Greater Manchester Fairer Health for All Framework.

Recommendations:

The committee members are requested to review and comment on the Fairer Health for All framework Engagement Draft and engagement questions, specifically:

1. What are your thoughts on the key goals, targets, and metrics we have identified in chapter 9? Are there any headline ambitions or key metrics that are missing or that require different emphasis?

2. Have we correctly identified the priorities – are there any that are missing or require a different emphasis?
3. If we collectively implement the proposals set out in the framework, how will this make a positive difference to your experience of achieving Fairer Health for All either as a provider, service user or delivery partner? What could be added to framework to improve on this?
4. Do you have any other views on the framework?

Contact Officers:

Paul Lynch, Director of Strategy and Planning, NHS Greater Manchester

paul.lynch@nhs.net

Dr Deborah Thompson – Public Health Consultant, NHS GM

Debs.thompson@nhs.net

Andrea Crossfield - Population Health Consultant, on behalf of NHS GM

a.crossfield@icloud.com

Background Papers

The Greater Manchester Integrated Care Partnership Strategy was approved by the ICP Board in March 2023 and is underpinned by a Joint Forward Plan which was signed of in June 2023.

Tracking/ Process

Does this report relate to a major strategic decision, as set out in the GMCA Constitution

Yes

Exemption from call in

Are there any aspects in this report which means it should be considered to be exempt from call in by the relevant Scrutiny Committee on the grounds of urgency?

No

GM Transport Committee

N/A

Overview and Scrutiny Committee

N/A – joint meeting

1. Introduction/Background

The Fairer Health for All framework sets out a collaborative approach and priority action across the system, aimed at advancing equity, inclusion, and sustainability whilst delivering health and care services that better meet the needs of the communities we serve.

Fairer Health for All has been co-produced through extensive locality and community participation and engagement over the past fifteen months, which has taken place alongside the development of NHS Greater Manchester's Integrated Care Partnership strategy and our Five Year Joint Forward Plan. It prioritises coordinated action to deliver against the six strategy missions and a roadmap for how we will:

- Work together to fulfil statutory NHS responsibilities such as unlocking social and economic potential and delivering against Core20Plus5 inequalities targets.
- Enhance and embed prevention, equality, and sustainability into everything we do as a health and care system.
- Tackle the discrimination, injustice and prejudice that lead to health and care inequalities.
- Create more opportunities for people to lead healthy lives wherever they live, work, and play in our city-region.

2. Engagement

The full engagement draft of the Fairer Health for All Framework (see Appendix 1) sets out the process of engagement to date as well as initial outputs of work. Its purpose is to provide as much opportunity as possible for the final version to be informed and shaped by our colleagues from the VCFSE sector and our service users, partner agencies, practitioners, staff, and leaders from across all ten localities, in the way it has been co-produced over the fifteen months to date.

We welcome all comments and will be engaging directly with all stakeholders to provide a space for feedback on the following 4 key lines of enquiry:

1. What are your thoughts on the key goals, targets, and metrics we have identified in chapter 9? Are there any headline ambitions or key metrics that are missing or that require different emphasis?

2. Have we correctly identified the priorities – are there any that are missing or require a different emphasis?
3. If we collectively implement the proposals set out in the framework, how will this make a positive difference to your experience of achieving Fairer Health for All either as a provider, service user or delivery partner? What could be added to framework to improve on this?
4. Do you have any other views on the framework?

3. Fairer Health for All in Action

A slide deck is enclosed with this cover note (see Appendix 2) which explores in more detail:

a) An overview of the key missions in the Integrated Care Partnership Strategy which collectively will reduce health inequalities by enabling a social model for health and a strategic shift towards prevention.

b) Summary of Integrated Care System Operating Model and governance to ensure tackling health inequalities is everybody's business and part of the 'way we work'.
c) Overview of priorities, principles, and tools in the Fairer Health for All Framework which enable co-ordinated action and delivery of Joint Forward Plan.
d) A deeper exploration of a small number of 'flagship' areas that show Fairer Health for All in action.

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Joint Health Scrutiny & Overview and Scrutiny Committee meeting

Greater Manchester Integrated Care Partnership

Creating Fairer Health for All: Co-ordinated action across the city-region to tackle Health Inequalities

8 November 2023

Summary of Report

a) An overview of the key missions in the Integrated Care Partnership Strategy which collectively will reduce health inequalities by enabling a social model for health and a strategic shift towards prevention

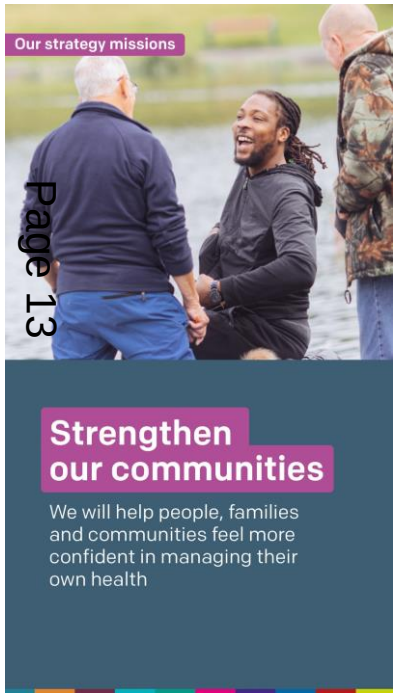
b) Summary of ICS Operating Model and governance to ensure tackling health inequalities is everybody's business and part of the 'way we work'

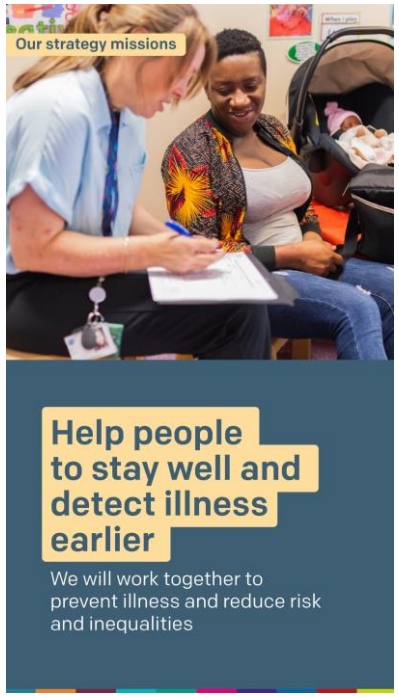
c) Overview of priorities, principles and tools in the Fairer Health for All Framework which enable co-ordinated action and delivery of Joint Forward Plan

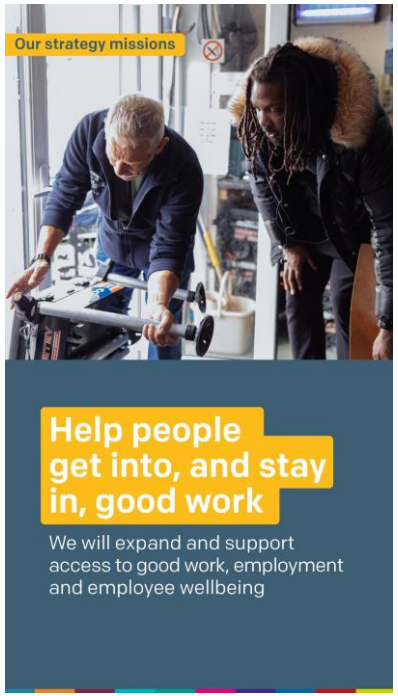
d) Fairer Health for All in action: A deeper exploration of a small number of 'flagship' areas:

- **Strengthening Communities** - Live Well, Best Start in Life
- **Helping People Stay Well and Detecting Illness Early**:
- Prevention and Early Detection Framework enabling delivery of comprehensive prevention programmes at scale (Making Smoking History, Ending All New Cases of HIV in Greater Manchester by 2030, Early Cancer diagnosis, CVD Prevention)
- Primary Care Blueprint enabling shift to social model of health, development of inclusion health standards and delivery of workforce development that supports person centred, trauma responsive care that 'makes every contact count'
- **Help People Get into and Stay in Good Work**: Working Well programme and GM Anchor network
- **Recover Core Health and Care Services** NHS GM Clinical Effectiveness Programmes

Our Strategy Missions – Overview







How we will work together

“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”

Understand and tackle inequalities
through taking action at individual, team, organisation, and system levels

Share risk and resources
through setting out our expectations of each other, supporting joint working with resource and a culture of collaboration at every level and in every place

Involve communities and share power
through taking a strengths-based approach

Spread, adopt and adapt
through sharing best practice effectively, testing and learning, celebrating success, with supportive governance and resources in organisations and across systems.

Be open, invite challenge, take action
through being honest, consistent and respectful in working with each other, within a compassionate environment.

Focus on names not numbers
through ensuring we listen to all people, putting the person at the centre.

Achieving these outcomes

This is our core work as a system – underpinning all that we do

Together we will …
✓ 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
✓ Make 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 COVID-19 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

Responding to the challenges: Embedding our Model for Health

Greater Manchester Integrated Care Partnership

Greater Manchester ICS Operating Model: Summary

This Operating Model sets out how partners in GM ICS will work together to improve outcomes for people living in Greater Manchester

Purpose of this document

The Greater Manchester Operating Model outlines how NHS GM will work to provide health and care services based on the needs of Greater Manchester's population – harnessing the benefits of integrated care. These include:

- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experience and access
- **Enhance productivity** and **value for money**
- Help the NHS support **broader social** and **economic development**

Components of this operating model consist of:

Vision	The vision of GM ICS, setting out the future we are trying to make happen
Missions	A set of statements which outline how GM ICS will deliver the overall vision for the system
Values	The values the need to be held by people working in GM ICS for it to be successful
Behaviours	The behaviours needed to underpin the values
Operating principles	The principles that the model needs to adhere to, to enable effective operations

The system architecture and roles in the system	The roles of the different elements of GM ICS, the way partners within the system collaborate, and the interrelations between the different structures in the system
The organisation of functions	How the functions are transacted, and responsibilities are discharged including where that is in collaboration
Governance arrangements	The manner in which decisions are made within the system, and the associated flows of accountability

This operating model has been co-designed with involvement from ICB colleagues and wider ICS partners. This document will articulate the GM vision, new system architecture and the future ways of working arrangements, including a detailed roadmap to get there. Please note that this model is deliberately flexible to allow for iterations and development in the future.

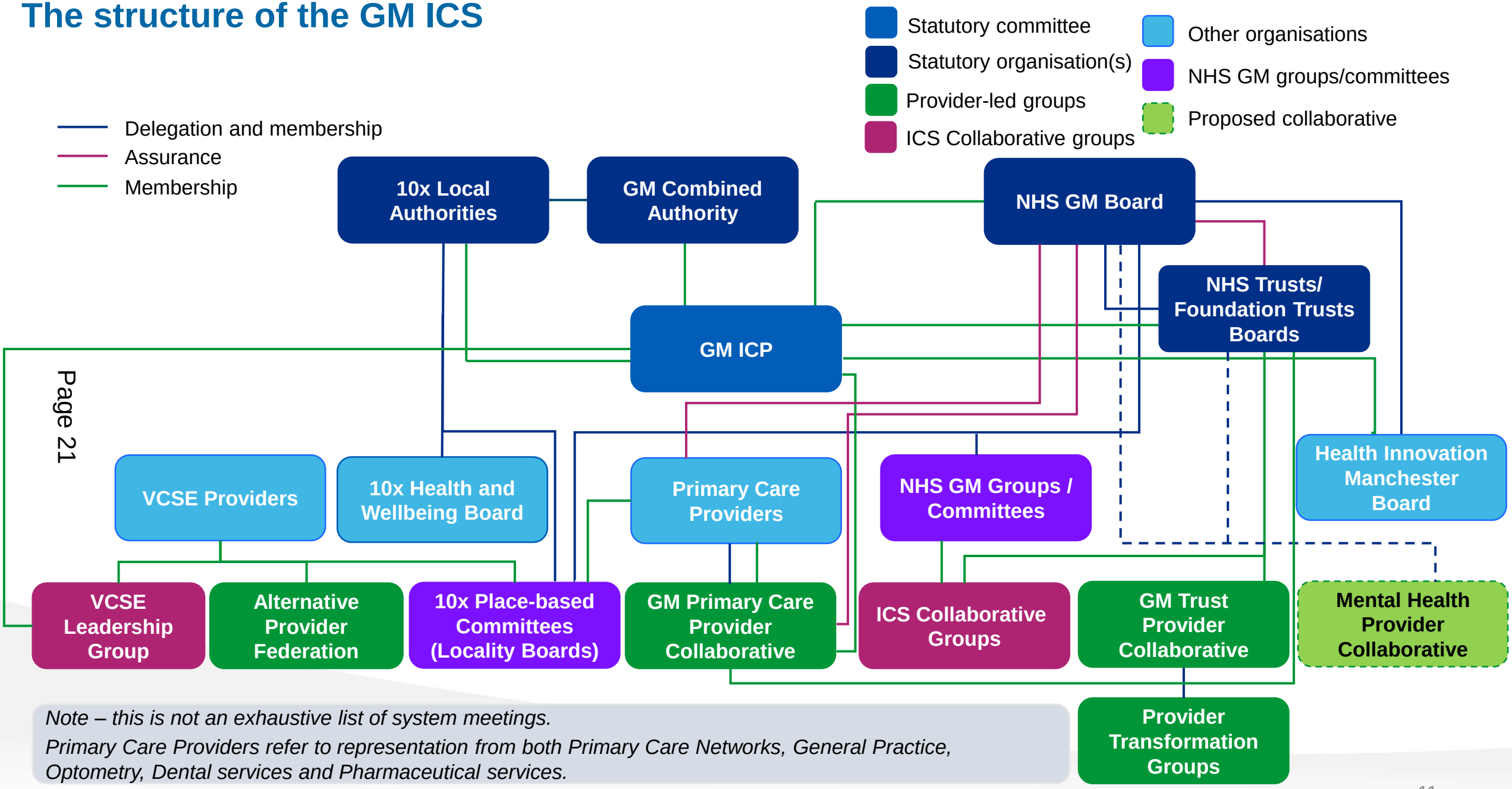
To ensure the smooth transition into the new operating model, there must be a process of engagement with wider ICB staff and ICS partners for colleagues to socialise and familiarise with the new arrangements and structures.

Who's Who in the Greater Manchester Integrated Care System (ICS)

The operating model brings together health and care organisations, local authorities and other partners which operate within GM ICS. They include:

NHS GM	The Greater Manchester-wide NHS body in the ICS – referred to in guidance as an Integrated Care Board (ICB)
Local Authorities	Greater Manchester has ten upper tier Local Authorities responsible for the provision of social care and other wider public sector services
GM Combined Authority	The GMCA has 11 members, including ten directly elected councillors from the GM metropolitan boroughs and the Mayor of Greater Manchester
Acute Care Providers	Includes services such as accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery in Greater Manchester
Primary Care Providers	Provides the first point of contact in the healthcare system, and includes General Practice, Community Pharmacy, Dentistry and Optometry services
Voluntary, Community or Social Enterprise Organisations	Charities, public service mutuals, social enterprises, and many other non-profits playing a key role in improving health, well-being and care outcomes as partners to statutory health and social care agencies
GM ICP	The partnership body of the ICS – referred to in guidance as an Integrated Care Partnership (ICP)
Health and Wellbeing Boards	Brings together representatives from NHS, public health, social care and children's services and Healthwatch to plan health and social care services
Place-based Partnership Committees	The collaboration of health, care and voluntary sector providers in each of the 10 localities, represented in the Greater Manchester ICP, and reporting to NHS GM
Neighbourhoods	Integrated Neighbourhood teams that work to inform commissioning of services and provide holistic care for people locally, also include the work of Primary Care Networks
GM Trust Provider Collaborative	A membership organisation made up of the 11 NHS Trusts and Foundation Trusts who provide NHS funded services across Greater Manchester
GM Mental Health Provider Collaborative	A group bringing together all mental health providers in GM to support transformation and commissioning of mental health services at scale
GM Primary Care Provider Collaborative	Formal, structured collaboration between primary care providers in Greater Manchester, collaboratively setting strategy, driving decision making and assuring delivery as an active partner all levels of the ICS
GM Alternative Provider Federation	A three-way collaboration agreement between the GM Combined Authority, ICS and GM VCSE Leadership Group, working towards a greater role for social businesses and charities within the NHS
Health Innovation Manchester	GM's integrated innovation organisation, HInM includes the GM AHSN, the MAHSC, the Manchester NIHR Applied Research Collaborative and the GM health & care digital transformation office, leading collaboration with industry and academia

The structure of the GM ICS



Note – this is not an exhaustive list of system meetings.

Primary Care Providers refer to representation from both Primary Care Networks, General Practice, Optometry, Dental services and Pharmaceutical services.

The ICP (a statutory committee)

The **GM Integrated Care Partnership** is responsible for developing the ICS strategy, providing direction for Greater Manchester and the plan for how we meet the wider health and care needs of people in GM.

NHS GM (a statutory organisation)

NHS GM holds overall responsibility for system performance and commissioning of NHS services across the ICS. It is governed by a board with representation from multiple sectors, and a series of committees support focused delivery of the board's responsibilities

GM Place-based Partnership Committees

Our 10 **Place-based Partnership Committees** arrange and deliver health and care services within a local area, combining resources to improve population health and tackle inequalities. They are not statutory bodies and have no legal requirements detailed in The 2022 Health and Care Act, leaving flexibility for local areas to determine their form and functions. They each have a Place-based Lead to represent NHS GM at place, while also representing their place interests at NHS GM.

Neighbourhoods

GM has 66 **Neighbourhoods** who support delivery of the plans that are co-designed within place. Multidisciplinary teams from across primary care, secondary care, social care, community groups and the voluntary sector offer varied perspective and detailed knowledge of population needs which they can use to maximise the use of resources within a local area.

Provider Collaboratives

We have four **Provider Collaboratives** – Trust, Mental Health, Primary Care and Alternative Provider Collaboratives – who each work together to deliver sustainable services at scale as well as drive service and pathway redesign to improve access, quality and performance, whilst reducing inequalities.

NHS GM responsibilities are overseen by the executive team with individuals holding delegated responsibilities for functions

Board member

Board attendee

Chair	Provides leadership to NHS GM, holding the board account for delivering on their responsibilities and ensuring they operate effectively
Chief Executive	Overall accountability for ICS performance – including, development and delivery of the joint forward plan, budget allocation, performance oversight and commissioning of services
Chief Financial Officer	Leads on financial control for NHS GM and the NHS in GM, resource allocation for commissioning and establishing funding streams
Chief Nursing Officer	Provides clinical leadership and joint oversight of system service quality. Professional leader for midwifery, nursing and AHPs
Chief Medical Officer	Provides clinical leadership and joint oversight of system service quality. Medical professional leader. Clinical advisor to system partners
Chief Officer for Commissioning, Population Health and Inequalities	Leads the commissioning of GM-level services and supports delivery of public health and population health management across the ICS
Chief Operating Officer	Responsible for performance and transformation oversight across the NHS in GM, including leading the system delivery unit
Chief People Officer	Leads and coordinates the system response to the NHS people plan, the GM People and Culture Strategy and is responsible for NHS GM staff recruitment, development and wellbeing
Chief Officer for Strategy & Innovation	Leads development of joint forward plan, system-wide action on data and digital, and communications & engagement
Place-based Leader (x10)	Represents and delivers on the functions of NHS GM at place, whilst speaking for interests of place and leading on place-based priorities

Draft Strategic Financial Framework

The Strategic Financial Framework

The Strategic Financial Framework covers:

- The demand for health and care services in GM over the next five years given current trends and how much it will cost the system to deliver on these requirements
- The opportunities to improve the health of our population
- How the change in population requirements will impact the demand on providers
- What the opportunities are for the more efficient delivery of this care
- The investments required to realise these opportunities and how quickly these can be realised
- The impact of these opportunities on the GM financial deficit

The Strategic Financial Framework is developed via a four-stage approach

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

The population segmentation enables division of the population by age band, place, and condition, showing 28% of the GM population experiences some aspect of poor health

Total population health baseline in 2022/23 for Greater Manchester

Cost per person

% of GM population

% of GM spend

Age	1 Good health	2 Maternity	3 Single LTCs	4 Multiple LTCs	5 Mental illness	6 Homelessness & substance misuse	7 Cancer	8 Frailty	9 Palliative care
	2.1m (71%) £1.3b (21%)	23.7k (0.8%) £110m (2%)	352.8k (12%) £690m(11%)	217.3k (7%) £1.0b (16%)	165.1k (6%) £1.0b (16%)	11.0k (0.4%) £234m (4%)	46.5k (2%) £444m (7%)	52.4k (2%) £1.2b (19%)	1.5k (0.1%) £116m (1%)
0-17 Pop: 520k Total Cost: £560m	Size: 442k £558 14.7% 4.0%	Size: 53 £3.7k 0.0% 0.0%	Size: 20k £2k 0.7% 0.6%	Size: 7.89k £4.3k 0.3% 0.5%	Size: 46.4k £4.5k 1.5% 3.4%	Size: 306 £21.0k 0.0% 0.1%	Size: 164 £29.9k 0.0% 0.1%	Size: 3.0k £6.6k 0.1% 0.3%	Size: 15 £49.1k 0.0% 0.0%
18-64 Pop: 2m Total Cost: £3.1b	Size: 1.53m £555 50.8% 13.7%	Size: 23.7k £4.6k 0.8% 1.8%	Size: 222k £1.7k 7.4% 6.1%	Size: 92.1k £4.1k 3.1% 6.1%	Size: 95.7k £6.7k 3.2% 10.4%	Size: 8.95k £20.7k 0.3% 3.0%	Size: 18.1k £9.5k 0.6% 2.8%	Size: 14.3k £19.9k 0.5% 4.6%	Size: 471 £84.4k 0.0% 0.6%
65+ Pop: 482k Total Cost: £2.6b	Size: 165k £1.2k 5.5% 3.2%	Size: 1 £255 0.0% 0.0%	Size: 111k £2.5k 3.7% 4.5%	Size: 117k £5.3k 3.9% 10.2%	Size: 22.9k £8.2k 0.8% 3.1%	Size: 1.7k £24.8k 0.1% 0.7%	Size: 28.2k £9.5k 0.9% 4.3%	Size: 35.1k £25.3k 1.2% 14.4%	Size: 1k £74.6k 0.0% 1.2%

From 2022/23, the health of the Greater Manchester population is deteriorating, with 13% fewer people in 'Good Health' Segments

Projected change in population segments from 2022/23 to 2027/28 for Greater Manchester

Upward trend
Downward trend
Limited/no movement
% of 22/23 GM population
% of 27/28 GM population

Age	1 Good health 2.1m –>1.9m (-13%)	2 Maternity 23k –>41k (+70%)	3 Single LTCs 353k -> 225k (-38%)	4 Multiple LTCs 217k –> 439k (+98%)	5 Mental illness 165k –>319k (+89%)	6 Homelessness & substance misuse 11k ->18k (+58%)	7 Cancer 47k –>69k (+46%)	8 Frailty 52k ->58k (+8%)	9 Palliative care 1.5k –>1.4k (-11%)
0-17 Pop: 5[illegible]k -> 547k (-20%)	↓ 14.7% / 12.9%	⇨ 0.0% / 0.0%	↑ 0.7% / 0.6%	↑ 0.3% / 0.5%	↑ 1.5% / 2.5%	⇨ 0.0% / 0.0%	↑ 0.0% / 0.0%	↑ 0.1% / 0.1%	⇨ 0.0% / 0.0%
18-64 Pop: 2.0m -> 2.4m (-7%)	↓ 50.8% / 44.6%	↑ 0.8% / 1.3%	↓ 7.4% / 6.1%	↑ 3.1% / 6.9%	↑ 3.2% / 6.5%	↑ 0.3% / 0.5%	↑ 0.6% / 0.9%	↑ 0.5% / 0.6%	⇨ 0.0% / 0.0%
65+ Pop: 482k –> 946k (+50%)	↓ 5.5% / 4.3%	⇨ 0.0% / 0.0%	↓ 3.7% / 4.5%	↑ 3.9% / 6.9%	↑ 0.8% / 1.5%	↑ 0.1% / 0.1%	↑ 0.9% / 1.3%	↓ 1.2% / 1.1%	⇨ 0.0% / 0.0%

Stage two of the SFF leverages patient-level linked data set in assessment of population health opportunities

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

Opportunity 1 focusses on keeping people in good health, and enabling people to manage long term conditions more effectively

Opportunity 1:
Reducing the growth in prevalence and progression of ill-health

Opportunities to reduce prevalence and incidence of ill health relative to baseline trend based on targeted prevention and early detection activities

What this opportunity covers

- This opportunity relates to the need for increased focus on prevention and improving population health outcomes for the residents of Greater Manchester
- The opportunity seeks to address the causes of ill health by considering the environments in which people live and work, and the experiences they have
- Reducing the prevalence of ill health and chronic conditions will see improvements in life expectancy and healthy life expectancy and slow the widening of inequalities

Benefits of this opportunity

- This opportunity will reduce the number of individuals that move between segments, particularly those that may drift out of the good health segment if this opportunity is not pursued
- Reducing the volume of individuals that become ill will allow for resource to be spent on those most in need and produce a saving to the system

Opportunity 2 focusses on optimising models of care to support population health

Opportunity 2: Optimising models of care

Opportunities to change a model of care to deliver more consistent proactive care to support effective population health management

What this opportunity covers

- This opportunity looks at how improving access to high quality care services can support effective population health
- The opportunity will understand how care delivery can have both a positive impact on the residents of Greater Manchester and also ensure services are affordable

Benefits of this opportunity

- This opportunity will consider how care could be delivered most effectively for each segment of the GM population
- Providing care more efficiently will be driven by improvement in population health management and also reduce the financial costs to the system if people are seen/supported by the most appropriate teams

Opportunity 3 focusses on reducing health inequalities across GM by improving health and care for the most disadvantaged communities

Opportunity 3: Improving care for the most disadvantaged communities

Opportunities to improve health and address and reduce disparities in care for people in deprived socioeconomic groups

What this opportunity covers

- This opportunity considers the inequalities in accessing different types of care between those who are most disadvantaged and the rest of the population
- By improving these inequalities, there will be an improvement in the general health of the population of GM

Benefits of this opportunity

- Delivering this opportunity will reduce the inequalities in care provision between those who are most deprived and the more affluent
- This will ensure that all residents of GM are seen in the most appropriate care setting, reducing the need for acute services which will improve outcomes and reduce costs to the system

Fairer Health for All

Fairer Health For All

Engagement Draft

Greater Manchester Integrated Care Partnership

What is Fairer Health for All?

- Framework that outlines our **approach to addressing root causes of ill health and inequalities** across the city-region
- **Consensus of priority action** across the system and **roadmap for how we will work together** to:
    - **fulfil statutory NHS responsibilities to create a greener, fairer, more prosperous city-region** and deliver **health and care services that better meet the needs of the communities** we serve
    - **enhance and embed prevention, equality, and sustainability into everything we do**
    - **tackle the discrimination, injustices and prejudice** that lead to health and care inequalities
    - create **more opportunities for people to lead healthy lives** wherever they live, work and play in our city region

Why is it needed? Deep rooted health inequalities

Greater Manchester Integrated Care Partnership

Inequalities at a glance in GM

There are **2.8 million people** in Greater Manchester

1.1 million of these residents live in the **most 10% deprived areas** of the UK

Female healthy life expectancy in GM is 60.9 years

Vs England average of 63.9

A female born in Salford could expect to live **9.5 years less** in good health than a female born in Trafford.

There are differences within localities too:

A woman living in Salford in the **most deprived neighbourhoods** can expect to live **11.1 years less** than a woman living in the wealthier neighbourhoods

Male healthy life expectancy in GM is 61.4 years

Vs England average of 63.1

A male born in Oldham could expect to live **10.3 years less** in good health than a male born in Trafford.

There are differences within localities too:

A man living in Salford in the **most deprived neighbourhoods** can expect to live **11.7 years less** than a man living in the wealthier neighbourhoods

68,200 people In GM are unemployed

5% compared to 3.5% UK average

117,400 residents are economically inactive due long term sickness. **30%** of our productivity gap is due to ill health

1/3 of the GM population are children and young people (CYP) **around 1 in 4 live in poverty**

40% of children living in poverty in GM **live in a smoking household**. Children living in a smoking household are **4 times more likely to start smoking**.

Asthma-related hospital admissions for CYP is consistently high in GM. **And 50% higher for CYP from disadvantaged GM communities.** Twice the rate of the national average.

8

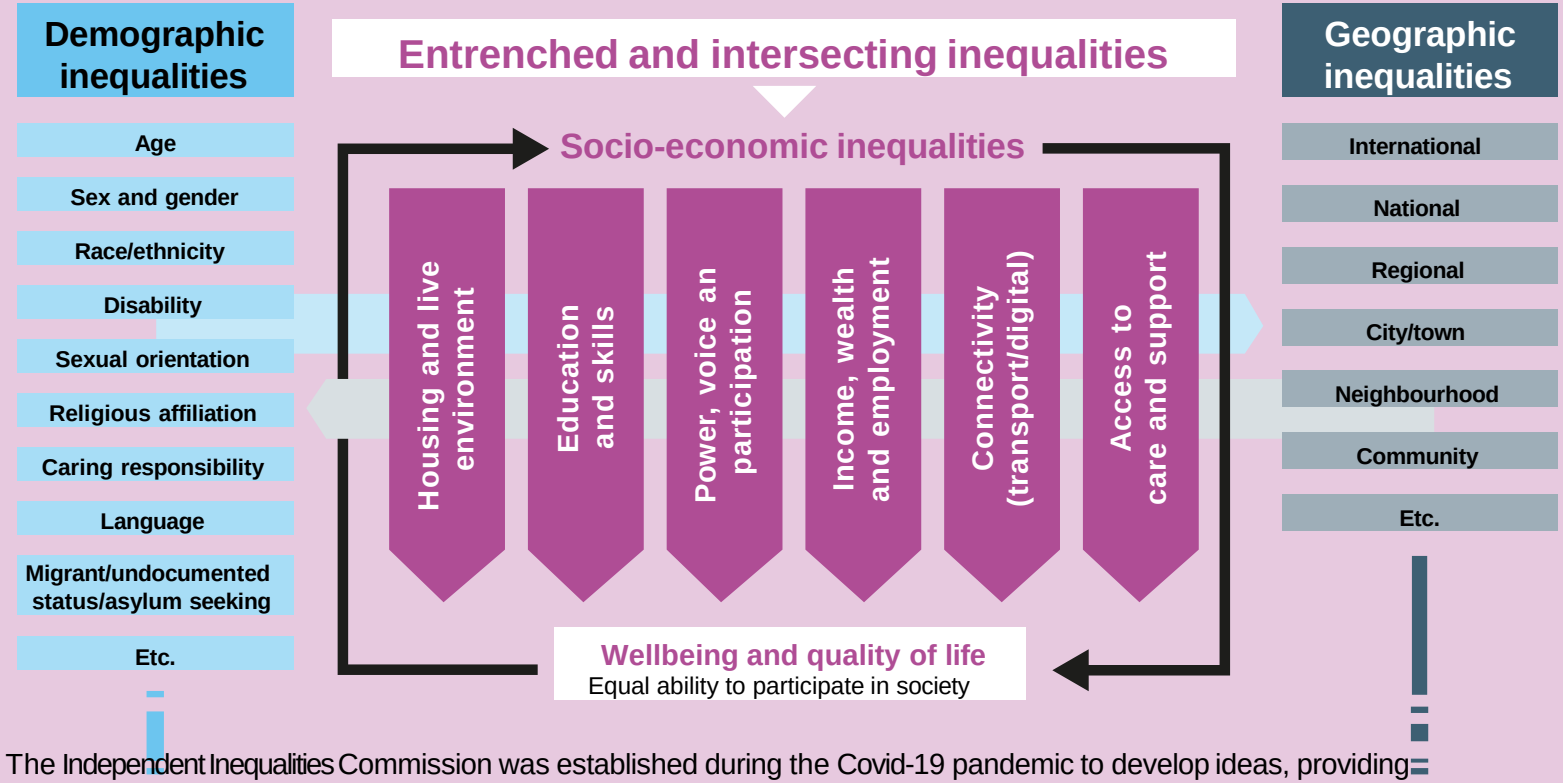
What is the context of this work?

- Entrenched and intersecting inequalities experienced in Greater Manchester – highlighting how different communities have unequal opportunities to be healthy.

The model of interacting inequalities provides the context for our ongoing system-wide commitment to FHFA.

Greater Manchester Independent Inequalities Commission

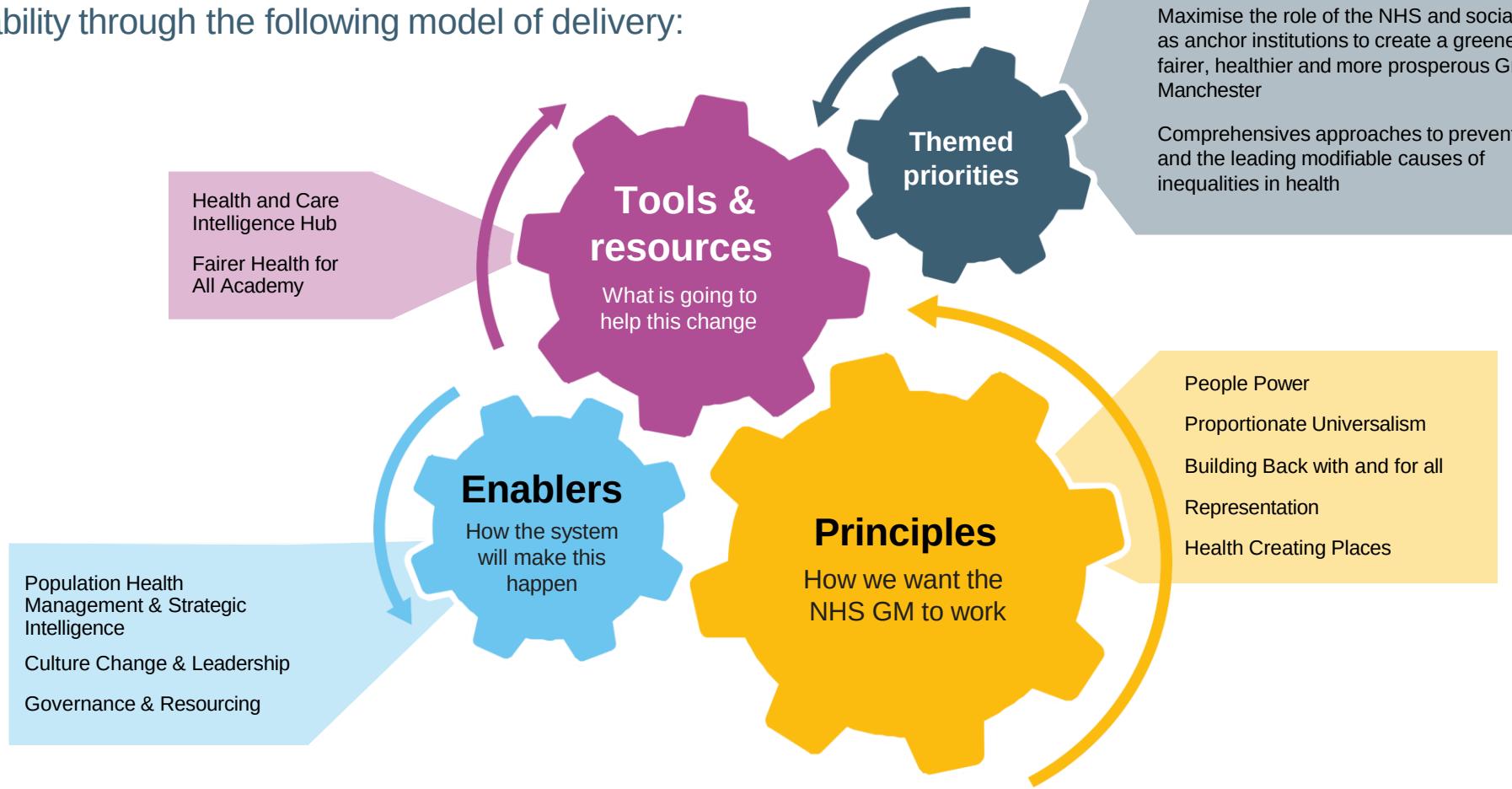
Model of Interacting Inequalities



The Independent Inequalities Commission was established during the Covid-19 pandemic to develop ideas, providing expert opinion, evidence and guidance to reshape Greater Manchester's economy and society for the future.

Fairer Health for All In Summary

The Greater Manchester Fairer Health for All framework will enable neighbourhood, locality and system action on health equity, inclusion and sustainability through the following model of delivery:



Fairer Health for All principles

The Fairer Health for All principles were co-designed by Greater Manchester partners and speak to how we will share risk and resources in a way that considers a strengths-led approach, building on the needs of individuals, communities and partnerships and to collaborative decision making, so that resource can be targeted and tailored to achieve good health across diverse places and people.

People power

We will work with people and communities, and listen to all voices – including people who often get left out.

We will ask 'what matters to you' as well as 'what is the matter with you'.

We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate universalism

We will co-design universal services (care for all) but with a scale and intensity that is proportionate to levels of need (focused and tailored to individual and community needs and strengths).

We will **change how we spend resources** – so more resource is available to keep people healthy and for those with greatest need.

Fairer Health is everyone's business

We will think about **inclusion and equality** of outcome in everything we do and how we do it.

We will make sure how we work makes things better, and makes our environment better, for the future.

We will tackle structural racism and systemic prejudice and discrimination.

Representation

The mix of people who work in our **organisations will be similar to the people we provide services for**. For example, the different races, religions, ages and sexuality and including disabled people.

We will create the space for people to share their unique voice and be involved in decision making.

Health creating places

As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

We will focus on place and **work collaboratively** to tackle social, commercial and economic determinants of health.

How are we going to do it?

Greater Manchester Integrated Care Partnership

1 Continue to develop Greater Manchester as a **Population Health System**, embedding population health approach, and building population health management capacity and capability

2 Strengthen and scale our approaches to **primary and secondary prevention:**

- Working together to address root causes of ill-health
- Comprehensive approaches to tackling behavioural risk factors - **Invest in the potential of people and communities to live well** through the continued expansion of a **social model for health**
- Upscaling secondary prevention across all part of the NHS and upstream models of care including **person and community centred approaches**.
- Treatment and Management of Health Conditions

3 Enhance the role of the Integrated Care Partnership as an **anchor system** in levering change by **shaping the wider, social, economic and commercial determinants of health in Greater Manchester.**

4 Strengthen our strategic approach to **sustainability** through delivery of our **Green Plan**

The 160 actions to deliver these strategic objectives are detailed within our recently published Integrated Care Partnership Joint Forward Plan.

Outcome targets

Greater Manchester Integrated Care Partnership

What we will do:

1 **Improve health and wellbeing to narrow the gap in life expectancy and healthy life expectancy**
Between men and women living in Greater Manchester, between all ten localities, as well as the England average, by at least 15% by 2030.

2 **Reduce unwarranted variation in health outcomes and experiences**
Eliminate the fivefold difference between the highest and lowest social groups in the experience of having 3 or 4 multiple health harming behaviours such as smoking and excess alcohol consumption, through whole system approaches.

3 **Increased social and economic activity because of reduced ill health**
Narrowing the 15-year gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population to 5 years by 2030.

4 **Reductions in preventable or unmet health and care needs leading to reductions in demand**
Evidenced in part by closing the health inequalities gap in of smoking prevalence with England by 2030.*

5 **Reduce the difference in life expectancy for those with serious mental illness and the incidence of physical health conditions, narrowing the gap with England by 15% by 2030**

6 **Reducing infant mortality through measures including narrowing the gap with England by 15% by 2030 and closing the school readiness gap within the same period**

**Smoking is our single greatest cause of preventable inequalities. 1 in 4 hospital patients' smoke and smokers need social care on average 10 years earlier.*

What are the delivery tools?

The Health and Care Intelligence Hub

- Co-designed to **consolidate data and insights from public and VCFSE sector partners** across the city region into a single portal.
- Range of **web-based intelligence tools to e**nable adaptive capability for Population Health Management

Access to the hub can be requested via https://www.gmtableau.nhs.uk/gmportal/new_Request and is open to all VCSE and public sector partners.

Fairer Health for All Academy

The aim of the Fairer Health for All Academy is to**:**

- **Facilitate shared learning and innovation** on equity, inclusion and sustainability
- **Build skills and values required to shift towards upstream models of care** and social model for health

Greater Manchester Integrated Care Partnership

Fairer Health for All

In Action

Mission 1: Strengthening Communities

Our missions to meet the challenges

Strengthening our communities

Delivery Leadership: Locality Boards

System Leadership: Population Health Board

Areas of focus	Actions
Scale up and accelerate delivery of person-centred neighbourhood model	Continue to develop Live Well and Social Prescribing
	Coordinate our response to poverty
	Expand community-based mental health provision
	Living Well at Home
	Take an inclusive approach to digital transformation
Develop collaborative and integrated working	Embed the VCSE Accord
	Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage
	Embed the GM Tripartite Housing Agreement
	Giving every child the best start in life
	Ageing Well
	Increase identification and support for victims of violence
Develop a sustainable environment for all	Delivering our Green Plan

Neighbourhood Model and Public Service Reform

Greater Manchester Integrated Care Partnership

Recent System Stocktake on 'Unified Public Services'

The GM Reform Delivery Executive commissioned a **stocktake exercise** to understand the current position in relation to our ambitions for public service reform, 'Unified Public Services', and the implementation of the integrated neighbourhood model.

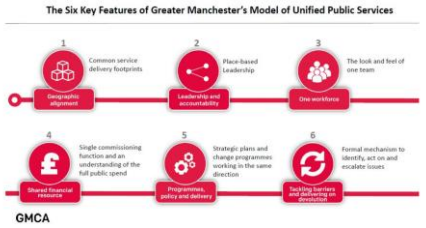
Recognising the complexity of the task, a '**modular' approach** was taken using a **survey tool** and as well as **reflective conversations** with the system, at a locality level and with organisations working across GM.

The approach taken was designed to allow an **open and honest** reflective exercise as opposed to a 'rate and rank' exercise. The stocktake was both a backwards looking understand of the **maturity of place based working** as well as a **forward looking & practical insights piece**.

Was designed to provide insight and **promote learning**, **highlight further areas for exploration** and help us understand **where we may need to re-prioritise our efforts**

Section 1

GM Model Key Features



Section 2

Spotlight Priorities

Section 3

ICS Developments

Section 4

Working with GMP

Findings and Insights relating to Health and Care

Some of the themes and issues arising from the stocktake exercise

1. Health and Care considered an essential part of the wider neighbourhood model and integral to the GM Model's emphasis on people, prevention and place.

2. Optimism around the possibilities presented by ICS developments.

3. A sense that initial ICS developments have proved challenging to local autonomy and in some respects have made it more difficult for health to integrate with other public services as part of a whole place agenda.

4. There are numerous examples of multiple integrated models in localities which points towards fragmentation.

Areas for Further Exploration

Developing the Neighbourhood Model with Public Service Reform

Greater Manchester Integrated Care Partnership

The Unified Public Services system stocktake has highlighted…

A need to work together to **create capacity and innovation** in **all** of Greater Manchester's public services so that they are **accessible**, **equitable** and **responsive** to the needs of people and communities, making our strongest contribution to tackling inequality, improving health and enabling Good Lives For All

…that this shared endeavour could initially focus joint effort on

PEOPLE & COMMUNITIES

A stronger role for public services in enabling the growth of community capacity and capability

SERVICE DELIVERY

A more integrated *full spectrum* response to the range of issues facing residents

SYSTEM SHIFT

A disciplined focus on changing the system conditions that produce inequalities in the outcomes people experience

…and taken forward through

- Joint work between ICP and GMCA in specific programmes and with identified cohorts (e.g. multiple disadvantage, Live Well, Family Help)
- Development of the Devo Deal Shared Outcomes Framework
- Joint Forward Plan reporting

Live Well

To improve health outcomes and address inequalities we need to **invest in the potential of people and communities:**

Greater Manchester Integrated Care Partnership

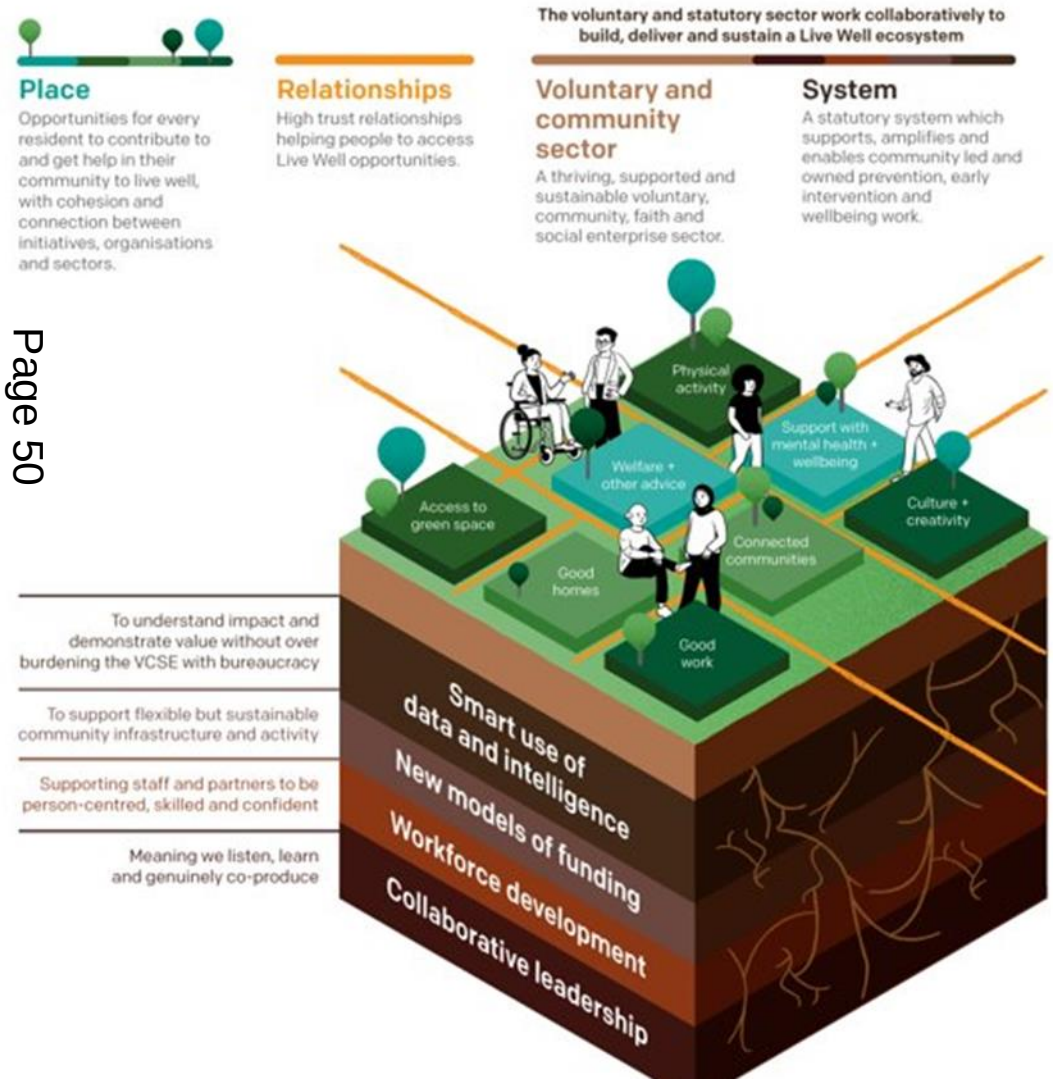
People feeling confident - to manage their own health and wellbeing, and getting good help to stay well and prevent ill health

Communities that create health – active thriving communities leading to happier healthier lives, helping address and overcome inequalities

A strong voluntary and community sector – providing support and capacity to grow and sustain community solutions, power and potential

A shift in power and resource - through community wealth building, real co-production and investment towards those who experience inequalities

Live Well



Live Well is our programme to support the expansion of an offer of local activities and support to live happily and healthily, feeling safe, connected and purposeful, as a key component of the person-centred neighbourhood model.

By helping grow community led health, we aim to expand the opportunities available to people, and reduce health inequalities. This builds out from our excellent track record as a city region on social prescribing.

Opportunities to build on our track record of innovative approaches that result in new and different possibilities for change

Greater Manchester Integrated Care Partnership

e.g. Elephants Trail in Bolton, Bury, Rochdale and Salford

- People with lived experience and professionals working equally together to solve the challenges that people face.
- Creating ‘Elephants spaces’ where everyone feels relaxed and informal. Leaving their ‘labels’ at the door.
- Starts with exploring and building **relationships** between people from very different backgrounds and life experiences. Getting to know each other enables discussion about power, inequality and the most difficult issues.

- The Elephants Trail makes use of approaches such as Deep Democracy. This means ‘leaning’ into situations where there are differences and tensions and saying what needs to be said, rather than using power and rank.
- The teams actively **work together for practical change** and how to work together effectively.

Developing new partnerships and collaborations:

5 Test and Learn sites have been working over 9 months to explore how better collaboration and relationships between VCSE organisations and Primary Care Networks can tackle inequalities.

3 things to take away:

- Effective collaboration needs leadership from both VCSE and PCN
- Community spaces help us to engage with people where they feel safe
- Partnerships need sustainable resources over a longer period of time to help them develop

And pro-active new approaches to addressing inequalities:

The Caribbean & African Health Network (CAHN) was commissioned to work with the Caribbean and African community to codesign, co-produce and evaluate pathways.

Connectors Testimonial during the period of training

“I saw the Core20PLUS5 community connectors role as an opportunity to make significant improvements in health and well-being within my community. We are receiving clear useful information that would go a long way in making us equipped for the role. I believe strongly in this movement. I see this connector role making a significant impact on how BAME people experience healthcare”.

Click on the picture above or here to find out more

VCSE Accord and long term sustainable VCSE funding is key

- VCSE organisations are running hot, burning out
- 63% of VCSE organisations are reporting challenges in volunteer recruitment (27% say organisational capacity is a factor)
- Contracts are not keeping up with increases in costs
- Many VCSE organisations are withdrawing from networks – and information about the sector is degrading
- Risk of organisations diminishing
- Medium sized organisations are at greater risk than large or small ones – but are the organisations close to communities with the capacity to deliver

Best Start in Life

Developing a set of Deliverables for Children & Young People

- Headline mission 'Giving every child and young person the best start in life'
- Paper went to GM Integrated Care Partnership in February '23 that made the case for ensuring CYP are seen a priority group.
- Joint working between ICB functions (PH, Strategic Clinical Network and Nursing directorate), GMCA, Deputy Place Based Leads and DCS to develop a detailed set of 'Deliverables' that improves outcomes for CYP including a set of shared commitments on understanding & tackling inequalities by:
  - incorporating the voice of CYP
  - taking a partnership approach and longer term view to resourcing our priorities.
  - Alignment and shared learning/service improvement across Core20PLUS5 clinical programmes (oral health, asthma, epilepsy, mental health, diabetes))
  - Shared intelligence to review gaps in service provision for particular groups (SEND, Cared for/care experience CYO, perinatal mental health, Learning Disabilities and Autism, CYP involved in the criminal justice system, CYP exposed to Domestic Abuse)
  - Integrated approach to Early Years – workforce development and pathways
- GM CYP Systems Group will support with overseeing progress against agreed deliverables with regular progress reports into the ICP Strategy Delivery Group and GM Children's Board.

Mission 2: Help People to Stay Well and Detect Illness Early

Mission 2: Helping people stay well and detecting illness earlier

Areas of Focus	Actions
Tackling inequalities	Reducing health inequalities through CORE20PLUS5 (adults)
	Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)
	Implementing a GM Fairer Health for All Framework
Supporting people to live healthier lives	A renewed Making Smoking History Framework
	Alcohol
	Enabling an Active Population
	Promoting Mental Wellbeing
	Food and Healthy Weight
	Eliminating New Cases of HIV and Hepatitis C
	Increasing the uptake of vaccination and immunisation
Upscaling secondary prevention	Early Cancer Diagnosis
	Early detection and prevention of Cardiovascular Disease
	Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry
	Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness
Living well with long-term conditions	Managing Multimorbidity and Complexity
	Optimising Treatment of long-term conditions
	Expansion of the Manchester Amputation Reduction Strategy (MARS) across NHS GM
	The GM Dementia and Brain Health Delivery Plan
	Taking an evidenced based approach to responding to frailty and preventing falls
	Anticipatory Care and Management for people with life limiting illness

A Strategic Approach: GM Prevention & Early Detection Framework

A Comprehensive Approach to Prevention and Early Detection

- Preventing poor health, and returning people to good health as soon as possible following illness, are fundamental to achieving an operationally and financially sustainable health and care system.
- To achieve this we need to enable a system-wide strategic shift towards Prevention.
- Prevention and Early Detection are complex and wide-ranging endeavours.
- To reflect this we have developed an NHS GM Prevention and Early Detection Framework which sets out the breadth of preventive activity that is required to achieve the scale of transformational change that is required.
- The Frameworks sets our the priority areas of focus, our approach to addressing them, the system characteristics and enablers that are required to achieve impact, and the outcomes that we would anticipate.

Achieving the aims of the Greater Manchester ICP Strategy and Joint Forward Plan requires a comprehensive commitment to Prevention and Early Detection consisting of a system-wide approach to health creation and delivery of a person-centred, upstream model of care

Shaping GM as a place conducive to good health	Supporting people to live healthier lives	Early detection of risk and early diagnosis of illness	Living well with long-term conditions	Leading to	Better outcomes

Achieved by focussing resource and energy on the following area

Working together to address the root cause of ill health

We must address the *'causes of the causes'* of ill health by considering the environments in which people live and work, and the experiences they have. These are the biggest determinants of health outcomes and inequalities.

These often sit outside the direct control of the health system and require system-wide collaboration focused on:

- Socio-economic factors: Education; employment: income: Social Capital
- Built and Natural Environment: Air Quality; Climate Change; Transport and Active Travel; Green Space, Housing
- Commercial influences

This will require NHS GM and providers to collaborate with key non-health partners at place and city-regional level to shape neighbourhoods that are conducive to good health.

Delivering comprehensive approaches to tackling behavioural risk factors

55% of years of life lost prematurely and 29% of years lived with disability are due to modifiable risk factors such as diet, alcohol, tobacco, physical activity, and drug use.

We recognise the stark disparities in the prevalence of healthy and unhealthy behaviour and variance in terms of the support that is available to people.

Addressing this will require us to play our role in creating environments that enable healthy choices and ensure that people who require additional support are able to access evidence-based interventions in a timely manner.

Upscaling secondary prevention across all parts of NHS

We must take a system approach to identity causes of ill health earlier by supporting people to take an active role in their health. Proximal risk factors can be detected and managed, and prevention measures (*such as screening, vaccination and immunisation, targeted health checks and evidence-based secondary prevention measures*) can sever the link between these risks and the development of preventable conditions.

The greatest impact will be achieved through an approach rooted in 'universal proportionalism' which includes universal services for all, and additional support for those who experience the worst health outcomes and inequalities, the highest risks, and who live in places that are not conducive to good health.

Optimising treatment and management of health conditions

For people who are diagnosed with a long-term health condition, it is important to provide timely access to high-quality, integrated and sustainable health and care where and when they need it.

It must be:

- Person-centred & personalised
- Holistic and mindful of multi-morbidity
- Supportive of people staying at home
- Anticipatory

Doing this in a way which tackles inequalities and supports the achievement of Core20Plus5 (including C20+5 CYP) ambitions requires a recognition of the additional challenges faced by some members of communities and rooting delivery in neighbourhoods and communities.

Tackling Inequalities & Reducing Unwarranted Variation
GM Fairer Health for All Framework
Core20Plus5 & Core20Plus5 CYP

Improve health and wellbeing leading to Improved Healthy Life Expectancy and Life Expectancy

Reduction in inequalities and unwarranted variation in health outcomes and experiences

Reduction in preventable or unmet health needs leading to a reduction in demand

Increased economic and social productivity as a result of reduced ill-health

Everybody has an opportunity to live a good life

Harnessing the following system characteristics

Person and Community Centred Approaches to Health and Care	Strategic Intelligence and Population Health Management	Whole System Partnerships/ Collaboration	Public Service Reform	A highly skilled and prevention focused Workforce	Clinical Excellence & Leadership	Finance, Contracting & Accountability rebalanced to increase focus & investment in Prevention & Early Detection	Evidence, Research, Technology and Innovation

Making Smoking History

Making Smoking History Approach

Based on the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC), Greater Manchester uses the adapted GMPOWER model to underpin its strategy to reduce demand for tobacco.

- **G** Growing a social movement
- **M** Monitoring tobacco use and prevention policies
- **P** Protecting people from tobacco smoke
- **O** Offering help to stop smoking
- **W** Warning about the dangers of tobacco
- **E** Enforcing tobacco regulation
- **R** Raising the real price of tobacco

MSH Highlights

- VCFSE leadership for Making Smoking History across city region
- Research, monitoring and evaluation through GM ARC and STS
- Expanding Smokefree Spaces with WHO Partnerships for Healthy Cities and as part of local Healthy Spaces
- Behaviour change campaigns shaping SF norms and quitting
- Advocacy for further regulation plus GM-wide enforcement activity
- Advocacy for price escalator plus regional illicit tobacco programme
- Local & specialist services, SF app, phoneline, pharmacy, GP – plus targeted Social Housing focus

Long Term Plan Delivery Highlights and Goals 2023/2024

Specialist Tackling Tobacco Dependency (TTD) services

- 100% delivery in all acute services since 2020
- 100% delivery in all maternity services since 2019
- 100% delivery in tertiary care since April 2023
- 100% delivery in all mental health trusts by September 2023
- NHS Staff Stop Smoking Offer in all GM Trusts

Coming this year…

- Advanced Pharmacy pathway rollout
- System wide digital platform to provide better reporting and monitoring of TTD pathway smoking status and quit journey (in development)
- Smokefree Hospital Toolkit for Trusts, following outcomes of behavioural insights review project
- Enhanced training and engagement package for all healthcare professionals and clerical staff

Making Smoking History Impact

Greater Manchester Integrated Care Partnership

4.1

percentage point reduction in adult smoking prevalence

90,000

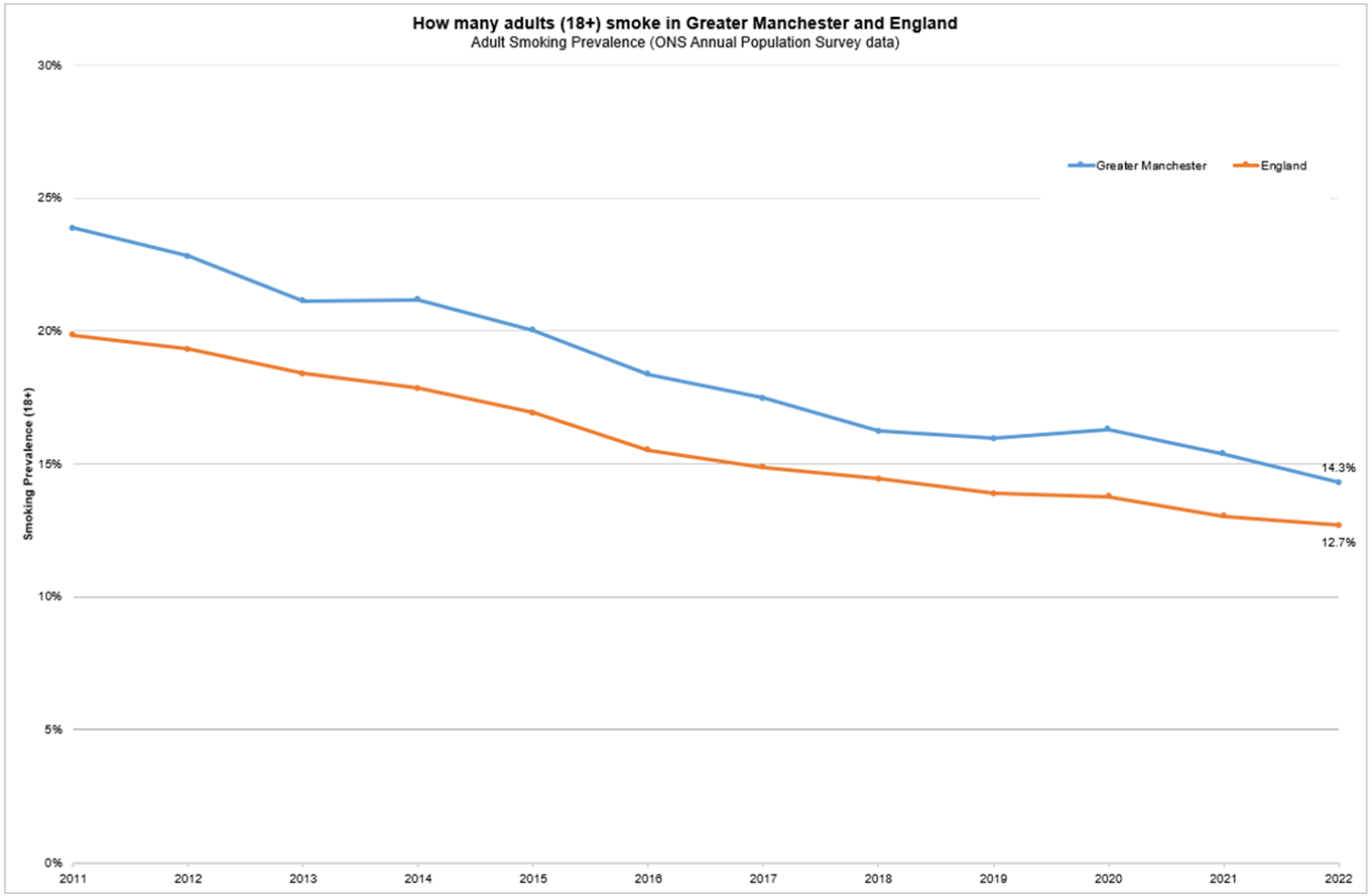
fewer smokers

1/3

reduction in smoking at time of delivery

4,500

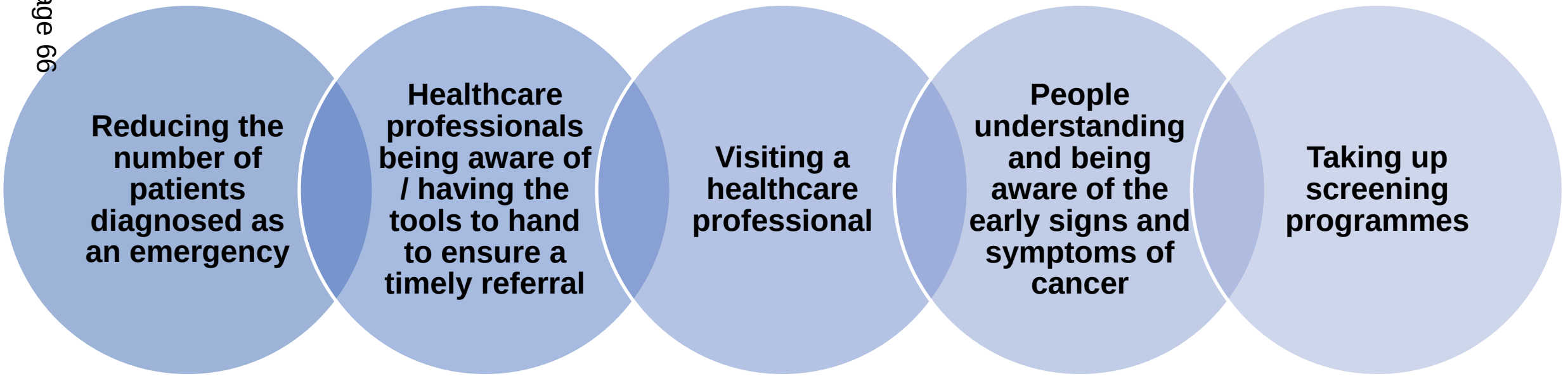
more babies born smokefree



Early Cancer Diagnosis

Early Cancer Diagnosis Context

By 2028, **75%** of people with Cancer will be diagnosed at an early stage (stage 1 or 2). Earlier and faster diagnosis of cancer is dependent on identifying and employing a range of interventions:



Greater Manchester Cancer Alliance – Early Diagnosis Programme Plan on a Page

Cross cutting: Health Inequalities Work Programme tackling inequalities across screening services, signs and symptoms recognition and barriers to seeking help.

1. Primary Care

Timely Presentation

+ Deliver projects encouraging symptom awareness and timely presentation from the public, supported by the Cancer Alliance's Communications and Engagement team.
+ Public & patient messaging re screening programme uptake
+ Tackle health inequalities with demographic data insights and produce resources in various languages and formats.
+ Work with each GM locality to deliver early diagnosis messages and engagement activities with their local population.

Primary Care Pathways and GP Education

+ Work with the 65 GM Primary Care Networks' Cancer Champions to support effective primary care pathways into secondary care on a suspected cancer pathway.
+ Review the Suspected Cancer Referral Forms annually.
+ Collaborate with GatewayC, GM Cancer Academy and GM Cancer pathway boards to deliver webinars and study days, increasing Primary Care knowledge and confidence in recognising and referring a suspected cancer.

PCN Engagement

+ Communicate with the PCN Cancer Leads via monthly meetings and bulletin; facilitate communities of practice.
+ Provide support to meet the requirements of the PCN DES (screening and symptomatic) via data searches, education and training resources.
+ Deliver Quality Improvement training aligned with the PCN DES.

2. Projects

NHSE Funded Projects

Prostate Cancer Case-finding

+ Mobile PSA testing health clinic in a van which is raising awareness of prostate cancer. The service is ONLY by invitation and for men, or people with a prostate, who are age 45 or over and fit the following criteria: black; family history of prostate, breast or ovarian cancer

Pharmacy Referral Project

+ Pilot project to test feasibility and acceptability of direct referral routes by Community Pharmacy into secondary care.
+ Evaluation will include patient, referrers and primary and secondary care experience.

Targeted Lung Health Checks

+ Establish local governance to provide oversight and coordination of programme delivery and expansion
+ Lead on locality engagement to ensure GM stakeholders can support programme expansion
+ Design and deliver communication and engagement projects to increase uptake and participation

Colon Capsule Endoscopy

+ National pilot of CCE to release capacity in LGI FDS pathway
+ Support pilot sites to establish and maintain CCE services
+ Ensure pilot sites report data efficiently and participate in the pilot evaluation

Cytosponge

+ National pilot of cytosponge to release capacity of endoscopy services.
+ Support pilot sites to establish and maintain cytosponge services

Lynch Syndrome

+ Support GMSAs in improving Lynch Syndrome testing in colorectal and endometrial cancer patients, as per NICE guidance
+ Embed mainstreaming of genetic testing required to diagnose Lynch Syndrome

3. Programme Governance

Early Diagnosis Programme Board

Steers the Early Diagnosis programme and ratifies decisions to be taken to Cancer Board. Membership includes representatives from GM Cancer programmes, GM Commissioning, Public Health, VCSE sector, and research.

GM Cancer Board

Brings together cancer providers, commissioners, clinicians, people affected by cancer and other colleagues to reflect the entire cancer system.

4. Innovation

Local Innovation

Commissioned 5 projects that result in innovative methods and outcomes for early cancer diagnosis.

GRAIL

+ Support retention of trial participants through producing and disseminating public-facing comms.
+ Work with providers to ensure clinical pathways for onward referral are functional

FIT

+ Implement FIT for symptomatic lower GI patients in primary care.
+ Support PCN's to monitor and achieve IIF target for lower GI cancer referrals.
+ Produced primary care pathway for Lower GI/FIT and education resources.

Early Cancer Diagnosis Actions

Primary Care Pathways: Review of referral forms for all cancer pathways; continued development of Clinical Decision Support Tool ‘Think Cancer’; ongoing education programme for primary care – pathway specific; Quality Improvement Training to commence Sept 2023; monthly PCN bulletins and briefing calls

Symptom Awareness: Ongoing patient and public facing comms – participate in and amplify national ‘Help Us Help You’ plus specific local campaigns for skin, gynae, blood cancer, Oesophageal, lung, urology podcasts for cancer and Health Inequalities

Targeted Case Finding: Targeted Lung Health Checks expansion into Wigan locality from October 2023; Prostate Cancer Case Finding project ongoing; Liver case finding – 3 GM PCNs selected for national project

Data and evidence drive programme: Rapid Cancer Registration data shows 57% stage 1 or 2 Q3 2022-23 (variation – breast 78% OG 24%; Bolton FT 67% Stockport FT 45%)

Innovation: Investment in Early Cancer Diagnosis Innovation in 2023-24/5; Pathway specific projects in areas with greatest scope for improvement and impact – initially lower GI (colorectal) gynae and lung; Prehab4Cancer evaluation and scope expansion

Early Cancer Diagnosis Actions

BREAST SCREENING

Undertake a deep dive to ensure screening locations are being utilised efficiently, meeting the capacity needed to maintain 36-month round length for the population and identify high DNA locations to improve access and uptake. This work forms part of the improving specialist care board breast workstream.

BOWEL SCREENING

Continue the staged roll-out of the NHS Bowel Cancer Screening Programme to aged 54-year-olds in Manchester, Trafford, Stockport and Tameside. Lynch syndrome surveillance roll out completed within all screening programmes.

Increase the uptake of diagnostic colonoscopy following SSP consultation across GM: including undertaking an audit with patients and comparing data and processes with comparable areas and working with the system and diagnostic pathways to increase the number of sites delivering diagnostic colonoscopy

CERVICAL SCREENING

Implement mitigating actions to ensure the turnaround time of 14 days for cervical screening results is achieved and maintained

DATA

Progress work to ensure that detailed and timely data on cancer screening from the GM Shared Care Record is available at a GM, locality, and practice-level
Improve the data recording for the faster diagnosis standard for cervical and bowel screening programmes

Mission 3: Helping People Get into and Stay in Good work

The actions to deliver our missions – the Joint Forward Plan

Helping people get into, and stay in, good work

Delivery Leadership: Locality Boards

System Leadership: Population Health Board; GM Good Employment Charter Board, GM Employment and Skills Advisory Board

Areas of Focus	Actions	Measuring our Delivery	Accountability
Enhance Scale of Work and Health Programmes	***Expansion of our Working Well System***	• Number of people supported into work • Number of people supported to remain in work • Number of people supported whose health conditions improve	• Locality Boards • Population Health Board • GMCA Employment and Skills Advisory Partnership / new Integrated Education, Skills and Work Governance Board
Develop Good Work	***Working with employers on employee wellbeing through the GM Good Employment Charter***	• Number of Health and Care organisations achieving Charter Accreditation	• People Board
Increase the contribution of the NHS to the economy	***Developing the NHS as an anchor system***	• To be confirmed through GM Anchors Network development	• Population Health Board • Provider Federation Board
	Implementing the Greater Manchester Social Value Framework	• Improvements against Social Value Reporting Tool metrics – being developed at national level	• Population Health Board

Working Well

Greater Manchester Working Well System

Greater Manchester Integrated Care Partnership

A whole population approach to health, disability and work

Economically Inactive

Support for economically inactive people with barriers such as complex health conditions and/or disability who want to work, to find and sustain paid work.

ESA Support and UC LCWRA claimants (plus non-claimants)

Long-term Unemployed

Support for long-term unemployed with barriers such as health conditions and/or disability to find and sustain paid work.

ESA WRAG, UC LCW and wider UC claimants

At risk of ill health related job loss

Advice, guidance and/ or support for employees with health issues and/or disability at risk of falling out of work and newly unemployed with health issues.

In Work

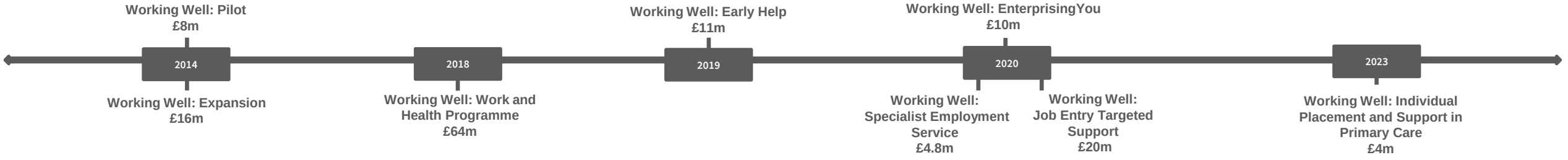
Cohort comprises those in good health, people with risk factors and people with a disability and /or health conditions, including fluctuating conditions.

Working Well: A Whole Population Approach to Health, Skills and Employment in Greater Manchester

Working Well started in 2014 with a small long-term unemployed pilot to challenge the DWP's Work Programme and create a case for devolution. It has since developed into the system of devolved and test and learn provision shown below that spans a whole spectrum of need.

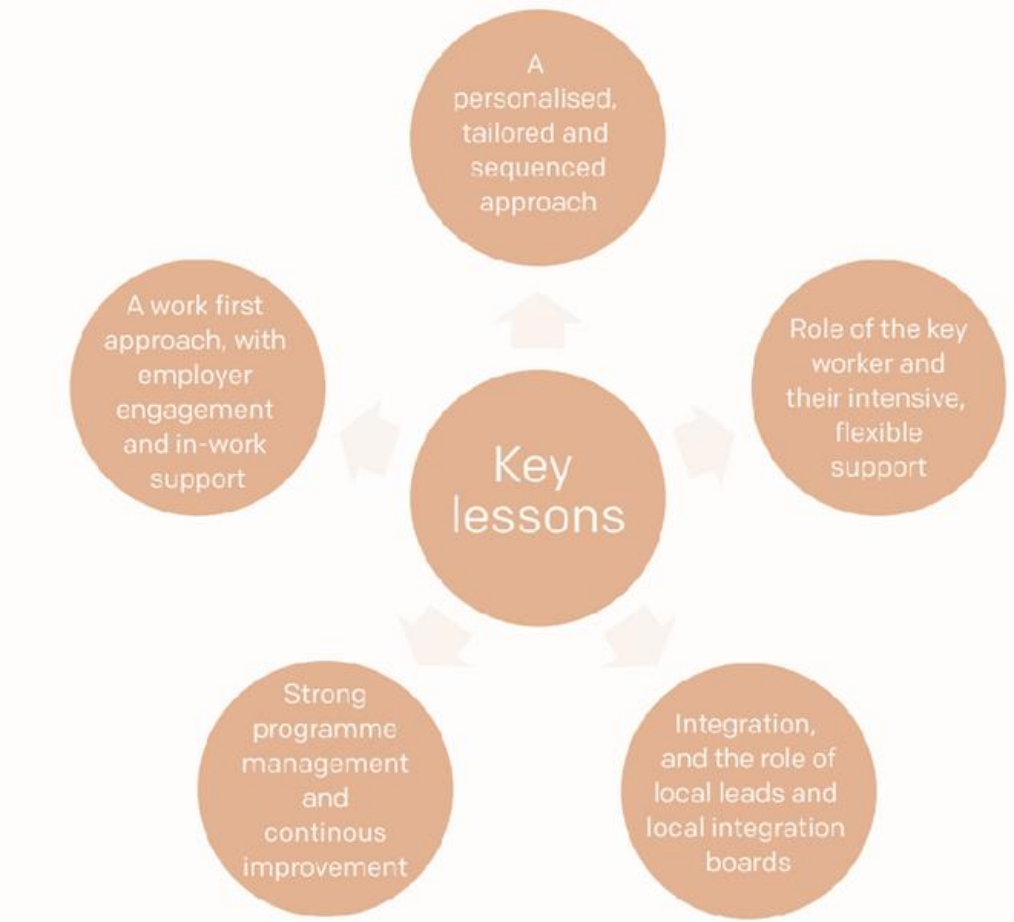
Working Well programmes (inc. pilots) have supported over 68,000 GM residents to date and helped nearly 25,000 people to find employment (many of whom were not likely to move into work without specialist support). At its heart are the following key principles: keyworker model, 1-2-1 personalised and sequenced support, and integration with the wider GM ecosystem. The Working Well: Work & Health Programme alone has delivered nearly 107,000 interventions with external/other services (10 times more integration than the North West).

	Working Well: Specialist Employment Service	Working Well: Work and Health Programme	Working Well: Individual Placement and Support in Primary Care	Working Well: EnterprisingYou
Service Offer	Support for people with complex disabilities and health needs to access and sustain paid work in the open labour market. Supported Employment (SE) for people with a learning disability and/ or autism; Individual Placement and Support (IPS) for people with a severe mental illness	15-month individualised support programme for long-term unemployed people with health conditions or disabilities. Bringing together expertise and local knowledge to include integrated health, skills and employment support to help participants to find and sustain work	Support for people with physical or mental health disabilities to retain work if they are in-work and off sick / struggling **or** to move into competitive employment if they are out-of-work	Support for self-employed residents Provides tailored support from a business coach, alongside access to specialist advice and guidance and a wide range of training and development opportunities
Referral	SE: Referrals through LA Adult Social Care Teams, Disability Employment Advisors at the JCP or through SEND Education Providers; IPS: Referrals through Secondary Mental Health Care Teams	Referrals must go through JCP so GM residents should ask their Work Coach if interested	Individuals can self-refer to this programme via the provider's website. Health professionals can also complete the initial enquiry form on behalf of the participant (with verbal consent)	Individuals can self-refer to this programme: Self-Employment Support Application | EnterprisingYou (enterprising-you.co.uk)
Performance	CTD – Data from August 2020 to end of March 2023: **1,262** referrals **744** programme starts **223** job starts **179** job outcomes	CTD – Data from January 2018 to end of March 2023: **34,356** 'unique' referrals **24,044** programme starts **10,150** job starts **6,221** job outcomes	This programme will be going live in Summer 2023	CTD – Data from February 2020 to end of March 2023: **2,910** programme starts **80%** have improved skills to run their business **48%** have seen an increase in earnings levels **32%** report an increase in business profits

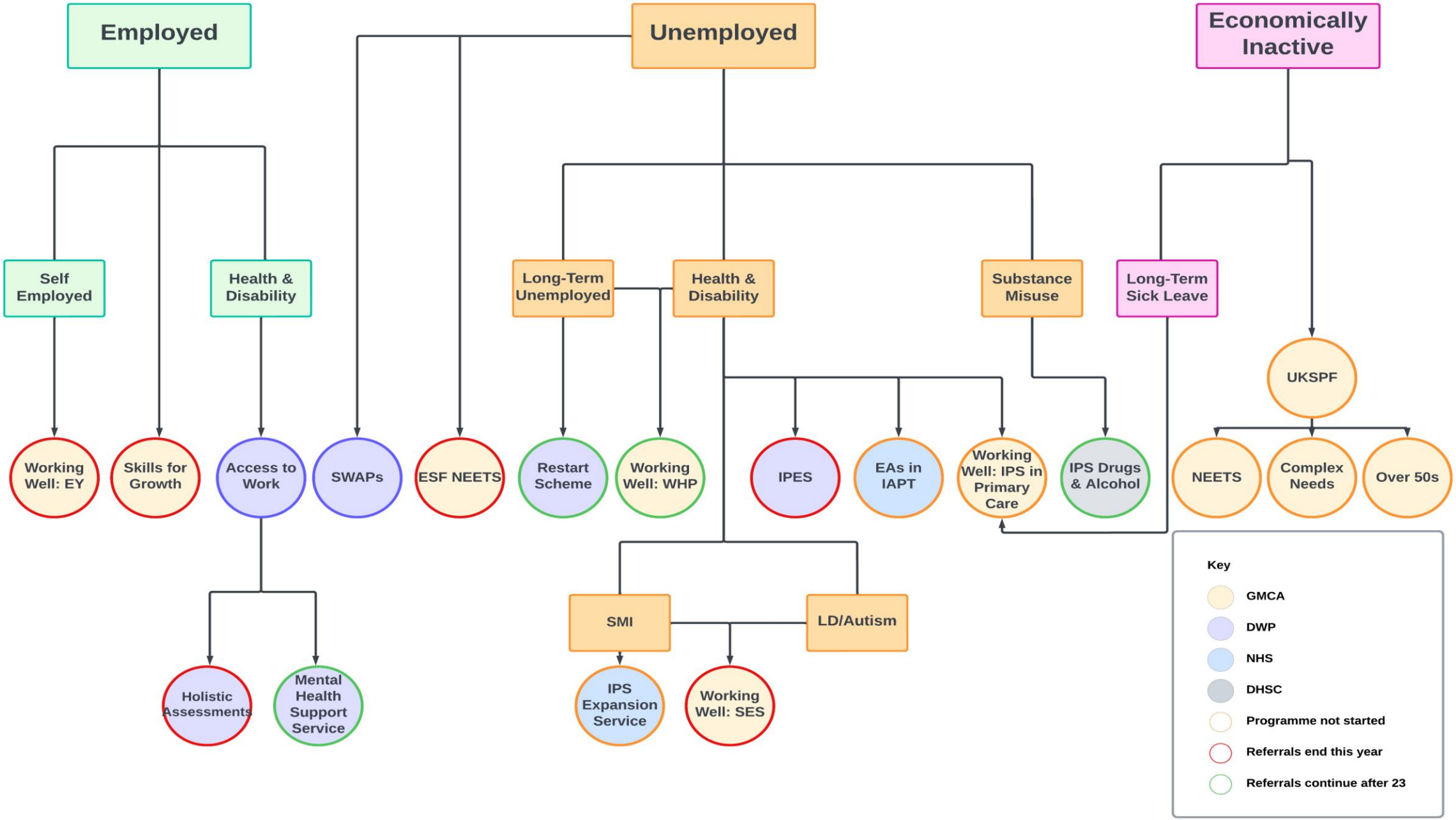


Working Well: Key Learning to Date

- A **personalised approach** to delivery is at the core of Working Well programmes
- The **key worker role** is essential to delivering the personalised approach to the programmes
- Gaining access to **integrated support services**, beyond what the providers can deliver internally, is also key to the tailored approach of the programme
- A **'work first approach'** to delivery is an important part of delivering on this ambition
- Strong **local programme management** and a flexibility to adapt to changing circumstances are an essential component of successful delivery
- **Strategic Partnership and Collaboration** – in the development and ongoing management of programmes from GMCA/LA's (Execs and Leaders) as well as JCP and the Integrated Care Partnership



Greater Manchester Employment Provision Landscape



Greater Manchester Anchors Network

What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

The Health Foundation

References available at www.health.org.uk/anchor-institutions

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NHS
Greater Manchester
Integrated Care

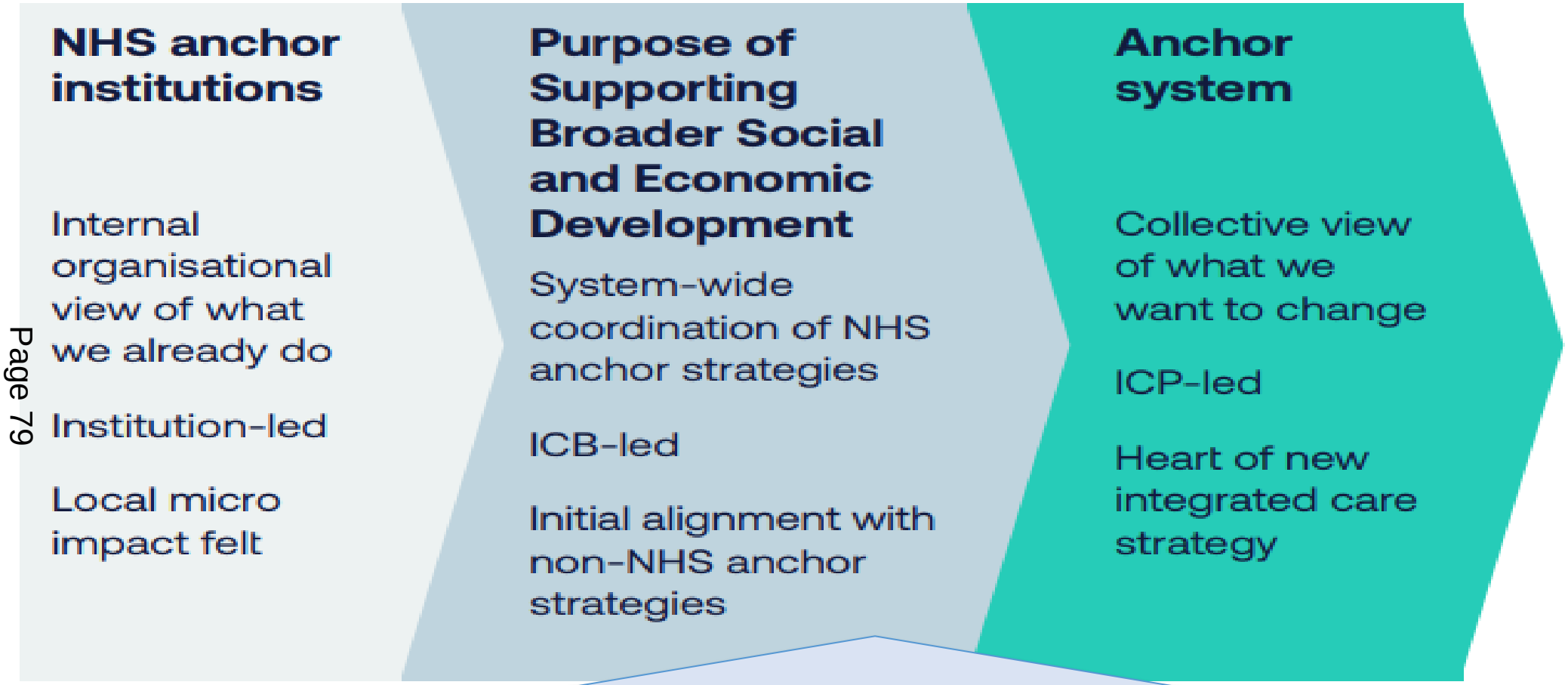
Defined as:

- having an important presence in a place, usually through a combination of being largescale employers, the largest purchasers of goods and services in the locality, controlling large areas of land and/or having relatively fixed assets.

- are tied to a particular place by their mission, histories, physical assets and local relationships.

From Anchor Institutions to Anchor Systems

Greater Manchester Integrated Care Partnership



ICS 4th Purpose: Support broader social and economic development

Source: Unlocking-NHS-social-economic-development-model_0_1.pdf (nhsconfed.org)

23/24 Anchor Network Priorities

- GM will pilot ICS level reporting indicators with NIHR ARC National Priority Consortium for Health and Care Inequalities project.
- Agreed UCL/NHSE Anchor Measurements are being mapped to currently reported & possible future reported indicators.
- Adoption of GM Employment Charter continues. 89 Health and social Care supporters and 13 members
- Several workshops & discussions held on adopting and embedding of Social Value into all commissioning and procurement activity with recommendation paper to follow.
- Progress on focusing on Social Value delivery within FM and Estates categories.
- Survey planned with Educational Transformational Alliance on local employment pathways and projects (in conjunction with GMCA).

Mission 4: Recover Core Health and Care services

Our missions to meet the challenges

Recovering Core NHS and Care Services

Delivery Leadership: Locality Boards and PFB

System Leadership: System Boards; Finance and Performance Recovery Board

Areas of Focus	Actions
Improving urgent and emergency care and flow	Access to urgent care in the community
	Admission/Attendance Avoidance
	Improving discharge
	Increasing ambulance capacity
	Improving emergency department processes
Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard	Integrated Elective Care
	Improving productivity and efficiency
	Improving utilisation of the Independent Sector
	Improving how we manage our wait list
	Recovering children and young people's elective services
	Reducing waiting times in cancer
	Diagnostics
Improving service provision and access	Making it easier for people to access primary care services, particularly general practice
	Digital transformation of primary care
	Ensuring universal and equitable coverage of core mental health services
	Digital transformation of mental health care
Improving quality through reducing unwarranted variation in service provision	Improving quality
	NHS at Home – including Virtual Wards
Using digital and innovation to drive transformation	Implementation of Health and Social Care Digital Strategy
	Driving transformation through research and innovation

Commissioning approach

- In July 2022, the responsibility for commissioning healthcare treatments for the population of Greater Manchester moved from clinical commissioning groups (CCGs) to the newly formed integrated care board (ICB), NHS Greater Manchester.

- Previously local areas made local decisions around their commissioning policies which has resulted in some differences across Greater Manchester. To address these differences, commissioning policies for a range of treatments will be reviewed to look at how they can be made the same for all places in Greater Manchester.

- The review of clinical policies is being carried out in stages. Some clinical policies were found to be the same across all the local areas of Greater Manchester.

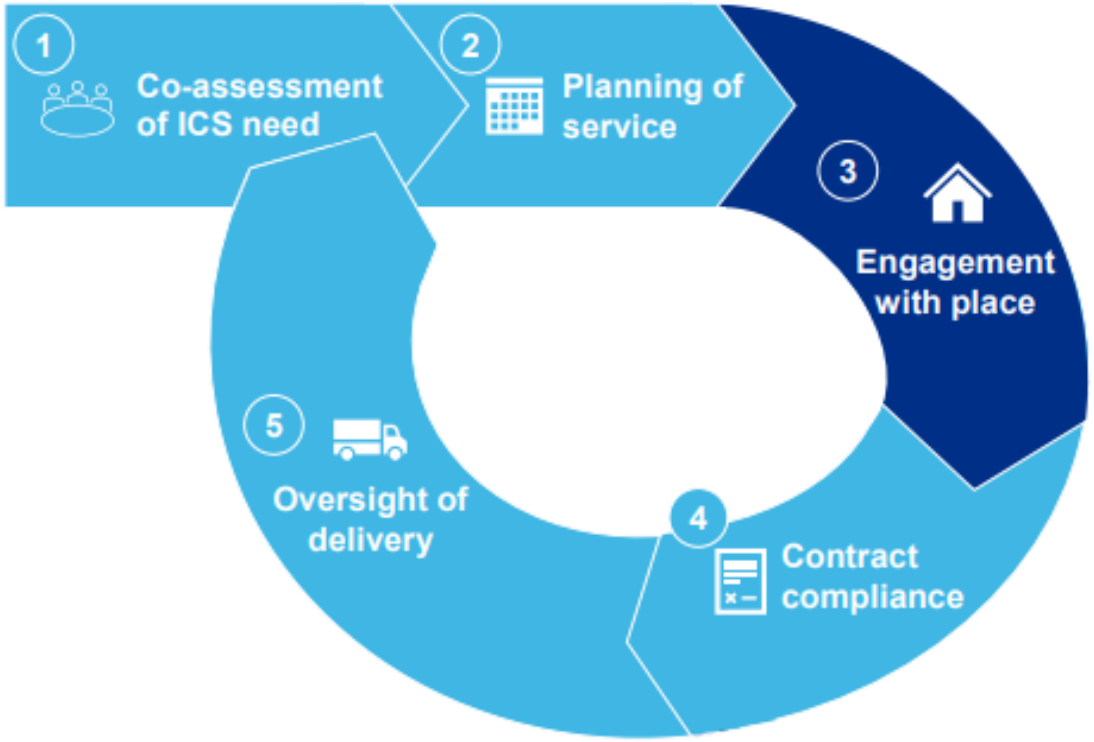
- Some of the clinical polices vary from area to area. Harmonising these clinical policies will mean changes for some areas. Where this is the case, we will ensure patients, members of the public and stakeholders can contribute to the process as we work through the different stages.

- The NHS GM Operating Model depicts the responsibilities for commissioning at both Place and GM level which seeks to ensure that the needs of the local population are met whilst ensuring removal of unwarranted variation

For GM-led commissioning, it is important to retain a mechanism to ensure that the offer meets local population needs

For commissioning led at a GM level, the needs of specific populations not being met remains a risk if local requirements are not properly catered to. For the services that are commissioned once across GM, it is important for places to retain an input to ensure local requirements are still met

1 Co-assessment of ICS need	The GM team will examine the overall population need for a service, including overall quantum, as well as cohorts that may require additional support – drawing on information from the place-based teams
2 Planning of service	From this a spec will be developed – engaging with relevant providers to ensure spec is appropriate and to flag any likely changes from the previous year
3 Engagement with place	The population need and service spec will be tested with representatives at place to ensure any local requirements are appropriately catered for
4 Contract compliance	Once agreed, the spec is translated into a contract for each provider
5 Oversight of delivery	Oversight for delivery and any adjustments to the in-year service spec are held at a GM level. This monitoring should also account for variation at a place level to ensure no unwarranted variation is persisting

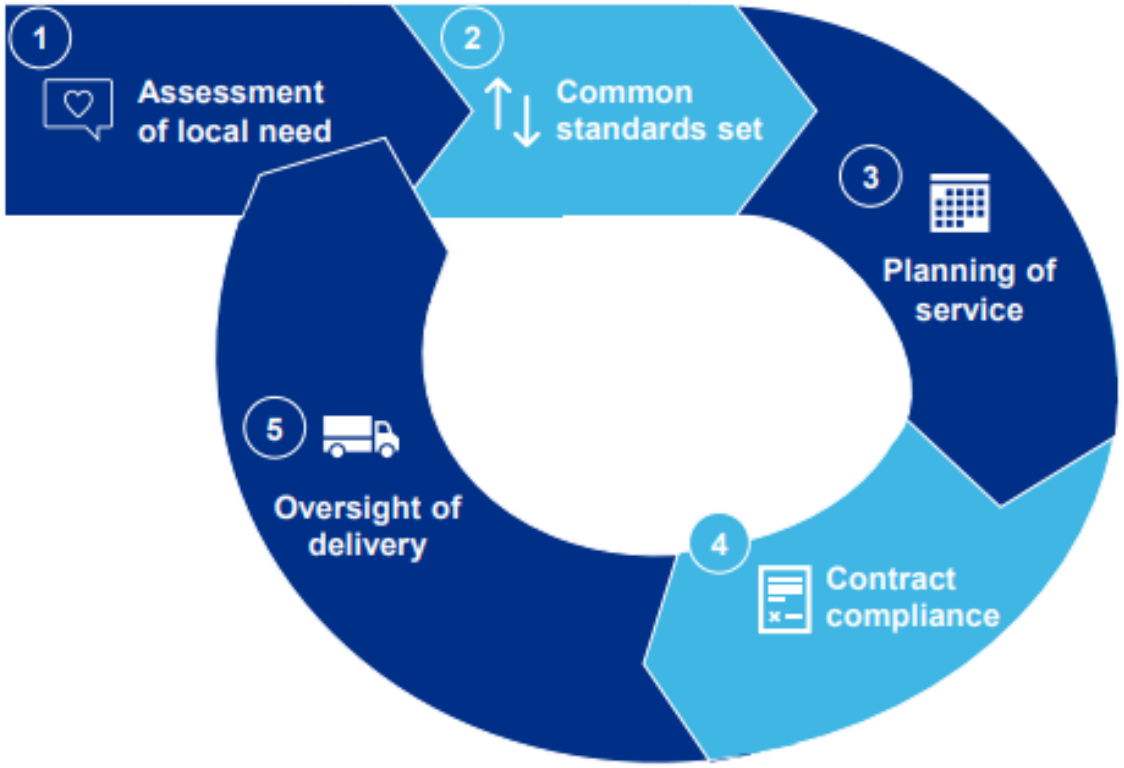


The commissioning processes, whether led at place or GM level, will expect to involve providers in design, planning, and review processes

For place-led commissioning, the translation of local need would be balanced against a set of common commissioning standards

Place-led commissioning will place an emphasis on local planning of services to ensure that there is sufficient matching of service design to local population need. However, there are a number of elements that will take place at a GM level to ensure that there is consistency of service offering and ensure removal of unwarranted variation. The process would be as follows:

1 **Assessment of local need**	The place-based team will review population health information (utilising GM wide systems) and will identify cohorts of patients that require additional support. This will be compiled by the GM Wide team and an overall needs summary produced
2 **Common standards set**	A set of common standards for locally planned services are developed by NHS GM and agreed once with service providers, users and representatives from place-based partnership committees – this would include minimum investment requirements and outcome standards that should be met
3 **Planning of service**	The place-based team including local providers will develop a service specification that meets the common standards and the local requirements
4 **Contract compliance**	These specs will then be brought together at GM level to create an overall contract for each provider
5 **Oversight of delivery**	The place-based board will then be responsible for monitoring delivery and will also articulate any requirement required in year – with GM retaining control over the contracts

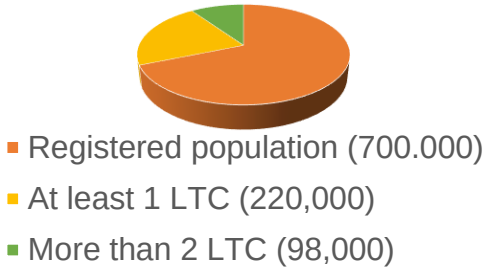


The commissioning processes, whether led at place or GM level, will expect to involve providers in design, planning, and review processes

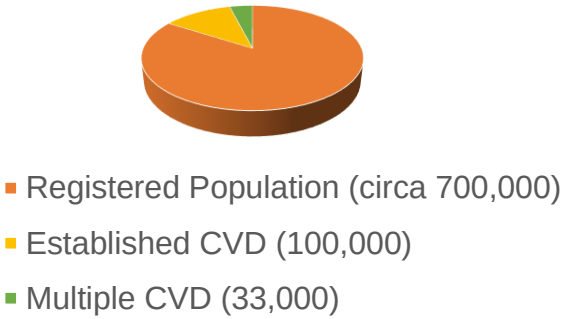
A Multimorbidity Approach –
Manchester Locality

Multimorbidity Approach to Diabetes and CVD

Long term Conditions (LTC)



CVD

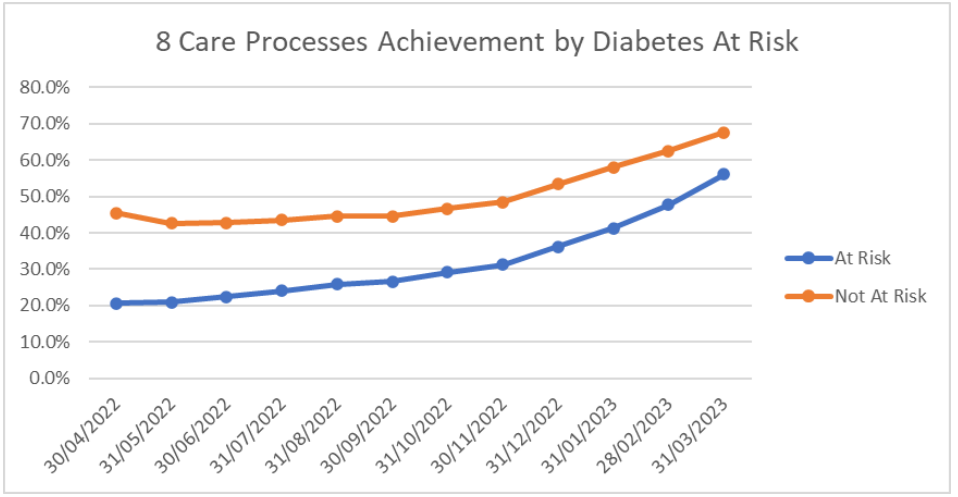


Our Approach

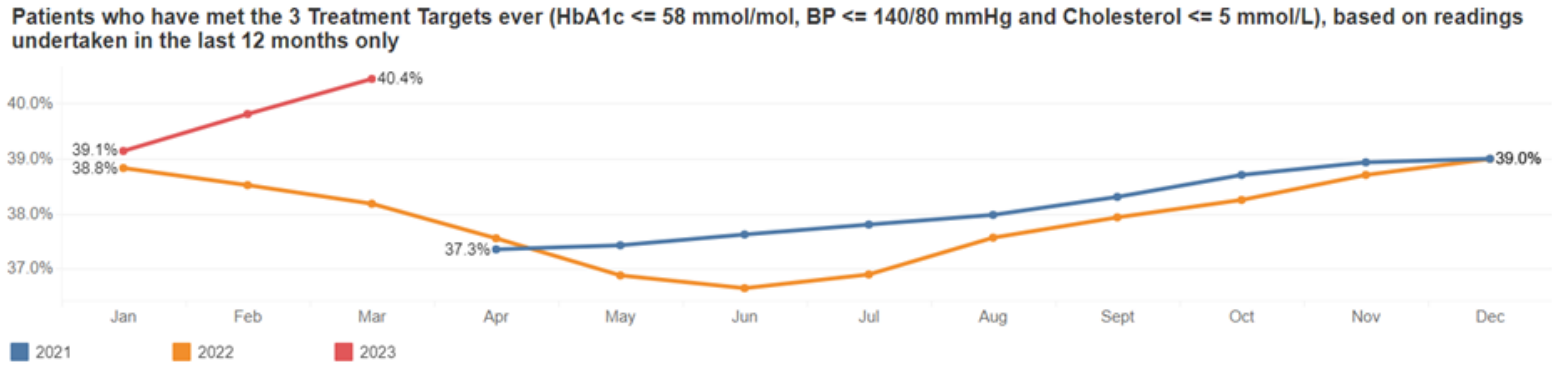
- Data led approach using the GM Analytics and Data Science Platform (ADSP)
- General Practice data innovatively used to produce a set of analytical tools to support population health management approach to identify and reduce health inequalities.
- GP Practices incentivised to prioritise those most *at risk* and to undertake a multimorbidity review to meet all health needs and to identify unmet need
  - Year 1 (2022/23) – incentivised review of people with Diabetes *at risk*
  - Year 2 (2023/24) – expanding to all Cardiovascular Disease *at risk*
- Long term condition dashboards were developed to support PCN-neighbourhoods to take a data-intelligence led understanding of at-risk cohorts by demographics and protected characteristics, thus enabling focused neighbourhood activity in collaboration with Local Authority and VCSE partners.

Multimorbidity Approach – Early Outcomes

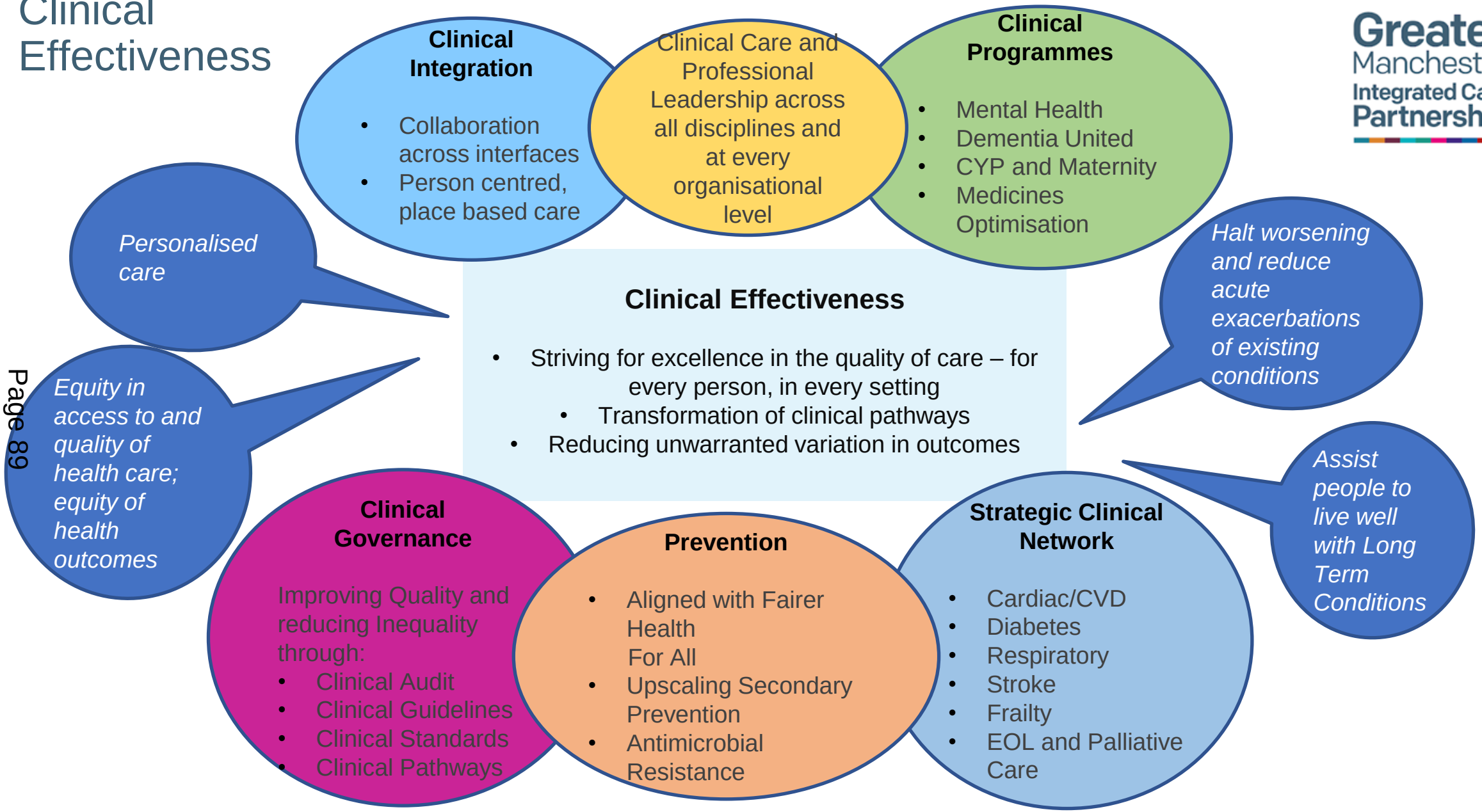
A) Chart showing narrowing of the gap between at risk and not at risk groups for achievement of complete diabetes care (the 8 Care processes)



B) Chart showing improvement in achievement of diabetes, blood pressure and cholesterol control in people with diabetes:



Clinical Effectiveness



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