Greater Manchester Integrated Care Partnership Board

Date: 29th September 2023

Subject: Implementing the Integrated Care Strategy – Mission 2: Helping People Stay Well and Detecting Illness Earlier

Report of: Sarah Price – Chief Officer: Population Health and Inequalities (NHS GM)
Manisha Kumar – Chief Medical Officer (NHS GM)

SUMMARY OF REPORT:

1. 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.

2. A key part of the Board's role in the implementation of our strategy and plan will be to examine in depth the delivery of the six missions in the strategy with a focus on the key system actions we can take collectively to deliver the missions effectively, efficiently and with impact on health outcomes and inequalities.

3. This meeting of the Board will focus on Mission 2 - Helping people stay well and detecting illness earlier.

4. A slide deck is enclosed with this cover note which explores in more detail:

   a) An overview of the priority actions in Mission 2

   b) What are we doing? Strategic shift towards prevention: GM Prevention and Early Intervention Framework

c) How will we achieve this?

- Fairer Health for All
- NHS GM Clinical Effectiveness Programmes

d) What it looks like in practice – summary examples:

- Making Smoking History in Greater Manchester
- Ending All New Cases of HIV in Greater Manchester by 2030
- Tackling Alcohol Harm
- GM Moving
- Mental Wellbeing
- Early Cancer Diagnosis
- CVD Prevention – Blood Pressure Optimisation
- A Multimorbidity Approach – Manchester Locality
- GM Dementia and Brain Health Delivery Plan

RECOMMENDATIONS:

The Greater Manchester Integrated Care Partnership Board is asked to:

- Note the update on Mission 2 and the work that is ongoing.

- Endorse the Prevention and Early Intervention Framework as a visual representation of our collective approach to preventing poor health.

- Endorse Fairer Health for All as our approach to ensuring that health inequalities are embedded across the work of NHS GM.

- Endorse the approach set out within the NHS GM Clinical Effectiveness Programme

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Mission 2:
Helping People Stay Well and Detecting Illness Earlier

Greater Manchester Integrated Care Partnership

GM Integrated Care Partnership Board

29th September 2023

Summary of Report

a) **An overview of the priority actions in Mission 2**

b) **What are we doing?**

- Strategic shift towards prevention: GM Prevention and Early Intervention Framework

c) **How will we achieve this?**

- Fairer Health for All
- NHS GM Clinical Effectiveness Programmes

d) **What it looks like in practice – summary examples:**

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Mission 2: Summary of Priority Action Areas

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 Framework sets out 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.
- The Framework directly frames the delivery of Missions 1 to 3 of the Strategy and JFP, and also has significance for missions 4 to 6.
- Focussing our efforts on parts of the Framework will not be sufficient as all parts are interdependent and reflect the journey of our population as the progress through life.

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 identify 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

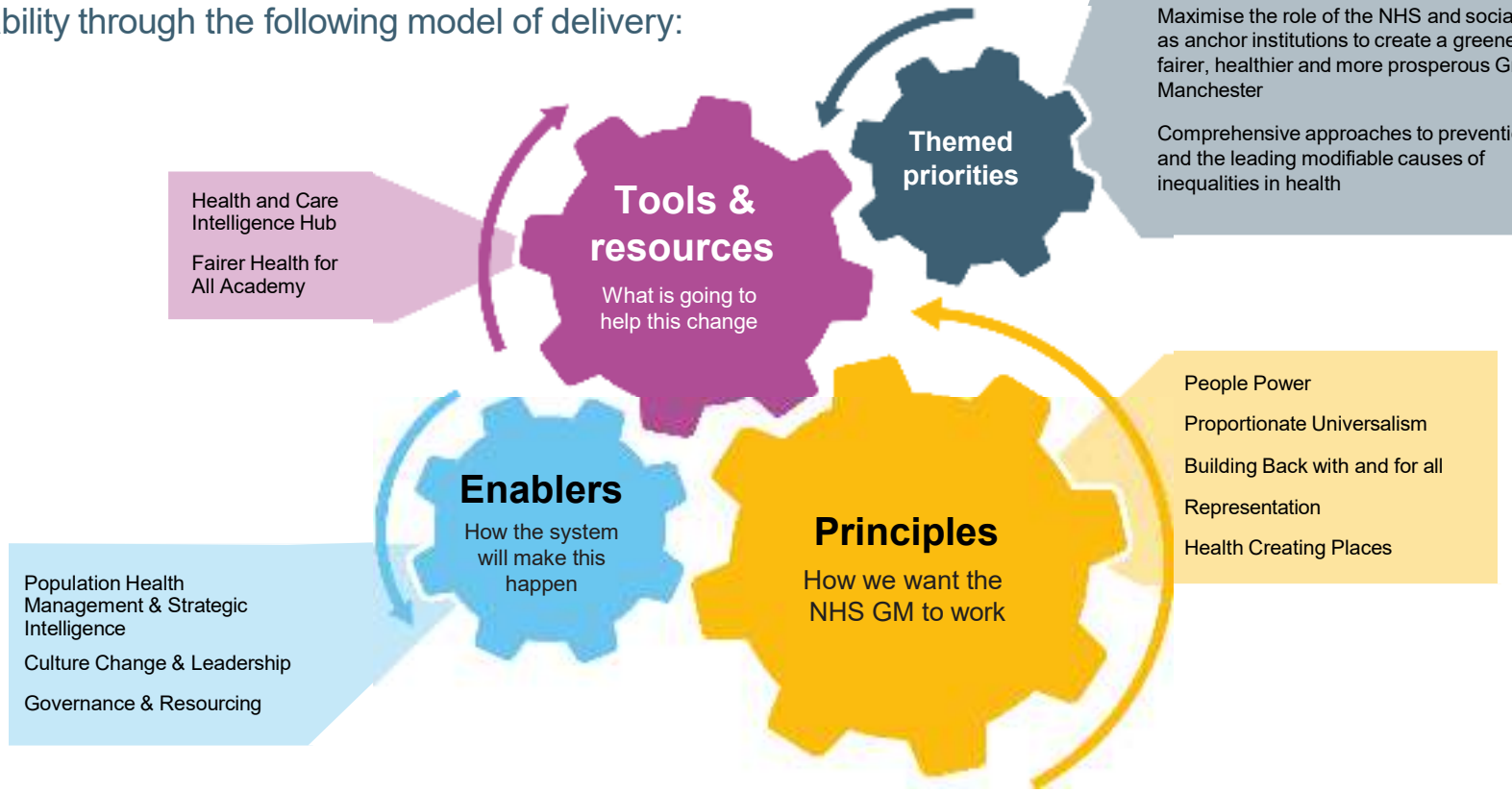
Harnessing the following system characteristics

- 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

Fairer Health for All

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 Aims and Objectives

Greater Manchester Integrated Care Partnership

What we will do:

1 **Improve health and wellbeing to narrow the gap in 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**
Leading to significant reductions in health inequalities between and within localities in avoidable mortality by 2027. Reducing avoidable mortality will also require us to 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.

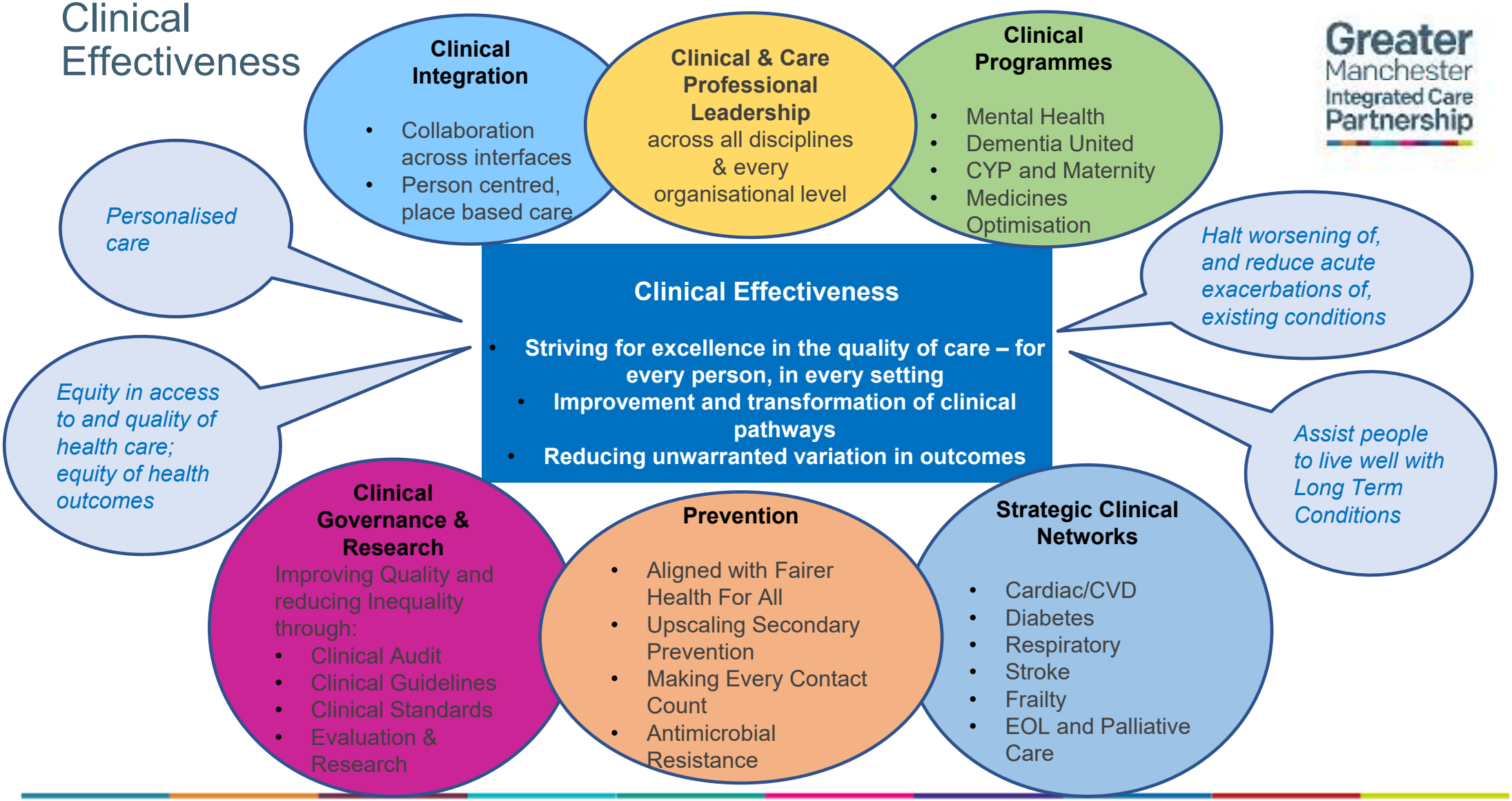
4 **Reductions in preventable or unmet health needs leading to reductions in demand**
Evidenced in part by closing the health inequalities gap in smoking with England by 2030. Smoking is our single greatest cause of preventable inequalities and 1 in 4 hospital patients' smoke.

5 **Eliminating the difference in life expectancy for those with serious mental illnes and incidence of physical health conditions**
For people experiencing mental health conditions by 2030.

6 **Ensuring all Greater Manchester children have the best start in life** Through measures including lower infant mortality by 2027, and when compared to England peers.

NHS GM Clinical Effectiveness Programmes

Clinical Effectiveness



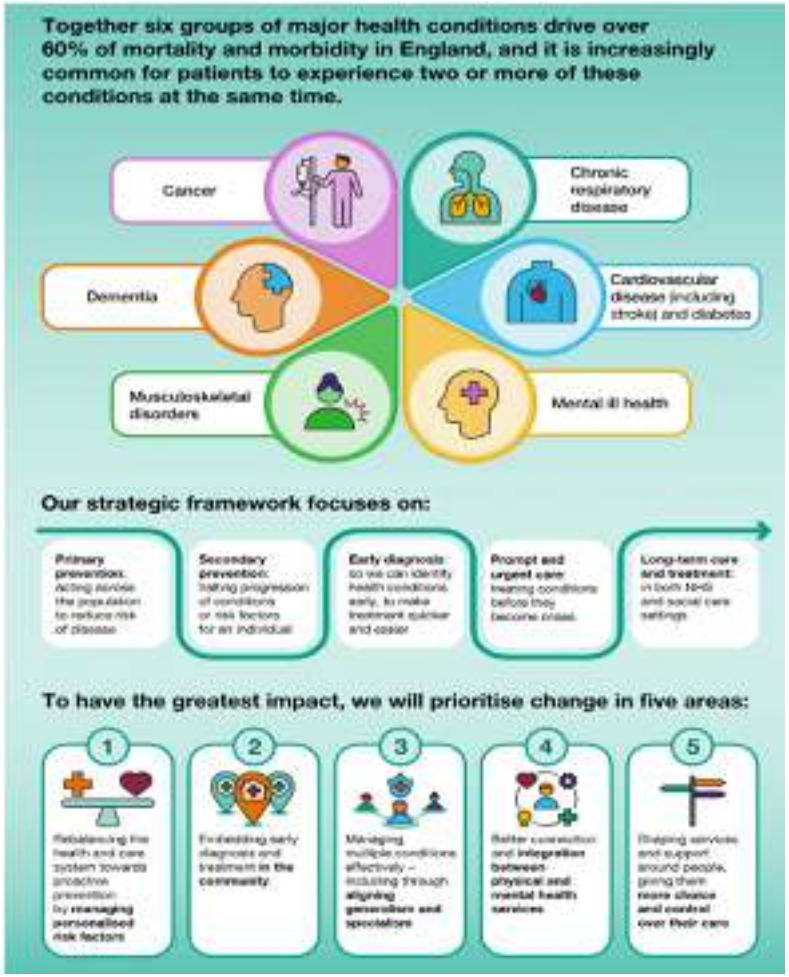
Major Conditions Strategy

- DHSC Strategy launched August 2023

Emphasis on the shift away from acute, reactive care towards:

- Prevention of ill-health and prevention of worsening illness
- Early diagnosis and treatment
- Managing multi-morbidity and complexity

- Alignment with our ICP Strategy and Mission 2 of JFP and Early Detection are complex and wide-ranging endeavours



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

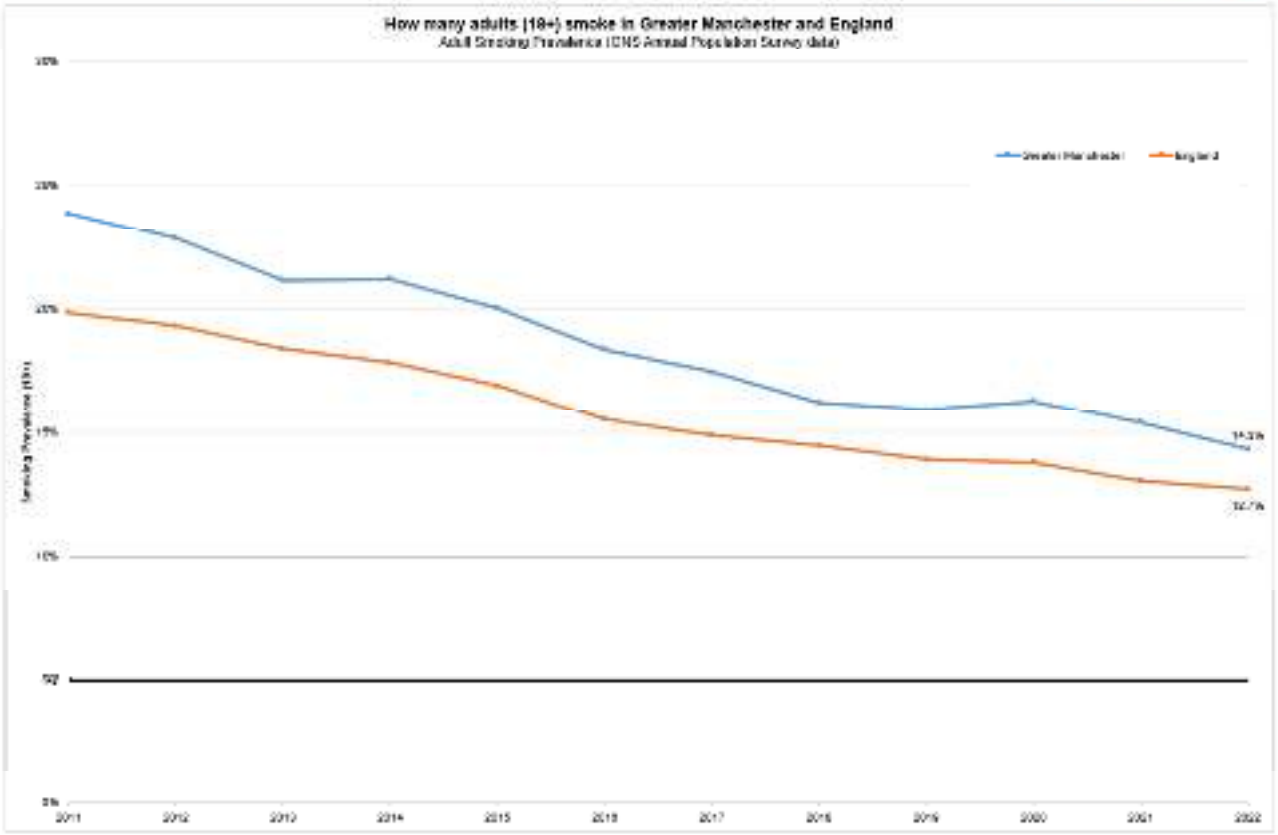
fewer smokers

1/3

reduction in smoking at time of delivery

4,500

more babies born smokefree



Ending all new cases of HIV by 2030

Ending HIV – A multicomponent, partnership approach

Greater Manchester Integrated Care Partnership

TARGETED WORK TO ADDRESS INEQUALITIES

Scaling and extending reach of community HIV prevention and sexual health interventions – condom/lube distribution, face-to-face and digital information, tailored resources and outreach/ community engagement

HIV/STI testing promoted and available through a variety of routes (PaSH)
Year-round access to postal self-sampling kits (SH24)
Opt-out testing in EDs

Intensive Support Service for people living with HIV who have complex needs – improving access to care, effective treatment and support (GHT)

Peer-led combination prevention campaign and website (PaSH)

Primary and Secondary Care awareness training and podcast featuring Positive Speakers (MFT, GHT, PASH)

E-learning module for healthcare professionals addressing HIV stigma (MFT, GHT & Dibby Theatre)

Positive Speaker programme reaching into a variety of settings (GHT)

HIV in the workplace resources (PASH)

ENDING HIV STIGMA AND DISCRIMINATION

Ending HIV – Highlights

Greater Manchester Integrated Care Partnership

Around 6,375 people living with HIV in GM **(95%) are aware of their status.***

99% of people aware of their status are receiving treatment to manage their condition.*

Over 130,000 people have been tested in Manchester and Salford emergency departments for HIV and/or HCV since April 2022. With **56 new diagnosis of HIV and 170 new diagnoses of HCV.**

97% of people being treated have an undetectable viral load meaning the condition cannot be passed on to others.*

Since 2011, there's been a 58% reduction in new HIV diagnoses amongst GM residents first diagnosed in the UK. **

36 people living with HIV and 46 people living with HCV have been identified who already had a diagnosis but **were not accessing care**. **53 people living with HIV and 140 people** living with HCV have now been linked to care, and many **have accessed community support.**

Greater Manchester attained 95:95:95 UNAIDS / Fast Track City Targets 9 years early

**UKHSA England Fast Track Cities Update 2022*
***OHID Sexual Reproductive Health Profiles 2019 data*

Ending HIV - Support and Impact

Greater Manchester Integrated Care Partnership

Evaluation of the Intensive Support Service showed that:

- People accessing the service had on average **96% improvement in clinic attendance**. They also had increased adherence to anti-retroviral (ARVs) resulting in nearly four out of five clients (79%) having, or being close to having, an undetectable viral load.
- 79% of people reported an **improvement in general wellbeing** within 9 months of allocation to the programme, and 85% reported an improvement in general wellness.
- After engagement with the service, **3 pregnant clients gave birth to HIV negative babies**.

ED opt-out diagnosed patient, male, aged 50

"I attended the emergency department for a completely unrelated reason. I was initially angry about being tested as I felt I had control taken away from me, but after being diagnosed and speaking with the doctors and learning HIV is just a long-term manageable condition and with treatment It does not reduce life expectancy, I now feel very grateful I have been diagnosed as I don't think it's something I would have been tested for in the near future."

Intensive support patient, female

"P wanted to say how grateful she was for Lauren's help. P had totally disengaged from services and was then admitted to Wythenshawe very unwell last year with a prolonged admission of 2 months with confusion. Since being discharged she has remained stable on treatment under the care of Withington, reached an undetectable viral load and her immunity is improving. She is now living independently and with Lauren's help now has PIP and a blue badge."

Tackling Alcohol Harms

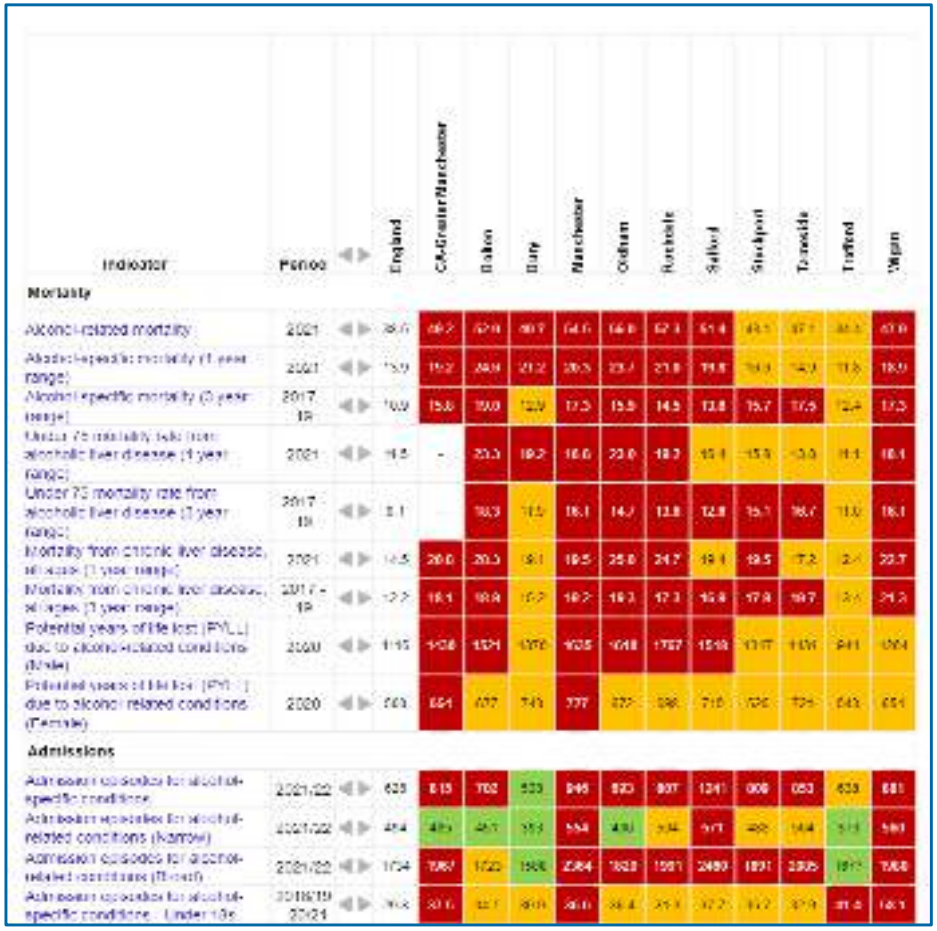
Tackling Alcohol Harms Context

Our System Challenge

GM performance outcomes are worse than the national average across almost all key national indicators.

Alcohol is a significant drive of morbidity, mortality and demand.

Alcohol is a systemic challenge which require a whole system response.



Indicator	Period	England	GM	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Mortality													
Alcohol-related mortality	2021												
Alcohol-specific mortality (1 year range)	2021												
Alcohol-specific mortality (3 year range)	2017 - 19												
Under 75 mortality rate from alcoholic liver disease (1 year range)	2021		-										
Under 75 mortality rate from alcoholic liver disease (3 year range)	2017 - 19												
Mortality from chronic liver disease, all ages (1 year range)	2021												
Mortality from chronic liver disease, all ages (3 year range)	2017 - 19												
Potential years of life lost (PYLL) due to alcohol-related conditions (Male)	2020												
Potential years of life lost (PYLL) due to alcohol-related conditions (Female)	2020												
Admissions													
Admission episodes for alcohol-specific conditions	2021/22												
Admission episodes for alcohol-related conditions (Narrow)	2021/22												
Admission episodes for alcohol-related conditions (Broad)	2021/22												
Admission episodes for alcohol-specific conditions - Under 18s	2018/19 - 20/21												

To tackle this our strategic priorities are:

- **Protecting Children and Young People from alcohol-related harm**
- **Providing high quality and integrated services**
- **Engaging people and communities**
- **Research, insight and future planning**

Tackling Alcohol Harms Deliverables

1. Protecting Children and Young People from drug and alcohol-related harm

- Maternity Equality and Equity Action Plan – "*Embed universally proportionate interventions to prevent the incidence and associated harms of alcohol use in pregnancy*" C
- Continued delivery of our nationally leading Alcohol in Pregnancy programme, and the implementation of the NICE Quality Standards for Fetal Alcohol Spectrum Disorder (FASD)
- Primary research into the drug and alcohol consumption behaviours of children and young people in Greater Manchester

2. Providing high quality and integrated services for those at the greatest risk of drug and alcohol-related health harms:

- Greater Manchester Maternity Equality and Equity Action Plan – "*Accelerate preventative programmes that engage those at greatest risk of poor health outcomes*".
- Strengthen end-to-end support for those experiencing drug and alcohol harm and/or those who are drug or alcohol dependent, including those who have co-morbid mental health needs.
- Monitor and evaluate Alcohol Care Teams (ACTs) in GM, improve quality and reduce variation, and assess future options post 2023/24 when funding ceases.
- Strengthen palliative and end of life care for individuals with drug or alcohol needs
- Reduce high risk opioid prescribing and routinely monitor the newly developed NHS GM Dependence Forming Medicines dashboard.
- Continue to support the development and delivery of HIV and HCV Emergency Department (ED) opt-out testing.
- Utilise Liaison and Diversion and Reconnect services to identify people in custody, court and through the gate and refer to substance misuse services

3. Engaging people and communities

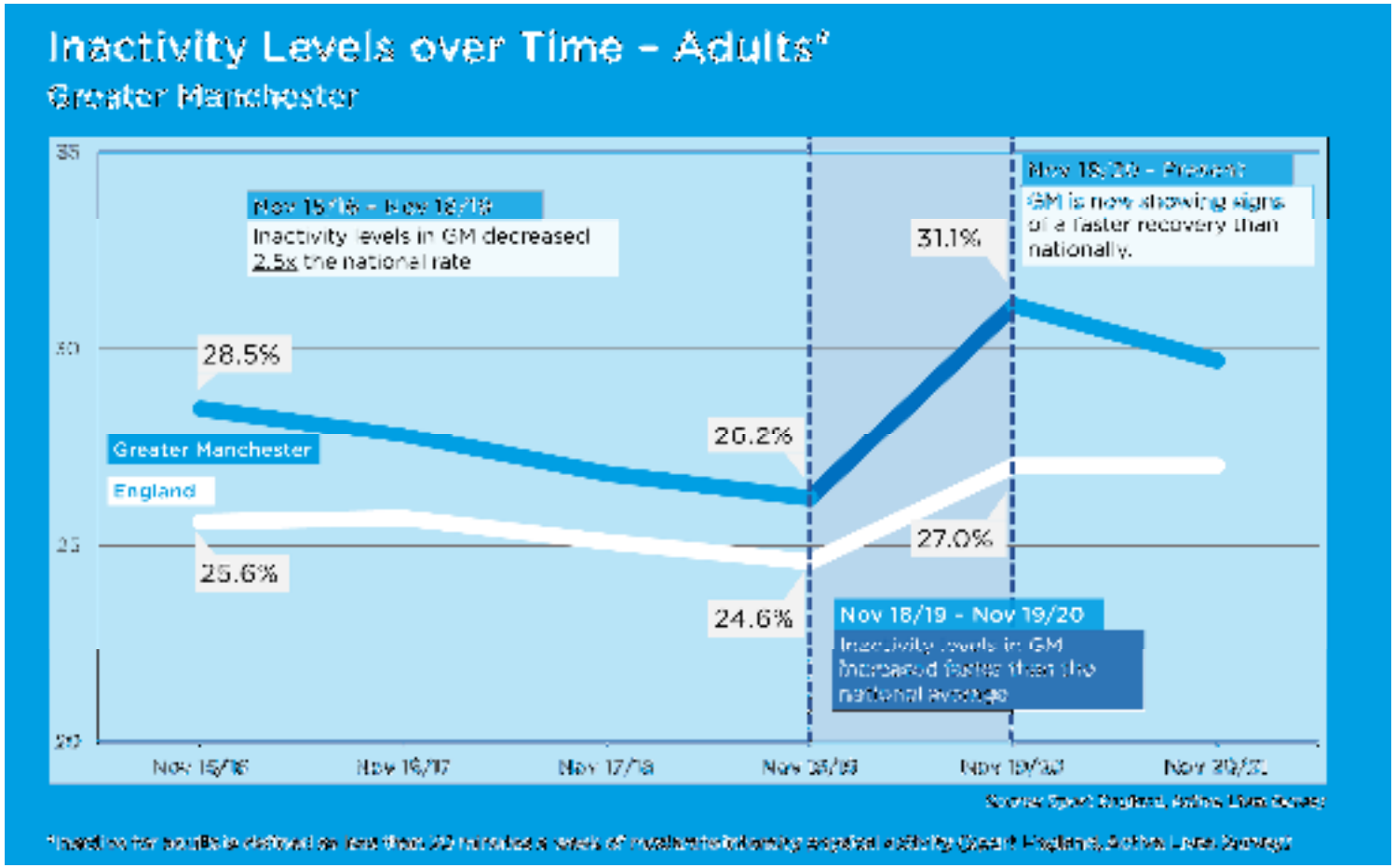
- Commission a community-led '*Ambition for Alcohol*' project aimed at catalysing a social movement for change in Greater Manchester, and a community-led demand for action.

4. Research, insight and future planning:

- Develop, implement, and commission the independent evaluation of an evidence-based and co-produced NHS GM plan to tackle the health harms associated with alcohol underpinned by:
- A Rapid Evidence Synthesis focussed upon the most effective approaches to reducing alcohol-related harm.
- An alcohol-focussed strategic evidence and research partnership with the NIHR Applied Research Collaboration (Greater Manchester).
- Focussed engagement with key risk cohorts within the GM population, including those from inclusion health cohorts, those who fall within the Core20Plus5 framework and those who have high levels of risk, but low levels of engagement.

Keep GM Moving

Keep GM Moving Context



Keep GM Moving Highlights

- Development of **GM Moving Integrating Physical Activity in Health and Care Forward Plan (23-28)** to combat this including work to date:
- Leading **priorities across the whole of the GM Moving in Action strategy** to **support Covid-19 recovery and resilience** and integration of physical activity at neighbourhood, locality and GM levels.
- Alignment of plans and investments to address health inequalities (e.g., **Together Fund** and Green Social Prescribing).
- Contributing to **Active Partnership Health and Inactivity Network** to connect with similar programme outside of GM.
- **Commissioning The Foundry to develop, test and learn from marketing and communications** approaches to develop the next phase of GM Moving and Health Integration.
- Developing '**Move More Better Conversations' to** increase knowledge of the benefits of moving for people working directly with communities.
- Continuing to grow and embed **the GM Walking Ambition** including a **Learning Event and GM Walking Grants** focused on health and long-term conditions.
- GM Walking Festival 2022 - **210 walks** were hosted by **66 organisations (10,000+ walkers** engaged in festival 2019-22).
- **Physical Activity and Health Integration Learning in Action Event** (over 80 attendees).

Mental Wellbeing

Mental Wellbeing Highlights

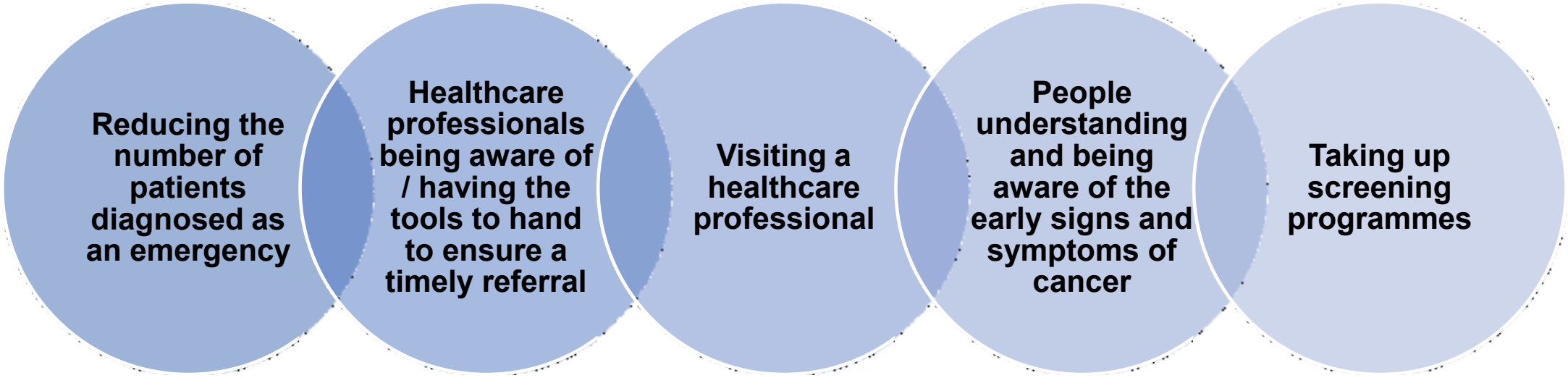
- There are **3,981 people** in GM in contact with mental health services for every 100,000 of the population compared to 2,176 nationally*. With the impact of Covid-19 and the cost of living crisis, mental wellbeing support is needed more than ever.
- We are currently working with OHID on a **nation wide community of practice linked to Mental Health prevention.**
- Work has been ongoing with population health analysis and Public Health leads across GM to co-develop **a Mental Wellbeing Outcomes Framework.**
- This year, sees the development of **a system wide,, Mental Health and Wellbeing Strategy** delivered as part of the GM consultation workshop as well as the delivery of the following key achievements:
- **GM Mental Wellbeing Grants fund were awarded to over 90 GM VCSE organisations** in 2022-23. A total of £150K allocated.
- **9 projects funded through the Culturally Appropriate Mental Wellbeing fund** - £91,553 was awarded in May 2022 to communities specifically working with marginalised ethnic groups to reduce the disparities experienced by communities who experience inequalities.
- **Eight of the 10 boroughs now have Councillor Mental Health Champions.**
- **Over 1,600 people participated in direct Connect 5 courses led by GM partners** (2020-2021) and over 200 train the trainers were trained to cascade Connect 5. GM has continued to offer direct delivery sessions (150 learners) to PCN workforce, Faith Sector and some localities who are not yet delivering Connect 5.

*Health Innovation 2019

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

Greater Manchester Integrated Care Partnership

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

Greater Manchester Integrated Care Partnership

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

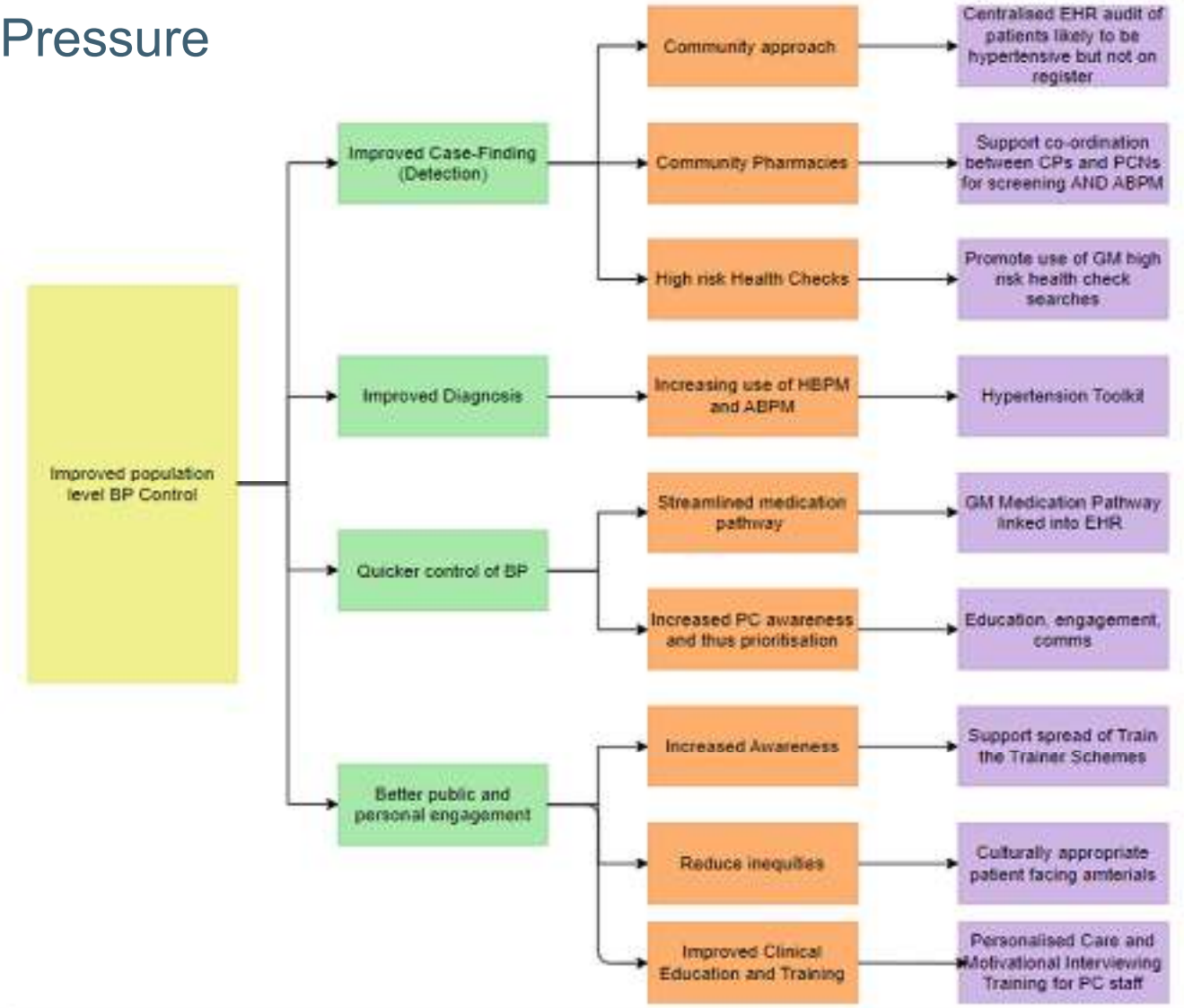
CVD Prevention – Blood Pressure Optimisation

Approach to Optimising Blood Pressure (BP)

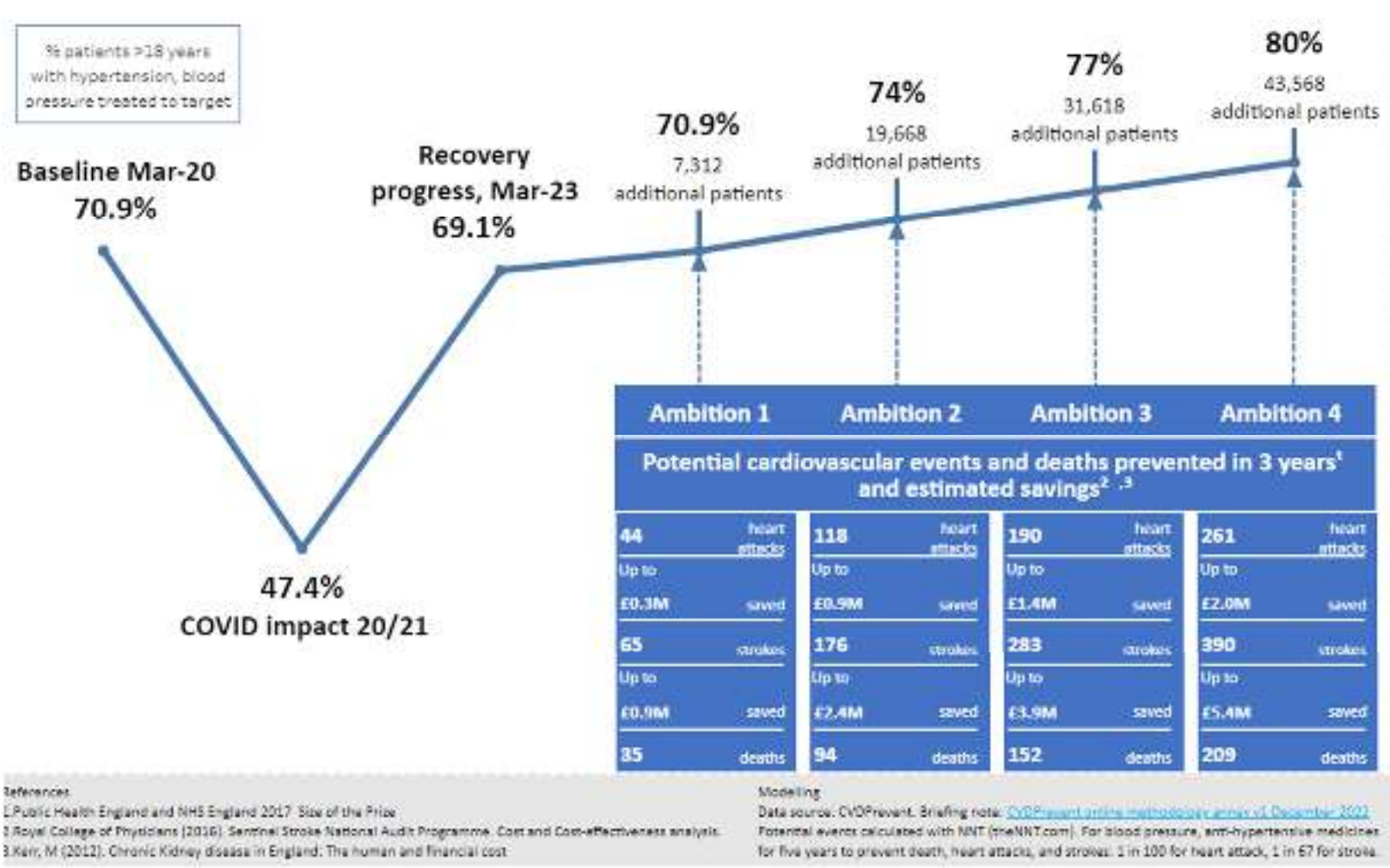
A population health, behavioural and system approach to improving Blood Pressure Control across GM has been taken.

This has led to an implementation that is:

- Community based
- Targets current key barriers
- Tackles health inequalities
- Reduces unwarranted variation



Impact of Optimising Blood Pressure (BP)



References
1.Public Health England and NHS England 2017 Size of the Prize
2.Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3.Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling
Data source: CVDPrevent. Briefing note: CVDPrevent online methodology paper v1 December 2021
Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes. 1 in 100 for heart attack, 1 in 67 for stroke.

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If we achieve **Ambition 1**, this will save:

- 44 heart attacks
- 65 strokes
- 35 deaths
- £1.2m

Over 3 years

<u>The aim is to achieve **Ambition 4**</u>

Progress of Optimising Blood Pressure (BP)

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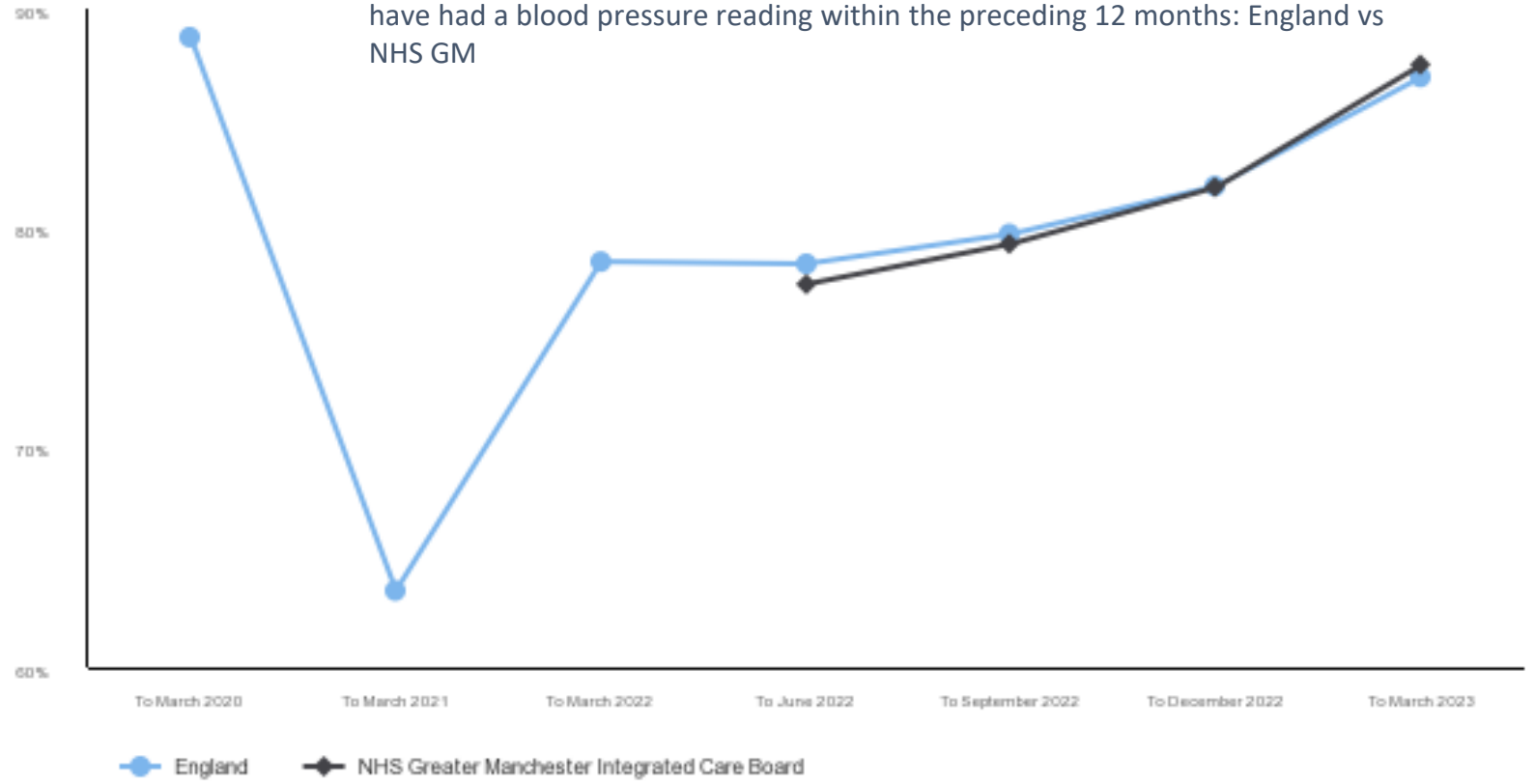
Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months: England vs NHS GM



Source: https://www.cvdprevent.nhs.uk/insights?period=6&area=E38000&group=0

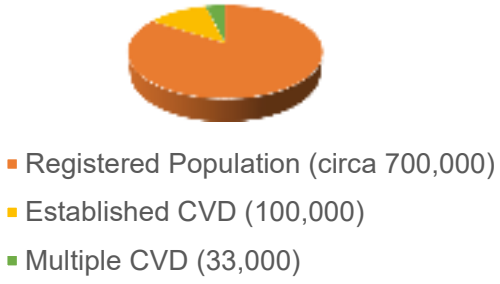
A Multimorbidity Approach –
Manchester Locality

Multimorbidity Approach to Diabetes and CVD

Greater Manchester Integrated Care Partnership

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

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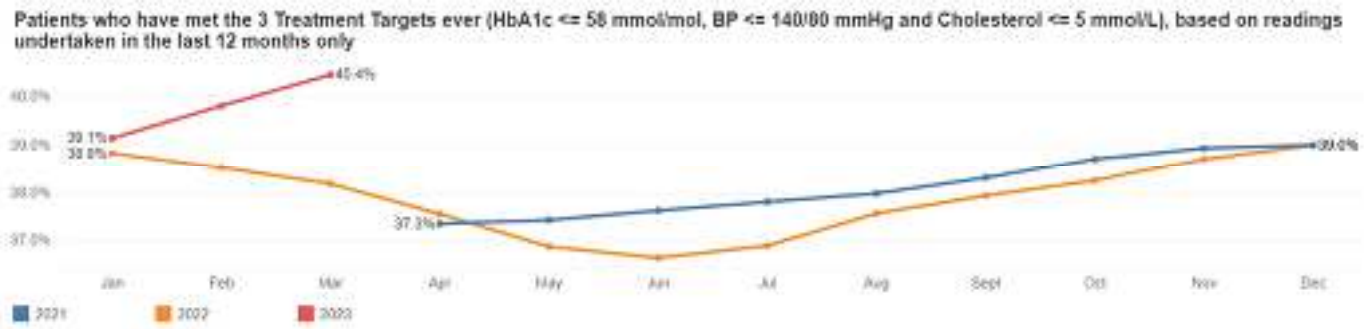
A) Chart showing narrowing of the gap between at risk and not at risk groups for achievement of complete diabetes care (the 8 Care processes)

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



The GM Dementia and Brain Health Delivery Plan

Dementia and Brain Health Delivery Plan

Greater Manchester Integrated Care Partnership

Improving connections, quality of care and experience for everyone affected by dementia

- Dementia Wellbeing Plan Digitisation
- Dementia Care Navigation
- Active inclusion of marginalised communities
- Improve quality and experience of being diagnosed with dementia
- Improve detection, treatment and management of Delirium
- Young onset and rarer forms
- Embed quality standards across the Dementia Care Pathway
- Support the provision of good End of Life Care

Promote brain health and help prevent avoidable cases of dementia, supporting wellbeing and independence

- Wellbeing grant initiatives; Big Brain Health Fund and Creativity in Care Homes
- Physical Activity and GM Moving.
- Creative Health, including Music and Dementia.
- Social Prescribing and Dementia support
- Wider determinants of health including finance and housing projects
- Links to new technology for falls prevention
- Brain Health Strategic Development work

Design, develop and facilitate education and training across all sectors

- Support the provision of mandatory dementia training resources
- Undertake training needs analysis to identify and address gaps
- Scope and identify specific locality, sector and project training needs
- Commission dementia and brain health training
- Promote and share broad range of Dementia United training resources
- Promote training for carers and lived experience
- Promote education re Brain Health, Dementia, Prevention and wellbeing
- Support person centred responses to distressed behaviours and complex needs

Increase access to benefits of dementia research through awareness, involvement and participation

- Work collaboratively with new and existing academic partner organisations
- Drive Innovation through Quality Improvement initiatives
- Increase research participation opportunities including through Join Dementia Research
- Horizon scanning and embedding the latest research
- Promote excellence through National and International research links
- Further develop Trailblazer and Proof of Value projects
- Mild Cognitive Impairment programme (Neurology Academy)

Diversity and Inclusion;
Co-production with people with lived experience of dementia and their carers;
Partnership working and the Dementia Care Pathway

Bounce Back Fund Evaluation

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"Music and Dance saved my sanity"

"Caring for someone 24/7 can be isolating, lonely and exhausting. Coming along to the Music and Dance gives me a place where I know the other people understand what the situation is...My husband loves the singing, and it is wonderful to see the glimmer of the man that I married."

"I speak on behalf of all the attendees at the lunches when I say many thanks to Dementia United for helping to tackle isolation and keeping people connected"

"The group gives me a chance to stop and relax on a regular basis. This 'me-time' is a chance to catch my breath and gives me energy to continue my caring duties."

"I observed my father come alive. He was smiling, laughing, and chatting in a way I have not seen for many years"