GREATER MANCHESTER HEALTH AND CARE BOARD

Date: Friday 11 May 2018
Time: 10.00am – 12.00 noon
Venue: Council Chamber, Manchester Town Hall

Access to the Council Chamber

Public access to the Council Chamber is on Level 2 of the Town Hall Extension, using the lift or stairs in the lobby of the Mount Street entrance to the Extension. That lobby can also be reached from the St. Peter’s Square entrance and from Library Walk.

There is no public access from the Lloyd Street entrances of the Extension.

AGENDA

1. WELCOME AND APOLOGIES

2. MINUTES

   To consider the approval of the minutes of the meeting held on 16 March 2018

3. CHAIR’S ANNOUNCEMENT AND URGENT BUSINESS

4. CHIEF OFFICER’S REPORT

   Report of Jon Rouse

5. DIABETES CLINICAL BEST PRACTICE STRATEGY

   Report of Dr Richard Preece
6. **CHILDREN’S HEALTH AND WELLBEING FRAMEWORK**
   Report of Warren Heppolette

7. **A GREATER MANCHESTER FRAMEWORK TO IMPROVE PALLIATIVE AND END OF LIFE CARE**
   Report of Dr Richard Preece

8. **URGENT EMERGENCY CARE IMPROVEMENT AND TRANSFORMATION**
   Report of Steve Barnard

9. **DRAFT BUSINESS PLAN 2018/19**
   Report of Warren Heppolette

10. **DATES OF FUTURE MEETINGS**
    13 July 2018 10am – 12 noon TBC
    14 September 2018 10am – 12 noon TBC
    09 November 2018 10am – 12 noon TBC
## GM HEALTH AND CARE BOARD

### MINUTES OF THE MEETING HELD ON 16 MARCH 2018

<table>
<thead>
<tr>
<th>Organization</th>
<th>Members</th>
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<tbody>
<tr>
<td>Alzheimer’s Society</td>
<td>Sue Clarke</td>
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<tr>
<td>Bury Council</td>
<td>Councillor Andrea Simpson, Pat Jones-Greenhalgh</td>
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<tr>
<td>Bury CCG</td>
<td>Stuart North</td>
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<td>Bolton CCG</td>
<td>Wirin Bhatiani</td>
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<td>Carbon Literacy</td>
<td>Phil Korbel</td>
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<td>Christie NHS FT</td>
<td>Tom Thorber</td>
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<td>Dementia United</td>
<td>Rachel Volland</td>
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<td>GM Mayor</td>
<td>Andy Burnham</td>
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<td>GMCA</td>
<td>Lindsay Dunn, Jamie Fallon</td>
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<td>GM ACCGs</td>
<td>Rob Bellingham</td>
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<td>GM H&amp;SC Partnership Team</td>
<td>Karishma Chandaria, Warren Heppollette, Claire Norman, Nicky O’Connor, Dr Richard Preece, Sarah Price, Jon Rouse, Vicky Sharrock, Steve Wilson</td>
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<tr>
<td>GM Cancer Team</td>
<td>Claire O’Rourke, David Shackley</td>
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<tr>
<td>GMCVO</td>
<td>Alex Whinnom</td>
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<tr>
<td>Healthwatch</td>
<td>Peter Denton</td>
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<tr>
<td>Manchester Foundation Trust</td>
<td>Kathy Cowell, Darren Banks</td>
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<tr>
<td>Manchester Health and Care Commissioning</td>
<td>Ian Williamson</td>
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NW Boroughs Healthcare NHS FT
Oldham Council
Oldham CCG
Pennine NHS Trust
Primary Care Advisory Group (Optometry)
Primary Care Advisory Group (Pharmacy)
Provider Federation Board
Rochdale MBC
Salford CC
Salford CCG
Salford Royal NHS Foundation Trust
SCN
Stockport CCG
Stockport MBC
Tameside MBC
Tameside NHS Foundation Trust
Trafford Council
Trafford CCG
Wigan Council

Also present at the meeting was Alan Mills, to provide his experiences as a resident of GM living with dementia.

HCB 01/18  WELCOME AND APOLOGIES

Apologies were received from:

Councillor Allan Brett, Eamonn Boylan, Matt Colledge, Julie Connor, Mayor Paul Dennett, Alan Dow, Noreen Dowd, Theresa Grant, Ranjit Gill, GM Deputy Mayor Beverley Hughes,
Tony Hunter, Kevin Lee, Councillor Richard Leese, Claire Molloy, Bob Morris, Councillor John Murray, John Patterson, Jim Potter, Councillor Rishi Shori, Steve Rumbelow, Jim Taylor, Tracey Vell, Dorothy Whittaker and Carolyn Wilkins.

**HCB 02/18 CHAIR’S ANNOUNCEMENTS AND URGENT BUSINESS**

The Chair passed on his appreciation to the personnel mentioned in the report of the Chief Officer and thanked them for their contributions to the Health Partnership and the Board.

**HCB 03/18 MINUTES OF THE MEETING HELD 19 JANUARY 2018**

The minutes of the meeting held 19 January were agreed as a true record.

**RESOLVED/-**

To approve the minutes of the meeting held on 19 January 2018.

**HCB 04/18 CHIEF OFFICER’S UPDATE**

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership (GMHSCP), provided an update on key items of interest across the GMHSC Partnership.

The following items were highlighted:

- It was reported that a ‘devolution difference’ communications and engagement campaign had been launched that week which aimed to demonstrate to staff, stakeholders and the public how health devolution was making a difference to the lives of the people of Greater Manchester. A devolution difference ‘toolkit’ would be available to assist staff and partners share the key messages and practical examples of successes;
- The World Health Organisation had announced that day that GM would be designated the UK’s first Age Friendly City Region. Greater Manchester Combined Authority was working in partnership with the Centre for Ageing Better to develop and share innovative approaches to ageing across the city-region;
- GM had been successful in their bid to the Department for Digital, Culture Media and Sport for a significant grant to roll out fibre infrastructure. It was advised that this was fundamental for the ambition for digital interoperability and innovation within health and care. The Board were informed that this would be followed up by a bid to obtain status to become a digital care exemplar, which would attract additional resources to accelerate the interoperability of the digital system across GM;
- With regard to Urgent and Emergency Care performance, the Chief Officer paid tribute to the whole front line workforce in and out of hospital who had continued to deal with a level of unpresented demand for services which had put significant pressure on patient flow. The work at Fairfield Hospital and Rochdale Infirmary was highlighted as an example of how working together across the health and care system could produce an incredible level of performance of maintaining A and E four hour performance;
- The Care Quality Commission (CQC) report into Pennine Acute Trust (PAT) had rated them as ‘requires improvement’ with ‘good’ leadership. This had improved from the previous overall inadequate rating. Although ongoing work was still required, it was noted that all inadequate ratings had been eliminated and 70% of all services were rated as either good or outstanding which demonstrated great progress;
The CQC report into Greater Manchester Mental Health Trust had found them ‘good’ overall with ‘outstanding’ leadership. Credit was extended to all the staff involved in the merger of Manchester Mental Health Trust with Greater Manchester West Mental Health, for recognising the opportunities and making improvements a year into the Trust acquisition;

Steve Wilson, Executive Lead, Finance & Investment, GM Health and Social Care Partnership provided the Board with an update on the financial performance of health and social care. It was reported that the current position for 2017/18 indicated a surplus of £1.3m against a planned deficit of £17.6m. Credit was extended for all the hard work undertaken in the individual organisations across the system. It was advised that the surplus was likely to grow once CCGs released the risk reserves that had been set aside. However, the Board were reminded that significant one off items had fed into the performance and there would be challenges over the forthcoming financial years.

The Chair reiterated his credit on behalf of the Partnership to staff across the system who have worked during high levels of demand over the winter period. The emphasis of the Partnership to work together to divert patients to treatment in the community was considered fundamental to secure improvements across the system.

RESOLVED/-

To note the update report.

HCB 05/18 SCHOOL READINESS – THE HEALTH CONTRIBUTION TO EARLY YEARS

Sarah Price, Executive Lead, Population Health and Commissioning, GMHSCP introduced a report which outlined the health contribution to improving levels of school readiness in GM.

The Board were informed that good health in the earliest years of a child’s life was vital to achieving the ambition of making the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people of Greater Manchester. There was a firm commitment to transform the system from expensive and reactive to prevention and early intervention and at no stage was this considered more important than the 1001 critical days from conception to age two years.

The report identified how health partners were working with wider partners to develop a shared co-ordinated work programme to ensure that school readiness was a key priority across Greater Manchester. It had been identified that pregnancy and birth provided a critical window of opportunity when parents were particularly receptive to advice, support and guidance.

Karen Clough, Specialist Midwife in Public Health Surveillance, Saving Babies Lives at Pennine Acute Hospitals NHS Trust supplemented this with an update on the work being done to help people to give up smoking during pregnancy.

It was reported that rates of smoking during pregnancy varied across Greater Manchester, with some of the highest rates in Pennine. For example, smoking at delivery rate in Rochdale reached 17.4 % in February, which was well above the national average of 10.8%.
An overview of the Greater Manchester smokefree pregnancy scheme called Baby Clear which would enable women to access specialist help for their smoking addiction was provided to the Board. It was advised that the Greater Manchester approach was on a larger scale than projects delivered before, was research backed and based on changing the culture around smoking in pregnancy. Throughout, the consistent message would be, that smoking in pregnancy would result in ill health for mother and baby.

It was believed that with the expertise of staff, enthusiastic leadership, funding and the commitment that the GM smokefree pregnancy scheme provided, a real difference to smoking rates in pregnancy could be achieved. This could ultimately improve the health of women and families and would have long term impacts on the health of future generations, giving children in Greater Manchester the very best start in life in a smoke free environment.

Members offered their support for the report and the Baby Clear programme but highlighted the constraints of resources and the financial sustainability across localities for the vital programme of work. It was agreed that cuts to local government budgets made the implementation of the programmes difficult. However, new monies allocated from the transformation fund allowed investment into such programmes often in the most deprived communities. The Board were provided with an update on the digital fund and it was reported that funding had allowed for the role out of mobile technology for health visitors which had enabled them to work more efficiently providing more time to support families. However, due to controls totals for both Tameside and Stockport not being agreed with NHS Improvement, access to capital funding for such investment was not available in those areas which was thus having a direct impact on families. Lobbying for access to discretionary capital, regardless of individual agreement on control totals would continue for those areas and be supported by the Partnership.

A member asked for clarification that the Baby Clear programme was only focused on tobacco smoking or included e cigarettes and vaping products. It was confirmed that at this stage tobacco related smoking was the primary focus.

The appetite for water fluoridation for the region in order to have the biggest impact on dental health inequalities was discussed and it was suggested that although it was a significant cost, it was a challenge that the Chair was keen to support and lead on.

The Chair offered support for the strategy but requested further information has to how the strategy would deliver the behaviour change required. It was suggested that the voluntary and community sector were utilised in order to influence behaviour change where possible. It was proposed that further information was requested from the GM School Readiness Board as to how the strategy would be implemented across the ten localities and in the service delivery areas where this would make a difference across the Partnership.

**RESOLVED/-**

1. To note the content of the report and commit ongoing support to the ambition to increase the number of children who are school ready in GM;
2. To continue to lobby NHSI and Central Government on the accessibility of discretionary capital for all localities;
3. To provide further consideration to fluoridation across the region;
4. To request further details from the GM Schools Readiness Board on the implementation of the health contribution to school readiness.
Simon Barber, Chief Executive, North West Borough Health Care and Chair of the Children and Young Peoples Mental Health Implementation Board provided an overview of the delivery to date of the Children and Young Peoples Mental Health Programme. It was reported that one in ten young people have a diagnosable mental health condition and 75% of adult mental illness begins before the age of 18. The Greater Manchester mental health ambitions, the achievements and the programme priorities for 2018-21 were outlined to the Board. Key reforms which included mental health leads in every school, new teams to support schools to meet mental health needs and shorter waiting times to get help and the deliverables were highlighted.

A video clip from a patient’s story demonstrating the community eating disorder service was presented providing an insight into the collaborative work having an impact across GM. The service was developed on the core values of the thrive model which provided help, advice and the support required.

The Mayor of Greater Manchester welcomed the pace of the GM Mental Health Children and Young People Programme, but highlighted the importance of ensuring that consideration was provided to the voice of young people and their call for a curriculum for life. It was suggested that the Youth Combined Authority were invited to be involved in the development of the model outlined and highlighted that mental health was central for the wider life advice for children and young people. He further added that there should be specific connections to the wider life readiness agenda being developed and clear commitments to care leavers and young carers with regards to mental health.

In support of the programme, members reiterated the comments made by the Mayor with regard to children, young people and their parents being involved in the development of the pathways to ensure that a child friendly approach is adopted. It was highlighted that looked after children are often placed in boroughs where they have not originated from, it was recommended that this vulnerable group continue to receive the correct support and attention wherever they live. It was confirmed that the looked after children cohort were included within the whole programme and in particular with regard to the implementation of the crisis care model.

The Board welcomed the key reforms proposed with regard to support for schools and asked if there would be additional resources allocated alongside training. It was advised that training would be provided prior to any additional funding that maybe announced in the forthcoming Green Paper which would allow GM to be in a better placed position.

As localities faced increasing substantial financial challenges and new models of care were developed, innovative ways to engage the voluntary sector in the programme was emphasised as significant. Furthermore, the connection of models across the GM footprint and the sharing of best practice operating in districts was considered to be necessary. It was advised that the successful models implemented in localities would be developed to deliver single service specifications and consistency across GM.

The Board considered the role of technology and the growing body of research and evidence that suggested that social media impacted on the health and wellbeing of young people. It was proposed that further consideration and connections were made with the digital strategy.
to ensure that the acceleration of the digital agenda did not have further bearing on the health and wellbeing of young people.

A member representing the voluntary sector provided the Board with reassurance that there had been a considerable level of engagement with young people, particularly with Children and Adolescent Mental Health Services commissioning and the work undertaken with young carers. There was a further offer of support from Healthwatch networks to help to develop the emerging agenda of mental health support for transition between Children’s and Adult’s services. The Board were informed that the voluntary sector and national charities had been engaged and were key partners in the delivery of all the identified workstreams.

It was confirmed that young people had assisted in the development of the programme and had provided consideration to the language used prior to implementation. Further engagement with the Children and Young People’s Mental Health Implementation Board was being considered in order to provide an effective interface to monitor and provide an understanding as to whether programmes were beginning to make a difference to children and young people.

In welcoming the report, the Chair suggested the Children and Young People’s Mental Health programme should be considered by the Youth Parliament. He reiterated the comments made by the Board with regard to the role of the voluntary and community sector.

RESOLVED/-

1. To note the progress update provided;
2. To note the comments from the Board with regard to continued children, young people, parental and carers involvement in service delivery and communication;
3. To provide the Children and Young People’s Mental Health programme to the Youth Parliament for consideration and comment.

HCB 07/18  DEMENTIA UNITED

Anthony Hassall, Chief Operating Officer, Salford CCG provided the Board with an update on the Dementia United programme. It was highlighted that Dementia United continued to be a priority for Greater Manchester and the opportunities and developing work plan to mobilise a strategy and system response for people living with dementia and those who care for them aligned to the GM dementia standards was outlined in the report.

Anthony introduced Alan Mills, Sue Clarke and Dr Jeff Schryer to the Board and in doing so described them as being the important people to provide a view of the work being done to meet the strong commitment made to make GM the best place to live in the world with dementia. It was reiterated that there was a strong commitment to co design by involving those living with dementia, their carers, the voluntary sector and clinicians working in the field. Credit was extended to Sir David Dalton who had initiated the programme of work in GM.

An overview of the facts, aims of the programme, the journey so far and further work plan development was outlined to the Board. Alan Mills, who had been diagnosed with early onset dementia and Alzheimer’s provided members with his experiences as a resident of GM living with dementia. He outlined the emotional and peer support that people with dementia required and described the variations offered at the specialist centres that perform further diagnosis and memory tests.
Sue Clarke from the Alzheimer's Society supplemented this by explaining that she had worked in the field of dementia over the last ten years across GM. She emphasised that people are more aware of the issues which those who have been diagnosed with dementia are living with and further encouraged members of the Board to provide support.

Dr Jeff Schryer, a GP in Bury provided an overview of the unique way in which Dementia United were working in partnership with people who suffer from dementia and their carers to help develop pathways. He provided an example of the work across the health and social care system and explained how it was making a difference to service delivery and provision.

The Chair thanked the individuals for the collective presentation which highlighted the exciting work underway to support people living with dementia. The Mayor of GM, reiterated his appreciation and acknowledged that support for people with dementia needed to be provided as well as the support delivered to people with cancer. He reflected that it had been confirmed that GM was the first UK’s city region to be receive age friendly status by the World Health Organisation, which reaffirmed the strength of plans and vision. He suggested that the focus should be on age friendly rather than the dependency in order to achieve the full potential. It was confirmed that £1 million of funding had been announced by Sport England to promote physical activity for older people along with a GM Festival of Ageing on 2-15 July 2018, funded by the Heritage Lottery. It was emphasised that the language around contribution rather than dependency was important to the wider sense of maximising people’s independence.

The Board were provided with an insight into the scheme introduced at Super League side Wigan Warriors reaching out to supporters with dementia and helping to tackle loneliness in the community. The club had set up a Rugby Memories group where fans of the team meet up once a week to watch an old game and reminisce about the glory days.

RESOLVED/-

1. To note the content of the report and proposed engagement with GM governing groups and localities;
2. To endorse the direction of travel;
3. To note the positive appreciation from the Board for the powerful presentation;
4. To note the announcement that GM was the first UK city region to receive Age Friendly status;
5. To note the announcement by Sport England that £1m of funding would be available to promote physical activity for older people;
6. To note the GM Festival of Ageing on 2-15 July 2018.

HCB 08/18 UPDATE ON CANCER WORK

Dr Richard Preece, Director of Quality, GMHSCP introduced a report which provided the Board with an update on cancer work across the Greater Manchester network. The report provided an overview, key data with associated commentary and outlined future priorities. The 2017 Report of the Greater Manchester Cancer Board, published in February 2018 which outlined many of the signature programmes in more depth was appended to the report.

It was reported that good progress was being made against the targets described in the 4-year GM Cancer Plan of Feb 2017 and also the cancer related aspects of the NHS planning guidance. The current highest priorities related to delivering accelerated pathways in lung,
colorectal, prostate and upper gastrointestinal cancer, alongside specific additional work in lung cancer, and delivery of the recovery package.

David Shackley, Medical Director and Claire O’Rouke, Lead Nurse, Greater Manchester Cancer supplemented the report with an overview of the highlights from the previous year and the forthcoming priorities from a professional perspective and progress for patients. Members were encouraged to attend the first GM Cancer Conference scheduled for 26 November 2018.

In welcoming the report the Chair acknowledged the work of the GM Cancer Board and the impressive achievements made in a short space of time.

RESOLVED/-

1. To note the progress made across the GM Cancer system;
2. To endorse the current approach and priorities;
3. To note the encouragement for members to attend the GM Cancer Conference on 26 November 2018.

HCB 09/18 HEALTHWATCH IN GREATER MANCHESTER – PROGRESS UPDATE

Peter Denton, Healthwatch Liaison Manager, Healthwatch in Greater Manchester introduced a report which provided an update of the first year of the GM Liaison function and identified development areas for Healthwatch for the coming year.

The report highlighted the statutory functions of local Healthwatch, particularly in terms of its role in assessing the quality of health and care services and in supporting community engagement.

It was reported that local Healthwatch priorities had been mapped against GM Health and Social Care plans. It was noted that Healthwatch priority activity with the Partnership was closely aligned with implementation of the Mental Health Strategy; Theme 3 Standardisation of Acute Hospital Services activity; and supporting effective engagement in the development and implementation of locality plans.

It was confirmed that Healthwatch had secured representation on a range of the Partnership’s governance boards for both Mental Health and Theme 3 as well as at a strategic level. Healthwatch had also developed a process of aggregating patient, service user and carer feedback to inform its role on the GM Quality Board.

RESOLVED/-

1. To receive and note the contents of this report;
2. To reaffirm support for all members of the Partnership to work collaboratively with Healthwatch both at locality and Greater Manchester levels.

HCB 10/18 CARBON LITERATE HEALTH AND SOCIAL CARE – SALFORD LOCALITY PRESENTATION

Charlotte Ramsden, Strategic Director for Community, Health and Social Care, Salford City Council introduced a presentation on behalf of Councillor John Merry, Deputy City Mayor, Salford Council. The Board were provided with an overview of the impact of the Boxing Day
floods in 2016, with regards to adopting a commitment to become more carbon literate and responsible.

The Board were informed of the collective work to develop the opportunity across health and social care to become carbon literate and the ambition to make Greater Manchester one of the leading green cities in Europe. It was advised that to help realise these ambitions, a landmark Green Summit would be held on 21 March 2018.

Phil Korbel, Director Carbon Literacy Project described the added value in engaging people to participate in carbon literacy in order to prevent harm and promote well-being. The scale of the challenge in GM to obtain zero emissions by 2038 in response to the Paris Agreement was highlighted to the Board.

It was advised that Salford CCG would be the first carbon literate NHS organisation. Anthony Hassall informed members that Salford CCG would take forward the issue of carbon literacy and the impact of pollution across GM health and social care providers and CCG’s.

The Mayor highlighted the opportunities from a health and economic perspective and encouraged organisations to make a pledge at the Green Summit. The individual benefits for organisations in terms of savings along with an overview of the GM plastics campaign to eliminate single use plastics was provided to the Board.

RESOLVED/-

1. To note the update provided;
2. To note the drive to eliminate single use plastics in GM;
3. To provide further consideration as individual organisations to making a pledge in advance of the Green Summit.

HCB 11/18  DATES OF FUTURE MEETINGS

Friday 11 May 2018  10:00am – 12:00 noon  Council Chamber, Manchester Town Hall
Friday 13 July 2018  10:00am – 12:00 noon  Council Chamber, Trafford Town Hall
Friday 14 September 2018  10:00am – 12:00 noon  Number One Riverside, Rochdale Council
Greater Manchester Health and Care Board

Date: 11 May 2018
Subject: Chief Officer’s Report
Report of: Jon Rouse, Chief Officer, GMHSC Partnership

SUMMARY OF REPORT:

This report provides the GM Health and Care Board with an update on activity relating to health and care across the Partnership. It includes key highlights relating to performance, transformation, quality, finance and risk.

The report also provides a summary of the key discussions and decisions of the Partnership Executive Board.

PURPOSE OF REPORT:

The purpose of the report is to update the GM Health and Care Board on key items of interest across the GMHSC Partnership.

RECOMMENDATIONS:

The GM Health and Care Board is asked to note and comment on the content of the update report.

CONTACT OFFICERS:

Vicky Sharrock
Deputy Director Strategic Operations, GMHSC Partnership
Vicky.sharrock@nhs.net
1.0 KEY UPDATES AND ISSUES

1.1 People

1.2 There have been a number of leadership changes which have taken effect last month. Theresa Grant, Chief Executive of Trafford Council has taken on the role of Accountable Officer at Trafford CCG. Carolyn Wilkins, Chief Executive of Oldham Council similarly has taken on Accountable Officer responsibilities at Oldham CCG. Caroline Kujerza has been appointed interim Chief Officer at Wigan CCG.

1.3 Neil Thwaite has been appointed as Chief Executive for Greater Manchester Mental Health Trust. Neil started his career in the NHS in 1993 and has worked across many NHS sectors including acute care, primary care, the Cancer Network and the Strategic Health Authority. Neil joined the Trust in 2006 and was the Executive lead for the successful Foundation Trust application.

1.4 The Greater Manchester Association of Clinical Commissioning Groups announced the appointment of a new chair, Dr Tom Tasker. Dr Tasker takes over from Dr Kiran Patel, who is taking on a leadership role in the Local Care Organisation in Bury. Kiran has been an exceptional Chair and leaves the Association with firm foundations upon which to build.

1.5 SYSTEM UPDATES

1.6 Operational plans for 2018/19

1.7 Each NHS clinical Commissioning Group and each NHS Trust has to draw up an operational plan in accordance with guidance issued by NHS England and NHS Improvement nationally. The content of the national guidance reflects the annual mandate to NHS England and equivalent letter to NHS Improvement from the Secretary of State for Health. Under the devolved settlement, GM organisations still have to develop and submit plans that meet the requirements of the national planning guidance. However, we are planning in a very difficult context where GM has set a five year plan, Taking Charge, localities have set equivalent and complementary plans and all are working to investment agreements based on a key set of activity assumptions, milestones and financial projections. We are now entering into the third year of our five year plan.

1.8 To support the operational plan sign off process, the Partnership Team met with all ten localities to discuss the operating plan submissions, and the alignment with the investment agreements. This process identified a number of areas where there is misalignment for 2018/19 for a variety of reasons such as baseline performance levels, differences in activity coding, implementation delays etc.

1.9 Having reviewed the operational plans following this period of targeted challenge and revision, we are in a position where in aggregate we are aiming to be more ambitious in terms of managing activity levels than the assumptions in the national planning guidance. This is a reflection of the fact that year 3 of our transformation programmes
is a significant year in terms of delivery of key programmes that should help us manage levels of demand.

1.10 The next step is for the localities to refresh their local plans and thus the content of their investment agreements to ensure they are reconciled with the one year operational plans. The proposed timeline for the Investment Agreement Refresh is shown below:

1.11 Development of national long-term health plan

1.12 Earlier this year the Prime Minister announced her commitment to developing a long-term plan and multi-year funding settlement for the NHS... In parallel, in his first significant speech since taking on the dual roles of health and social care, Secretary of State Jeremy Hunt outlined the seven key principles of reform to the adult social care system in England that will form the backbone of a Green Paper to be launched this summer. The seven principles are:

1. Quality and safety embedded in service provision
2. Whole person, integrated care with the NHS and social care systems operating as one
3. The highest possible control given to those receiving support
4. A valued workforce
5. Better practical support for families and carers
6. A sustainable funding model for social care supported by a diverse, vibrant and stable market
7. Greater security for all – for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be

1.13 Following on from these announcements the Government is now undertaking a comprehensive engagement exercise with key leaders in the health and social care system across the country to discuss the proposals in more detail. GM has taken part in these discussions at the highest level and will continue to provide advice as requested.
1.14 First Anniversary Commemoration Programme

1.15 There will be a series of events commemorating the first anniversary of the bomb. The commemoration programme is based around three themes: Remembrance, Reflection and Celebration of Life – recognising each of the 22 people who lost their lives in the attack, those who were injured and first responders - and Manchester Together, embracing the solidarity shown by the city.

- **Remembering Together Manchester Cathedral 2-3pm** - One of the events is a Civic Memorial Service at Manchester Cathedral. The service will be attended by bereaved families and first responders. The Partnership will be represented at the service through senior members of the core team and through representatives from several of the organisations involved on the night.
- **Manchester Together - With One Voice Albert Square 7.30-9pm** - This event is open for all to come together, with one voice, for a mass singalong in a united act of remembrance. Supported by choirs from across the region, we’ll have a selection of songs that evoke pride and solidarity.
- **Manchester Together - There is a Light St Ann’s Square - From Dusk 22-26 May** - For five nights, song lyrics will be projected onto the pavements and buildings in the St Ann’s Square. The square became an important place for reflection and paying respects to those who lost their lives. We will project lyrics from songs chosen by the public
- **Manchester Run and City Games 20 May** A one-minute silence will also be held during the Great Manchester Run, with further commemorative elements during the Games including fundraising for the We Love Manchester Emergency Fund

1.16 Breast screening system failure

1.17 The NHS Breast Screening programme is overseen by Public Health England and commissioned in GM by the GMHSCP. They invite women for a breast screening between the ages of 50 -70 every three years up to their 71st birthday. Earlier this year, PHE analysis of trial data from the service found that there was a computer algorithm failure dating back to 2009. This led to some women who were due to be invited for mammography between their 68th and 71st birthday, missing their final invitation.

Our collective priority is making sure the women who have missed their final screen get one as quickly as possible. NHS England will be leading the NHS response with providers to identify additional capacity to provide screens to women. It is a priority for us to ensure that the additional scans do not cause any delays in the regular breast screening programme for those under 71.

Our Public Health commissioning team is leading the capacity response with providers directly. This will require a significant capacity planning and implementation exercise and robust monitoring. All women affected who wish to have a breast
screen will receive an appointment to take place before the end of October 2018; we expect additional screens to commence in May 2018.

Anyone concerned should contact the free helpline 0800 169 2692. There is also information on the NHS Choices website at https://www.nhs.uk/pages/home.aspx

1.18 Flu Vaccination outturn and emerging plans for next year

1.19 Between 1st September 2017 and 31st January 2018, Greater Manchester Health and Social Care Partnership (GMHSCP) delivered a successful 2017/18 influenza programme. There were 1,217,028 people eligible for the influenza (flu) vaccine (according to provisional data) and 765,995 influenza vaccinations were administered to eligible people within Greater Manchester, a 62.65% uptake overall which is an increase of 126,287 vaccines administered compared to the 2016/17 programme.

1.20 GMHSCP was the highest ranked area (out of 25) for uptake among those individuals in at risk groups aged 6 months to 65 years, and the second highest performing amongst all pregnant women, and for those aged 65 or over. There has been significant improvement in the average uptake of the vaccine in school aged children across GM in comparison to 2016/17, with over 10% improvement demonstrated across all eligible age cohorts in all 10 GMHSCP Local Authorities, but there is still work to do to improve uptake among 2 and 3 year old children in GM.

1.21 GMHSCP providers of the influenza vaccine have worked hard to achieve the successes seen in the 2017/18 seasonal influenza programme: this is acknowledged and appreciated. The multi stakeholder collaborative operational flu groups within each locality area have also significantly contributed to ensuring the improved uptake was achieved. A number of innovative pilots were employed and a partnership with AstraZeneca was used to promote uptake. These pilots are being evaluated and will inform planning for the 2018/19 season which is already underway and will hopefully improve uptake across eligible cohorts. Finally, special mention must go to Stockport for their exceptional performance as the leading CCG in the country across several cohorts.

1.22 Local Health and Care Record Exemplar

1.23 GM has submit a bid to become a Local Health and Care Record Exemplar (LHCRE) which could attract £7.5 million capital investment over 2 years in order to accelerate the sharing of integrated care records, patient access to records and to support delivery of population health management approaches.

1.24 At the core of the bid is the development of an Interoperability Hub which will implement common standard for information sharing across organisational boundaries. The hub will build on the existing investment made in Graphnet and DataWell, systems that enables information sharing to support direct care.

1.25 The bid was submitted on 25 April and we expect to hear if GM has been successful by the end of May.
1.26 Development of Local Care Organisations

1.27 In April, we held two important events relating to the development of Local Care Organisations (LCOs) in Greater Manchester.

1.28 The first was a joint event with the King’s Fund. This was facilitated by Professor Chris Ham – the Chief Executive of the King’s Fund and aimed to:

- Build on the learning from the peer to peer conversation review process that we undertook with all of the LCOs in early 2018;
- Translate learning from that process into an action plan;
- Progress plans for the LCO Network’s programme of work in 2018/19

1.29 Four localities – Salford, Stockport, Tameside and Wigan – gave examples of the work that they are doing to develop their LCO. The ten areas worked on some of the common challenges they face: for example, on new contract arrangements; the development of neighbourhood teams from across a range of organisations; improving engagement with the voluntary and community sector; and setting outcomes for the LCOs to aim for.

1.30 The second event was held with emerging leaders from the neighbourhoods within Local Care Organisations. The event was led by Dr Joanna Bircher – who is the Greater Manchester lead GP for the GP Excellence Programme.

1.31 Three localities – Bolton, Manchester and Tameside – gave examples of how they are building neighbourhood teams around groups of GP practices. The event also considered the key characteristics of neighbourhood working, quality improvement in general practice and reviewed the primary care business intelligence tool.

1.32 Launch of the Development Work for the Children and Young Person mental health crisis pathway

1.33 The Children and Young People’s (CYP) Crisis Care Pathway was launched on 17 April 2018. The launch event, which took place at the Macron Stadium in Bolton, was attended by over 100 people who work to support CYP mental health in Greater Manchester. The CYP Crisis Care Pathway comprises innovative new services and ways of working to ensure accessible, responsive, 24/7 crisis care for children, young people, and their families.

1.34 The pathway is based on a REACH IN model, which centres on seven core values:

- Recovery focused and responsive
- Evidence-based and effective
- Accessible and available
- Comprehensive
- Holistic
1.35 Key to success of the pathway will be effective collaboration between all partners: commissioners and providers from across the NHS and Local Authority and the voluntary, community and social enterprise sector (VCSE). The launch event was held to bring together stakeholders from across Greater Manchester to share experiences of current services and work together to develop the model further. The first services that will be delivered will be the CYP MH Assessment Centre and the CYP MH crisis rapid response teams and staff recruitment for these services is underway.

1.36 National Audit office visit to GM

1.37 On the 20 April GM and Tameside jointly hosted a study visit from the National Audit Office who are looking at the interface of social care and health and were keen to hear about those areas of the country most advanced in becoming truly integrated. They met with key representatives from the system and were given an overview of progress being made across Greater Manchester and specifically in Tameside. They were then taken out to visit some neighbourhoods in Tameside to see integration in practice.

1.38 Association of British Pharmaceutical Industry (ABPI) Conference

1.39 On 26 April, the GMHSCP and Health Innovation Manchester profiled our relationship with the pharma industry at the ABPI annual conference. This was a great opportunity to showcase some of our flagship projects and most innovative collaborations. The session was very successful and the examples from Greater Manchester shone out amongst the programme. The session also gave a much wider audience the opportunity to see the potential opportunities for creating long-term partnerships in GM.

1.40 Greater Manchester Flexible Purchasing System – Finalist for a National Award

1.41 An innovative, collaborative approach to procurement being applied in Greater Manchester has been shortlisted as a finalist for a national award.

1.42 STAR Procurement is a finalist in the GO Excellence in Public Procurement Awards. STAR is the shared procurement service for Stockport, Trafford and Rochdale councils. It has worked with more than twenty partners in GM, including Councils and CCGs, to develop a new approach, using a Flexible Purchasing System, to develop ethical Learning Disability and Autism services.

1.43 This approach to procurement has led to the delivery of person-centred support to people with learning disabilities and autism with a focus on enabling people to live independently at home. Service users were also given a much greater say in how...
providers were chosen. All providers in the process had to commit to the highest ethical employment standards.

2.0 SYSTEM PERFORMANCE

2.1 There are a number of performance measures that the GM Health and Social Care Partnership is monitored against. Current performance against these is outlined in Appendix A

2.2 Key measures for the Partnership and the current performance against them is highlighted below:

- **Urgent Care 4 hour standard (National standard is 95% with higher being better performance)** – The published 4 hour performance position for all attendance types across Greater Manchester for March 2018 was 81.5%, compared with a February 2018 position of 83.7%. The good news is that, although the figures are yet to be validated, performance was substantially better in April.

- **Delayed Transfer of Care (National Standard is 3.5% with lower performance being better)** - Published data from NHS England for February 2018 shows a position of 4.1% for all Greater Manchester Trusts. This is 0.3% higher than the North Regional position and a deterioration of 0.1% on January 2018 published data. Performance for acute trust sites has remained at 4.2% when compared to the previous month’s performance. Analysis of the data for February 2018 showed that the top three reasons for delayed transfers of care were: delays in arranging domiciliary care packages; delays in transfer to further non-acute NHS Care and delays in arranging residential home placements. For the first time in the past year, the number of patients waiting for residential home placements is higher than those waiting for nursing home placements. Performance improved in March and April.

- **Referral to Treatment (National Standard is 92% of patients should wait less than 18 weeks for treatment with higher performance being better)** - The published data for February 2018 shows GM has missed the 92.0% standard with a performance of 90.6%. This is a slight deterioration on the January position of 0.2% and was expected due to cancellations over the winter period. We are working with all the commissioners and Trusts to ensure that we get back on track as soon as possible.

- **Diagnostic Waiting Times (National standard is for no more than 1% of people waiting 6 weeks or more with lower performance being better)** - The published data for February 2018 shows GM’s performance in diagnostics waiting time is 1.1%, which is an improvement of 1.2% on the January 2018 position. A new Endoscopy suite opened in January 2018 at Manchester Foundation Trust and a further new suite is planned at Bolton Foundation Trust in May/June 2018. This capacity alongside the use of
subcontracting arrangements across GM is helping to increase the diagnostic capacity. Although we haven’t quite met the national target for 1% this level of performance is a considerable achievement in the context of winter pressures.

- **Cancer** – Greater Manchester achieved six of the eight cancer standards in February 2018. The areas where the standard failed were “62 day referral to treatment” with a performance of 82.8% against a standard of 85% and “Treated within 62 days following a referral from screening” with a performance of 82.7% against a national standard of 90%. Recovery work is being led through the Cancer Board.

- **Improving Access to Psychological Therapies recovery rate (IAPT) (National standard is 50% with higher being better performance)** – While GM met its mental health access and waiting time standards, it has missed the IAPT Recovery rate standard in the published December 2017 data with 47.2% rolling quarter figure against a standard of 50%. This is a slight deterioration of 0.3% on the November position. Work is underway to understand the issues which affect recovery rates, particularly given the variations between localities. There are a number of population groups such as older people and people with long term conditions such as diabetes, CVD, respiratory problems particularly who have good recovery rates from IAPT. BAME groups have poor access rates and also poorer recovery rates than the general population.

### 3.0 QUALITY

3.1 The Quality Board next meets on 17 May. In addition to a focus on locality performance the Board will be discussing ambulance service care. The main focus of the meeting will be on learning from other systems and the regulation and inspection of new models of care. The Board will welcome senior leaders from the Royal Navy and the Care Quality Commission to contribute to the discussion. The Quality Board’s membership continues to evolve and future meetings will include a representative of the Provider Federation Board (in addition to locality and Arm’s Length Body organisations).

3.2 Work has continued to develop assurance around the GM Quality Improvement Framework. The Framework will be used increasingly in locality assurance beginning in quarter 2 of this financial year.

3.3 Work has begun to review how our system provides clinical leadership and accountability prompted by the Kirkup Review of Liverpool Community Health. The Chief Nurse and Executive Lead for Quality will be meeting with medical and nursing leaders in June to discuss this and will bring forward a paper for consideration by the Health and Care Board.

3.4 **General Practice Nurse awards**
3.5 Following the successful General Practice Nurse (GPN) awards in February, a lead for this work has now started with the Partnership to develop our response to the GPN 10 point plan to deliver the workforce of the future. Working with the Workforce Collaborative, the GM nursing recruitment campaign will also include a community and practice nurse focus, and work will commence this month to improve the skill awareness of heart failure in the nursing community through a dedicated telephone support system and the delivery of appropriate patient information and self-management for people living with heart failure.

3.6 Primary care complaints

3.7 The GM Health and Social Care Operational Management team agreed to bring the complaints service in house to NHS England in May 2016 at which time there were 390 ongoing complaints. Over the last two years we have worked hard to reduce this number and currently have 85 ongoing complaints, our lowest ever number.

4.0 FINANCE - MONTH 11

4.1 The financial performance of GM Health & Social Care at the end of February (Month 11) shows the current forecast is for GM to deliver a surplus for 2017/18 of £14m. This represents an £32.5m improvement against agreed Plan. This improvement whilst welcome is largely driven by one off factors which will not be repeated in subsequent years. The underlying position for GM remains a deficit and presents a number of challenges. The position by sector is shown in the table below:

<table>
<thead>
<tr>
<th>Sectors</th>
<th>Plan Surpl/ (Def) £m</th>
<th>Forecast Surpl / (Def) £m</th>
<th>Better / (Worse) than Plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planned controls</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHSE (excl Spec Comm)</td>
<td>0.0</td>
<td>6.1</td>
<td>6.1</td>
</tr>
<tr>
<td>CCGs</td>
<td>3.1</td>
<td>(3.0)</td>
<td>(6.1)</td>
</tr>
<tr>
<td>Providers</td>
<td>(21.6)</td>
<td>11.0</td>
<td>32.6</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total Surplus / (Deficit) - GM Control</strong></td>
<td><strong>(18.5)</strong></td>
<td><strong>14.0</strong></td>
<td><strong>32.5</strong></td>
</tr>
<tr>
<td>CCGs 0.5% risk reserve</td>
<td></td>
<td>19.8</td>
<td>19.8</td>
</tr>
<tr>
<td><strong>Total Forecast Surplus after release of 0.5% risk reserve</strong></td>
<td>33.8</td>
<td>52.3</td>
<td></td>
</tr>
</tbody>
</table>

4.2 The £32.5m forecast surplus does not include £20m (0.5%) risk reserve set aside by CCGs at the start of the year to support the national NHS financial position. Guidance has now been issued from NHSE for CCGs to release this to their bottom line at the end of the year, improving their financial positions by that amount.

4.3 The key points to note in relation to the financial position are:
• Before the release of the 0.5% risk reserve, CCGs have forecast a deficit of £3m at month 11 against a £3m planned surplus, resulting in a deterioration of £6m against Plan. This deterioration relates to Trafford CCG.

• The Provider forecast outturn is a £11m surplus, an improvement of £32.6m against Plan and largely attributable to significant movements in two Trusts (improvement of £54m at The Christie and a deterioration of £27.9m at Pennine Acute). The financial position across Providers remains challenging with five Trusts currently forecasting not to deliver against Plan.

• It is likely that the provider position will improve further at month 12 when NHS I deploys any underspent Sustainability and Transformation Funding to local trusts. It is not possible to estimate this figure at this time.

• All Local Authorities are projecting a breakeven position at year end.

5.0 TRANSFORMATION PORTFOLIO

5.1 Over recent months, the piece of work has been undertaken to understand the current position of all the projects across the GM Health and Social Care Partnership. Each project has been put into one of the following categories:

• Being implemented in 18/19
• To be costed and designed for implementation in 18/19
• To be prioritised for implementation in 19/20

5.2 The combination of the projects already in being implemented, plus those to be accelerated for implementation in 2018/19 will ensure that Greater Manchester delivers against national mandatory improvements.

5.3 A task and finish group is being brought together from Directors across the GM system and will work over the next three months to:

• Oversee the development of business cases (where required) for projects being accelerated in 18/19
• Oversee the prioritisation process for 19/20
• Review the detail of individual proposals for the remaining Transformation Fund

6.0 MANAGING OUR RISKS

6.1 The GM Health and Social Care Partnership Executive Board maintain a risk register which draws together risks identified through the GM Partnership Team and the 10 locality risk registers. This is reported to the Partnership Executive Board on a quarterly basis. The key risks to the delivery of the GM HSC Transformation Programme are outline below:
• **New models of care do not deliver the desired transformation or shifts in finance** – There are a number of actions aimed at reducing this risk including the recent work around planning and alignment with investment agreements outlined above and the ongoing monitoring of delivery through the quarterly assurance processes in place.

• **Lack of capacity to deliver** – The Workforce Collaborative is working with national bodies to coordinate investment into the GM workforce and maximise impact of our workforce development activities. In addition we are working across Partnership Organisations and with education providers to develop our own workforce of the future.

• **Digital Strategy not delivering in line with the requirements of GM and locality transformation programmes** – Strong links have been made between the digital strategy and the GM transformation programmes and locality transformation plans. This is evidenced in the first round of Digital Transformation Funding which focused on supporting localities to delivery their commitments in their locality plans. The LHACR work outlined above will also enable GM to accelerate progress on the Digital Strategy and improve access to health and care records.

• **Availability of required funding for Estates** – a pipeline of investment requirements has been developed across GM and we are currently working to develop the required investment strategy to support this.

• **Variation in quality of provision across GM** – Quality concerns are picked up through the GM Quality Board. Aligned to this we have developed ‘Communities of Practice’ to support facilitate learning across organisations and localities.

• **Failure to deliver against operational performance standards** – There are a number of activities in place to ensure operational performance standards are delivered including the establishment of our non-elective hub. This is supported by the use of Tableau, a new information management system that will provide up to date information on an ongoing basis to inform decisions on the best use of capacity.

**7.0 GOVERNANCE**

**7.1 Strategic Partnership Executive Board Decisions**

7.2 The Health and Care Board is asked to note the recommendations supported by the Partnership Executive Board at the meetings in February and March 2018. These are outlined in more detail the decision log in Appendix 3.

7.3 **28 February 2018 Partnership Executive Board:**

- **Transformation Fund Update** - current position on Transformation Fund and options for use of the remaining funding

- **Elective Hub Programme** – programme for ensuring resilience around elective services
• **Workforce Collaborative** – implementation of workforce strategy and pan-GM protocol to protect continuity of service

• **NHS Operational Planning Guidance** - response to the requirements set out in the national guidance and alignment to locality Investment Agreements

• **Care 2020** – Implementation of GM model supporting independent living and discussions with government around supporting financial model

• **Engaging with Communities about Devolution Difference** – proposals on communications and engagement campaign involving service users, resident and the community, voluntary and Social Enterprise sector

• **Kerslake recommendations on Charter for Families Bereaved through Public Tragedy** – agreement from members of PEB to commit to the Charter

• **Dementia United** – progress to date and proposals for next steps supported by £2.29m Transformation Fund

7.4 **22 March 2018 Partnership Executive Board:**

• **Standardising acute specialised care** – communications and engagement strategy for the programme for 2018/20

• **Commissioning update** – progress in implementing the Commissioning Review

• **Digital Interoperability and innovation Programme** – proposals for the areas of focus for the next six months and governance arrangements by which the programme will be managed

• **LCO Peer to Peer conversational Review process** – findings from the process outlining the core model features driving success and how we continue to increase pace of change for the benefit of GM residents

8.0 **RECOMMENDATIONS**

8.1 Greater Manchester Health and Care Board is asked to:

• Note and comment on the contents of the update.
## Appendix 1: GM System Performance Dashboard

### GM System Performance Dashboard

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Dec-16</th>
<th>Jan-16</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Patients Admitted, Transferred or Discharged from A&amp;E Within 4 Hours</td>
<td>84.1%</td>
<td>82.9%</td>
<td>85.4%</td>
<td>87.9%</td>
<td>89.0%</td>
<td>88.8%</td>
<td>88.9%</td>
<td>90.2%</td>
<td>89.4%</td>
<td>89.1%</td>
<td>86.7%</td>
<td>81.5%</td>
<td>83.8%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Delayed Transfers of Care - Bed Days</td>
<td>4.8%</td>
<td>5.7%</td>
<td>6.1%</td>
<td>4.3%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.4%</td>
<td>3.7%</td>
<td>4.2%</td>
<td>4.1%</td>
<td>4.2%</td>
<td>4.0%</td>
<td>3.8%</td>
<td></td>
<td>3.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Dec-16</th>
<th>Jan-16</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Treatment - 18 weeks</td>
<td>91.9%</td>
<td>92.2%</td>
<td>92.3%</td>
<td>92.8%</td>
<td>92.6%</td>
<td>92.8%</td>
<td>92.8%</td>
<td>92.4%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>92.0%</td>
<td>91.9%</td>
<td>91.1%</td>
<td>90.8%</td>
<td>92%</td>
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<tr>
<td>Diagnostics Test Waiting Times</td>
<td>1.9%</td>
<td>1.7%</td>
<td>1.0%</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>2.0%</td>
<td>1.7%</td>
<td>2.6%</td>
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<td>1%</td>
</tr>
<tr>
<td>Cancer - Two week wait from cancer referral to specialist appointment</td>
<td>95.9%</td>
<td>94.0%</td>
<td>96.3%</td>
<td>95.1%</td>
<td>92.9%</td>
<td>96.1%</td>
<td>93.4%</td>
<td>93.5%</td>
<td>92.4%</td>
<td>93.8%</td>
<td>93.8%</td>
<td>93.1%</td>
<td>96.7%</td>
<td>95.4%</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer - Two week wait (breast symptoms - cancer not suspected)</td>
<td>95.1%</td>
<td>95.9%</td>
<td>95.1%</td>
<td>93.7%</td>
<td>92.3%</td>
<td>94.3%</td>
<td>88.8%</td>
<td>91.9%</td>
<td>85.6%</td>
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<td>85.9%</td>
<td>95.1%</td>
<td>96.0%</td>
<td></td>
<td>96%</td>
</tr>
<tr>
<td>Cancer - 31-day wait from decision to treat to first treatment</td>
<td>99.1%</td>
<td>97.8%</td>
<td>98.2%</td>
<td>98.7%</td>
<td>98.7%</td>
<td>99.2%</td>
<td>98.8%</td>
<td>98.3%</td>
<td>98.3%</td>
<td>98.1%</td>
<td>98.9%</td>
<td>98.3%</td>
<td>99.0%</td>
<td></td>
<td>96%</td>
</tr>
<tr>
<td>Cancer - 31-day wait for subsequent surgery</td>
<td>98.4%</td>
<td>98.8%</td>
<td>98.2%</td>
<td>98.5%</td>
<td>94.8%</td>
<td>98.3%</td>
<td>90.4%</td>
<td>99.1%</td>
<td>97.7%</td>
<td>97.9%</td>
<td>96.9%</td>
<td>97.4%</td>
<td>97.6%</td>
<td>99.4%</td>
<td></td>
</tr>
<tr>
<td>Cancer - 31-day wait for subsequent anti-cancer drug regimen</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.2%</td>
<td>100.0%</td>
<td>99.5%</td>
<td>100.0%</td>
<td>99.6%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.5%</td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td>Cancer - 31-day wait for subsequent radiotherapy</td>
<td>99.6%</td>
<td>99.7%</td>
<td>99.3%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.1%</td>
<td>100.0%</td>
<td>98.9%</td>
<td>98.0%</td>
<td>99.0%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>Cancer - 62-day wait from referral to treatment</td>
<td>86.6%</td>
<td>86.9%</td>
<td>84.6%</td>
<td>84.8%</td>
<td>85.6%</td>
<td>86.6%</td>
<td>83.6%</td>
<td>81.7%</td>
<td>85.3%</td>
<td>86.7%</td>
<td>84.2%</td>
<td>85.3%</td>
<td>86.7%</td>
<td>85.2%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Cancer - 62-day wait for treatment following a referral from a screening service</td>
<td>98.1%</td>
<td>92.2%</td>
<td>97.1%</td>
<td>91.6%</td>
<td>96.5%</td>
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<td>92.6%</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>Cancer - 62-day wait for treatment following a consultant upgrade</td>
<td>87.6%</td>
<td>84.6%</td>
<td>82.3%</td>
<td>91.7%</td>
<td>88.2%</td>
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<td>89.6%</td>
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<tr>
<td>MRSA</td>
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<td>0</td>
<td>1</td>
<td>3</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>C. Difficile (Ytd Var To Plan)</td>
<td>3.1%</td>
<td>3.3%</td>
<td>2.9%</td>
<td>3.9%</td>
<td>2.0%</td>
<td>-0.4%</td>
<td>1.4%</td>
<td>9.0%</td>
<td>12.9%</td>
<td>14.0%</td>
<td>10.3%</td>
<td>8.4%</td>
<td>7.5%</td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>Estimated Diagnosis Rate For People With Dementia</td>
<td>77.6%</td>
<td>77.1%</td>
<td>77.3%</td>
<td>77.4%</td>
<td>77.2%</td>
<td>76.9%</td>
<td>77.1%</td>
<td>77.0%</td>
<td>77.2%</td>
<td>77.3%</td>
<td>77.4%</td>
<td>77.6%</td>
<td>77.3%</td>
<td>76.7%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies Access Rate</td>
<td>4.21%</td>
<td>4.32%</td>
<td>4.14%</td>
<td>4.60%</td>
<td>4.31%</td>
<td>4.42%</td>
<td>4.19%</td>
<td>4.39%</td>
<td>4.28%</td>
<td>4.23%</td>
<td>4.27%</td>
<td>4.20%</td>
<td>4.25%</td>
<td></td>
<td>4.20%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies Recovery Rate</td>
<td>46.3%</td>
<td>47.5%</td>
<td>49.0%</td>
<td>50.8%</td>
<td>50.2%</td>
<td>49.2%</td>
<td>49.2%</td>
<td>49.2%</td>
<td>49.2%</td>
<td>49.3%</td>
<td>49.3%</td>
<td>48.6%</td>
<td></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies Seen Within 6 Weeks</td>
<td>82.3%</td>
<td>84.6%</td>
<td>83.7%</td>
<td>83.5%</td>
<td>82.5%</td>
<td>84.0%</td>
<td>82.6%</td>
<td>85.2%</td>
<td>82.8%</td>
<td>82.2%</td>
<td>82.9%</td>
<td></td>
<td></td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies Seen Within 18 Weeks</td>
<td>96.2%</td>
<td>97.0%</td>
<td>96.8%</td>
<td>97.3%</td>
<td>97.3%</td>
<td>98.8%</td>
<td>97.3%</td>
<td>98.6%</td>
<td>98.4%</td>
<td>97.8%</td>
<td>97.6%</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral</td>
<td>83.8%</td>
<td>80.4%</td>
<td>76.0%</td>
<td>77.7%</td>
<td>74.7%</td>
<td>70.1%</td>
<td>64.0%</td>
<td>63.4%</td>
<td>58.4%</td>
<td>59.8%</td>
<td>72.8%</td>
<td>56.5%</td>
<td>60.9%</td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>
Appendix 2 – GM HSC Partnership Finance Dashboard

### Greater Manchester Health & Social Care Partnership - Financial Performance Dashboard (Month 11)

#### 1. Financial position by type of organisation (appendix 2-1)

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Income</td>
<td>Expenditure</td>
</tr>
<tr>
<td>GM HSCP exc. Spec. comm</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>GM HSCP exc. Spec. comm</td>
<td>489.7</td>
<td>488.7</td>
</tr>
<tr>
<td>CCGs</td>
<td>440.2</td>
<td>440.9</td>
</tr>
<tr>
<td>Providers</td>
<td>1,796.7</td>
<td>1,783.2</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>1,255.0</td>
<td>1,253.5</td>
</tr>
<tr>
<td>PALP exc. Spec. comm</td>
<td>1,036.9</td>
<td>1,036.9</td>
</tr>
<tr>
<td>Spec. comm. (before reserves)</td>
<td>1,036.9</td>
<td>1,036.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,036.9</td>
<td>1,036.9</td>
</tr>
</tbody>
</table>

#### 2. Financial position by locality (appendix 2-2)

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan surplus</th>
<th>Year to Date surplus</th>
<th>Forecast surplus</th>
<th>Trend - forecast variance vs plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'m</td>
<td>£'m</td>
<td>£'m</td>
<td>£'m/£'m</td>
</tr>
<tr>
<td>Bolton</td>
<td>10.3</td>
<td>9.7</td>
<td>(0.6)</td>
<td>8.6</td>
</tr>
<tr>
<td>Bury</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Manchester</td>
<td>20.0</td>
<td>15.0</td>
<td>3.1</td>
<td>37.8</td>
</tr>
<tr>
<td>Oldham</td>
<td>(11.3)</td>
<td>(29.2)</td>
<td>(15.1)</td>
<td>(36.6)</td>
</tr>
<tr>
<td>Rochdale</td>
<td>3.4</td>
<td>(3.7)</td>
<td>(9.6)</td>
<td>(4.2)</td>
</tr>
<tr>
<td>Salford</td>
<td>(1.4)</td>
<td>(1.2)</td>
<td>0.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Stockport</td>
<td>(25.0)</td>
<td>(23.9)</td>
<td>0.6</td>
<td>(24.5)</td>
</tr>
<tr>
<td>Tameside</td>
<td>(24.5)</td>
<td>(31.6)</td>
<td>0.8</td>
<td>(23.2)</td>
</tr>
<tr>
<td>Trafford</td>
<td>1.5</td>
<td>(12.2)</td>
<td>(12.2)</td>
<td>(15.1)</td>
</tr>
<tr>
<td>Wigan</td>
<td>(1.6)</td>
<td>(3.3)</td>
<td>(1.2)</td>
<td>1.0</td>
</tr>
<tr>
<td>Spec. Comm. (before reserves)</td>
<td>10.3</td>
<td>(27.1)</td>
<td>(37.7)</td>
<td>15.6</td>
</tr>
<tr>
<td>Out of Area</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>(15.5)</td>
<td>(194.2)</td>
<td>(27.3)</td>
<td>(30.4)</td>
</tr>
</tbody>
</table>

#### 2017/18 Forecast surplus; variances vs plan by type of org’n

- Overall forecast M11 position is a £34.7m deficit, which is:
  - an improvement of £9.3m from last month. This is mainly due to an improvement across providers.
  - The Spec. comm. team has clarified that the position reported here is before the application of reserves. If these reserves (0.5% contingency and growth reserve) were factored in, the forecast deficit would increase from £23.5m to £28.6m which reflects the deterioration at CMFT and Salford.
  - Provider Trusts forecast outturn surplus is £11m which is an improvement of £12.8m on month 10.
  - CCGs’ forecast position has not changed since last month.

#### Capital Expenditure

- **GM Primary Care capital**
  - **Provider**
    - Capital Budget
    - YTD Net Expenditure
    - Forecast Net Expenditure

#### Transformation Fund 2017/18

- **Confirmed Commitments**
  - **Allocated**
### Report summary

#### Transformation Fund update

Report outlined the proposed approach to assure delivery of the GM Transformation Portfolio.

Transformation Funding has been received by all localities and options for the remaining funds were being considered.

A new highlight report will be introduced from April 2018 and will ask for assurance around the impact of specific interventions to ensure benefits delivery is on track.

#### Month 9 Finance Locality Report

The report provided an update and an overview of the 2017/18 year to date financial position and forecast outturn for the individual organisations and sectors within GM.

### Recommendations

The Partnership Executive Board was asked to:

- Note and support the proposed approach

- It was agreed the Chief Operating Officer and Chair of the Provider Federation Board would meet to discuss further development of the performance metrics

### Outcome

- The content of the report was approached

- The report was noted
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Hub Programme</td>
<td>The significant movement in the provider forecast position reported at month 9 which has contributed to the improvement in GM financial performance</td>
<td>The proposals were approved</td>
</tr>
</tbody>
</table>

The report set out the Elective hub programme for GM. This was aimed at ensuring resilience around elective services and ensuring robust systems and processes are in place to understand and manage demand.

GM has an opportunity to link with the national NHS England Elective Programme which will further strengthen capability to deliver improvement across the whole system.

The paper set out the principles around how the programme would operate and the governance for how it would be managed along with the resources required to deliver.

Four key areas of focus were identified:
- Dermatoscope and tele-dermatology
- Direct access to scope in the gastro pathway
- Developing a toolkit to include standard to harness maximum impact for musculo-skeletal services

The Partnership Executive was asked to:
- Support the plans for the Elective Hub
- Support the work programmes identified
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| **GM Health and Care Workforce Collaborative Update** | The Partnership Executive Board was asked to:  
  - Note the workforce Programme Implementation  
  - Endorse the proposals for the continuous service protocol  
  - Note the progress and next steps on the Workforce Race Equality leadership package | • The programme was noted and continuous service protocol endorsed |
| **NHS Operational Planning Guidance update** | The Partnership Executive Board was asked to:  
  - Note the work done to date and the infrastructure put in place to support the annual planning process  
  - A further update will be provided in March | • The report was noted |
| **Care 2020: Position update** | The Partnership Executive Board was asked to: | • The contents of the report were noted |
  A progress report on the development of a GM Care


<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>2020 model was outlined which sets out a new approach to supporting independent living. Initial discussions with Department for health have explored the GM model and potential support for its delivery. The proposition needs to be further refined to develop indicative budgets, finalise the estates requirements define the position around gain share and phased implementation. A steering group to support the further development of Care 202 is now in place and the first meeting was held on 9 February.</td>
<td>• Note progress to date  • Note the refreshed proposition to Government around the potential for co-investment</td>
<td></td>
</tr>
</tbody>
</table>

**Engaging with our communities about the difference devolution is making**

A report outlining proposed approach to engaging with communities across GM was shared. This also highlighted the specific work planned for the next six months.

The proposals have been developed with engagement leads from across GM. The voices of patients, residents have been incorporated and engagement has taken place along with wider stakeholders including the Community, Voluntary and Social Enterprise sector to ensure a broad approach.

The Partnership Executive Board was asked to:

• Give views on the communications and engagement campaign around the difference devolution as making

• Agree the proposed engagement framework

• Agree to jointly own the framework and campaign approach

• The Partnership Executive Board agreed the proposals in the paper
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| **Kerslake Recommendations on Charter for Families Bereaved through Public Tragedy** | The Partnership Executive Board was asked to:  
• Note the context of the Kerslake review and  
• Support the recommendation for committing to the Charter for Bereaved Families | • The recommendations were agreed |
| **Dementia United** | The Partnership Executive Board was asked to:  
• Note the progress made and the funding conditions  
• Ratify the next steps in delivering the programme | • The Partnership Executive Board noted the content of the paper and agreed the next steps |

The Kerslake review was established at the request of the Mayor of Greater Manchester to look into the Manchester Arena terrorist attack. The Kerslake Arena panel expressed a view that leaders in public bodies in Greater Manchester and the rest of the North West should demonstrate commitment to the Charter for Families Bereaved through Public Tragedy which was based on the experiences of the Hillsborough families.

An update report on the progress made by Dementia United aimed at making GM the best place to live with dementia. This included regular engagement with localities, the development of the GM Dementia Standards and locality profiles indicating where standards are already being met.

The Dementia united programme has secured £2.29m from the Transformation Fund that will support the delivery of the programme. A governance structure has been put in place to oversee delivery; this includes a Strategic Board and an Implementation Operations group.

The report outlined a number of next steps including:  
• Analysis of the information gained through
<table>
<thead>
<tr>
<th>Report summary</th>
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</thead>
<tbody>
<tr>
<td>locality visits and system wide engagement</td>
</tr>
<tr>
<td>Development of a work plan to deliver the overarching strategy aligned to the dementia standards.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GM HSC Partnership Executive Board – 22 March</th>
</tr>
</thead>
</table>

**Performance and Transformation Update**

The report provided a summary of current performance issues and progress points drawn from the work of the Performance and Delivery Board.

The key system performance issues were:

- Increase in activity in GM compared with 2016/17
- The impact of winter on urgent care, RTT and diagnostic performance
- Increases in early intervention in psychosis (EIP) referrals

The GM HSC Partnership Executive Board was asked to note the content of the report and consider:

- The programme plan to further refine the Portfolio between now and June 2018
- Any areas of disagreement regarding understanding of projects which are currently being implemented
- The proposals to be accelerated for 18/19
- The key risks to the Portfolio

The report was noted

It was agreed to provide members with a revised draft dashboard for further consideration and discussion at the next meeting of the Partnership Executive Board in April 2018.

It was agreed To dedicate most of the April meeting to consideration of the Urgent and Emergency Care Improvement Plan.

<table>
<thead>
<tr>
<th>Risk Register and Board Assurance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report highlighted the current risks for the GMHSC</td>
</tr>
</tbody>
</table>

The GM HSC Partnership Executive Board was asked to:
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Partnership. This paper included:  
  - The GMHSCP Risk Register – this quarterly update provides the latest risk update.  
  - The Board Assurance Framework and supporting assessment material.  
  - The final version of the ‘Risk and Issues Management Framework’ for approval |  
  - Consider the risks highlighted in the Risk Register and discuss any omissions or concerns.  
  - Consider the Board Assurance Framework (BAF) and dashboard and discuss any concerns.  
  - Approve the final ‘Risk and Issues Management Framework’ | The report was noted and The final Risk and Issues Management Framework was approved |

**Month 10 Locality Finance Report**

The purpose of the report was to provide an overview of the 2017/18 month 10 year to date financial position and forecast outturn position for the individual organisations and sectors within Greater Manchester (GM).

The GM HSC Partnership Executive Board was asked to:  
  - Note that GM has set a deficit plan of £17.6m for 17/18  
  - Note that the year to date (Month 10) deficit of £58.5m represents an adverse movement of £30.3m against M10 plan.  
  - Note that the forecast position is currently reporting a £1.3m surplus which represents a... | The report was noted |
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standardising Acute and Specialised Care – Communications and Engagement Strategy 2018-20</strong></td>
<td>£18.9m improvement against plan. This is largely driven by one of the factors in 2018/19. The report was noted and the Board supported the strategic approach.</td>
<td>The report was noted and the Board supported the strategic approach.</td>
</tr>
</tbody>
</table>
| This report presented the final draft of the Communications and Engagement Strategy which has been developed to support the Theme 3 Programme for 2018-2020. It sets out the context for the strategic approach, the objectives and the main priorities to enable a consistent approach to communications and engagement. | The GM HSC Partnership Executive Board was asked to:  
- Agree the strategic approach, objectives and priorities for 2018/20 |                                                                                               |
| **GM Commissioning Update**                                                   | The GM HSC Partnership Executive Board was asked to:  
- Note progress in the implementation of the Commissioning Review.  
- Support the proposed SCF maturity framework self-assessment process as a means of validating SCF | The report was noted and recommendations supported.                                           |
<p>| This report set out progress in implementation of the Commissioning Review which was approved by the Strategic Partnership Board on 28th July 2017. The Review recommendations were divided into Place Based, Scale Based and Support Services. |                                                                                                                                                                              |                                                                                               |</p>
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>progress.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Note the agreed actions from the JCB workshop on the 20th February, setting out the future plan for commissioning of services at GM level and the management of the Commissioning Hub.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support the strategy being adopted within the Corporate Services Review of exploring synergies between GM Commissioning Support Services and the work of the Commissioning Hub in supporting SCFs</td>
<td></td>
</tr>
</tbody>
</table>
| GM Digital and Interoperability and innovation programme | The GM HSC Partnership Executive Board was asked to:  
• Note the progress made to date  
• Comment on the GM Interoperability and Innovation narrative  
• Note the updated roadmaps for the initial 6 months for both interoperability and innovation | The report was noted the way forward supported. |

The report provided an update for the Partnership Executive Board on the GM Interoperability and Innovation Programme in order to finalise the governance arrangements.
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>delivery teams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discuss and agree the governance proposals for the programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Confirm the arrangements for the chairs of the proposed governance arrangements</td>
<td></td>
</tr>
</tbody>
</table>

**LCO Peer to Peer conversational review process**

This paper sets out our approach and findings towards understanding the development of LCOs. It describes the core model features that drive success, our learning to date and how we will continue to work together to increase the pace of change so that all residents in GM can benefit from these models of care

The GM HSC Partnership Executive Board is asked to:

- Note the contents of this report and
- support the way moving forward

The report was noted.
SUMMARY OF REPORT:

‘Tackling Diabetes Together: Greater Manchester Diabetes Clinical Best Practice Strategy’ was developed to reduce the incidence of diabetes and the resulting complications in GM, and to help identify and reduce variation in diabetes healthcare.

KEY MESSAGES:

The number of people diagnosed with diabetes in England is increasing and prevalence has doubled over the last 20 years. In GM, there are approximately 160,000 people presently living with diabetes. Most have what is known as type 2 diabetes (T2D) but about 11,000 have type 1 diabetes (T1D). An equivalent number of people are also thought to be at risk and it is expected that over 25% of the GM population will develop the condition in their lifetime. There is also variation between and within CCG areas in patient outcomes and experience when tackling the condition. There is also variation in prevalence between different communities in GM. These facts resulted in the decision to develop a diabetes strategy for the whole of GM.

Diabetes clinical experts, patient representatives, health professionals and commissioners met throughout 2017 to develop a clinical best practice strategy to improve diabetes care. Wide scale discussion took place in late 2017 and early 2018 to inform development of the final strategy which sets out a vision for improvement and action over the five year period 2018 to 2023. Tackling Diabetes Together has been supported by the Directors of Commissioning and the CCG Association Governing Group and is, in effect, a ‘roadmap’ towards at achieving that vision.

PURPOSE OF REPORT:

The GM Diabetes Strategy's vision is:
To improve the lives of all people across Greater Manchester affected by diabetes or at risk of developing diabetes.

Its mission is:

To empower people to manage effectively their diabetes or their diabetes risk, by making them aware, educated, and able to access high quality and equitable care.

It recognises the diverse nature of the population and aims to support health and social care professionals to work with people from all communities to:

- Improve blood glucose control
- Reduce cardiovascular risks and cardiovascular complications
- Reduce other complications
- Improve safety
- Improve experience of diabetes services for those living with the condition

It sets out a range of actions which would generate improvements in the above areas and is structured to address issues which relate to the prevention of diabetes, controlling diabetes and preventing complications. It also identifies a number of additional issues which impact on peoples’ diabetes outcomes and experience and actions for improvement.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Support and endorse the Tackling Diabetes Together as a statement of clinical best practice and the vision for improving diabetes care in GM.

CONTACT OFFICERS:

Richard Preece, Executive Lead for Quality, GMHSC Partnership
richardpreece@nhs.net

Ewan Jones, Programme Manager, Greater Manchester & Eastern Cheshire Strategic Clinical Networks, GMHSC Partnership
ewanjones@nhs.net
Tackling Diabetes Together

The Greater Manchester Health & Social Care Partnership

Diabetes Clinical Best Practice Strategy 2018-2023

April 2018
Foreword

A great number of people including clinicians, commissioners, improvement teams and patients have contributed to the development of this Diabetes Clinical Best Practice Strategy. This is a clinically led document which articulates a vision of best practice for diabetes care in Greater Manchester and proposes actions and interventions aimed at achieving that vision. While clinical consensus is key to improving standards, this strategy also aims to reflect the need for a partnership approach. It recognises that best practice cannot be achieved overnight and that a great deal of work, and indeed investment, will be required to meet our goals. In the strategy we have adopted a positive ‘we will’ approach to tackling the challenges that lie ahead but we are under no illusions that this will necessitate a continuous and iterative approach to implementing improvements over time as local and GM budgets and priorities allow. As a Diabetes Network, we expect to support commissioners and providers where appropriate in benchmarking and costing services to help identify how and where improvements should be implemented. We do believe, however, that it is vital that we set out our goals in a document such as this to guide our long term direction. We also recognise that clinical and technical innovation will continue and that we will need to revise our plans and expectations accordingly as these evolve.

I commend this strategy to you and call for your support in realising what we believe is a bold vision for delivering outstanding diabetes care to the people of Greater Manchester.

Naresh Kanumilli
Clinical lead for diabetes
GMEC Strategic Clinical Networks
Greater Manchester Health & Social Care Partnership
1. Introduction

1.1 Introduction

The number of people diagnosed with diabetes in England is increasing. The prevalence has doubled over the last 20 years. It is expected that over 25% of people living in Greater Manchester will develop the condition in their lifetime.

Insulin manages the way glucose is used and stored in the body leaving an appropriate level of glucose in the blood. There are two main types of diabetes. Type 1 diabetes (T1D) is an autoimmune disease that leads to little or no insulin being available to the body. Type 2 diabetes (T2D) tends to occur later in life, as the ability to produce insulin declines at a time when the body becomes resistant to the effects of insulin, resulting in reduced glycaemic control. An international clinical consensus has created thresholds that categorise the reductions in glycaemic control during this process as non-diabetic hyperglycaemia or T2D.

The Greater Manchester Strategic Clinical Network (SCN) is part of the quality improvement architecture in the Greater Manchester Health & Social Care Partnership (GMHSCP). The Partnership was born out of recognition that health can only be improved by all agencies working together and in partnership with the third sector and the community. The Partnership has identified a number of priorities which include diabetes. This principle is central to the production of this Greater Manchester (GM) strategy for tackling diabetes which has been devised within the context of the GM Population Health Plan, its focus on lifestyle approaches to health and its aims to improve the utilisation of personal health budgets and social prescribing.

The overall aim of the diabetes programme and the strategy is to improve the quality and consistency of services in line with both local and national standards and funding programmes. A GM Diabetes Strategy is required in order to facilitate a collective approach to achieving this aim. The GMHSCP’s vision is to improve the lives of all people across GM affected by diabetes and at risk of developing it. Much of this strategy will be relevant to children but issues specific to children will be addressed at by the Childrens’ Strategic Clinical Network.

1.2 Diabetes prevention and care at a population health level

Prevention is key to improving patient outcomes and reducing treatment costs. GMHSCP, through the SCN, are already responsible for co-ordinating roll-out of the National Diabetes Prevention Programme (NDPP) as noted in section 1.5 of this strategy. The GM Population Health Plan (2017-21), however, also recognises that “Our population continues to suffer higher than national instances of heart disease, diabetes and other lifestyle related illnesses.”, and this is a key reason for developing this strategy, which is designed to support CCGs to tackle this issue both locally and jointly at a GM level. The population health plan also highlights the importance of obesity and lack of exercise as modifiable risk factors for diabetes and the fact that, in both cases, the GM population figures are worse than national averages. By
developing a vision for clinical best practice and a Diabetes Network to help identify and reduce variation, we aim to contribute to the achievement of the population health plan objectives.

1.3 Diabetes care services in GM

The development of diabetes care in GM over the period 2018 to 2023 will comprise of:

1. What is already being delivered in localities (business as usual)
2. New activity proposed by CCGs (in 2017 locality transformation fund bids)
3. GM-wide collective transformation work (which would be difficult for CCGs to undertake individually)
4. Delivery of national programmes at a local level (which are separately funded)

The above elements need to be combined to generate improvements which can be embedded in the system and address unwarranted variation. Variation occurs on a local basis (eg in delivery of primary care) and on a GM basis (in different approaches and outcomes across different CCGs). A GM Diabetes Strategy is required in order to take a collective approach to understanding variation at different levels and addressing it to embed improvement. It needs to ensure that the organisation of services in GM is focussed on the prevention of diabetes, the control of diabetes and complications of the disease. Some examples of the recommendations are:

**Prevention of diabetes:** Preventing the onset of T2D requires effective policies for children and young people as well as adults. The GM Diabetes Strategy supports the GM Population Health Plan commitments in relation to improved nutrition and physical activity for young people. It will also complement the plan to revamp NHS Health Checks in GM meaning more people at risk will be identified earlier. SCN focus on transition from childrens’ to adult services will include diabetes, leading to improved transition.

**Control of diabetes:** In T1D, control of diabetes depends upon balancing diet, physical activity and the use of exogenous insulin whilst accepting that diabetes will be ever present. In T2D, lifestyle changes and/or clinical interventions will improve glycaemic control – indeed, in some people, glucose levels may become normalised. The commissioning of more structured education will be an important element in achieving this.

The requirement for high quality information to be embedded into GP standards and other clinical specifications will improve the fight against the progression of T2D and the development of complications. In all diabetes care there will be improved quality of information provided to people with diabetes with the assistance of novel use of new technology, and improving the electronic communication between primary and secondary care. Flash glucose monitoring, for persons reliant on insulin, will improve self-managed care and this will be further supported by personalised care planning. More proactive discussion around bariatric surgery, for people with T2D satisfying the NICE criteria, will help to ensure that an increased number of these people will
be able to access the benefits of this cost-effective intervention. A GM-wide strategy for tackling diabetes will mean that an increased number of persons will receive all designated care services and the inclusion of additional processes over and above those already agreed nationally.

**Prevention of complications:** The introduction of an inpatient care bundle and a commitment to ensuring one nurse with specific diabetes knowledge to every 250 inpatient beds will help to reduce complications and improve patient care and experience. Improved management of cardiovascular disease and risk factors and rapid access to lower limb care will help to reduce cardiovascular complications including amputations. Older people with diabetes will be screened for atrial fibrillation and, because they have diabetes, their CH_{2}DS_{2}-VASc score will be at least 2 which means they should be prescribed anticoagulation.

### 1.4 Key work areas

Within the context of the above framework, there is significant potential to improve services in both traditional and innovate ways and contribute to national targets in areas such as:

- Structured education
- Lower limb care
- Treatment targets
- Diabetes nursing levels

Localities will be supported to work together to build on the existing baseline measures on the quality and uptake of structured education and agree targets for improving both. A co-ordinated approach is required in order to facilitate an integrated lower limb pathway (including with non-diabetes care services) in order to build rapid access coverage across GM. Information sharing and mutual support will help all areas meet treatment targets. A joint initiative by localities to increase nursing provision is required to improve patient care. A **GM Diabetes Strategy** will provide a platform to support a conversation between localities and with the GMHSCP on increased joint working. The GM Diabetes Strategy provides a framework for the development of a comprehensive service specification supported by agreed pathways and processes which will help people with diabetes across GM to experience the same high level of care.

### 1.5 The National Diabetes Prevention Programme

The GMHSCP has agreed a memorandum of understanding with the National Diabetes Prevention Programme (NDPP) to facilitate direct funding to CCGs for implementation of the ‘Healthier You’ programme in all areas of GM not covered by the early rounds of funding. The SCN is funded by NHS England to co-ordinate the Wave 2 roll-out of the NDPP in GM.
2 Background

2.1 Background

In recent years the number of people diagnosed with diabetes in England has risen (see Fig 1) with the prevalence expected to rise to near 10% by 2025:

*Figure 1: GM Diabetes prevalence (17+ yrs)*

![Graph showing GM and England diabetes prevalence from 2012/13 to 2016/17](image)

2.2 The GM context

Over a quarter of people living in GM will develop diabetes in their lifetime. In GM, there are approximately 160,000 people presently living with diabetes. Most have T2D but about 11,000 have T1D. An equivalent number are also thought to be at risk. There is some variation in the prevalence of diabetes across GM (see Fig 2).

*Figure 2: Diabetes Prevalence (+17yrs) 2015/16*

![Bar chart showing diabetes prevalence by area in 2015/16](image)

Diabetes causes over 1,000 premature deaths in GM each year. Complications will vary by type of diabetes, its severity and the age of the patient. Compared to the general population, people with diabetes have a 55% higher chance of having a myocardial infarction; a 34% increased risk of having a stroke; a 164% increased risk of having renal replacement therapy; a 221% increased risk of having major amputation above the ankle and a 337% increased risk of having a minor amputation. Sight loss is common with diabetic retinopathy affecting a third of
people. Depression and anxiety is at least twice as common in people with diabetes than in the general population. Babies born to women with diabetes have a high risk of congenital abnormalities, prematurity and experience a high rate of complications during childbirth with the risk of needing admission to a neonatal intensive care unit.

Direct medical costs are high and include both the costs of treating diabetes, such as medication, testing supplies, GP visits and the costs of treating its complications. One study estimated the approximate cost of a person diagnosed with T2D aged between 25 and 44 to be over £80,000 over their lifetime.

Standards of diabetes care have shown a steady improvement but there is still much to do to improve our overall response and to reduce variations in outcomes and quality of services. This GM diabetes strategy will lay out how we intend to reduce the incidence of diabetes and the complications of diabetes. It will pave the way to the development of standards and service specifications to improve our services.
3 Vision, mission and goals

3.1 Our Vision

To improve the lives of all people across Greater Manchester affected by diabetes or at risk of developing diabetes.

3.2 Our Mission

To empower people to manage effectively their diabetes or their diabetes risk, by making them aware, educated, and able to access high quality and equitable care.

3.3 Overarching Goals

To achieve our vision we should aim to prevent the onset of diabetes; improve the management of diabetes and prevent its complications. To achieve our mission we should support health care professionals and those with or at risk of diabetes to:

1. Improve blood glucose control
2. Reduce cardiovascular risks and cardiovascular complications
3. Reduce other complications
4. Improve safety
5. Improve experience of diabetes services for those living with the condition

3.4 How do we achieve it?

The GMHSCP, commissioners, providers and other key stakeholders will need to work together to realise the vision. This strategy outlines key actions for consideration and implementation locally and at GM level to enable the overarching goals to be achieved. It is supported by more detailed resources including a technical reference document and a GM draft diabetes service specification. We recognise the diverse nature of the population in GM and will proactively seek to engage in different ways, through different formats and with different sectors.
4 Prevention of Diabetes

4.1 Health in children and young adults

There has been an alarming rise in the prevalence of both T1D and T2D. Part of this is due to increasing life expectancy as the overall prevalence of T2D increases with age. However there are also preventable causes for the rise. Whereas the reasons for the rise in T1D are less clear, it is changes in lifestyle, driven by an obesogenic environment, that have caused the surge in T2D. Reversing this trend will potentially have the greatest impact in tackling diabetes.

Even small shifts in lifestyle behaviours, in particular a reduction in refined carbohydrates, an increase in dietary fibre and an increase in physical activity, will have an effect on reducing the incidence of diabetes.

This diabetes strategy will complement the Greater Manchester Population Health Plan 2017-21 (www.gmhsic.org.uk/assets/GM-Population-Health-Plan-Full-Plan.pdf). The Plan contains commitments to the production of a comprehensive physical activity plan and a comprehensive plan for better nutrition and healthy weight. These plans will include the role of schools and colleges in encouraging children to develop healthy lifestyles; the move to a more leptogenic environment, that is an environment that is more conducive to people maintaining a healthy weight; and innovations such as the Oldham proposal to give business rate relief to takeaways offering healthy options. The successful implementation of the Plan is vital in reducing the burden of diabetes.

4.2 Identification of those at risk and behavioural interventions

There is an increasing identification of people at the early stages of declining glycaemic control both systematically (eg through the NHS Health Check) and opportunistically (eg when people present with obesity, hypertension or periodontal disease). People with elevated glucose levels who are identified as having non-diabetic hyperglycaemia are not only at an increased risk of developing diabetes but also have an increased risk of cardiovascular disease even if they do not develop diabetes.

The NHS Health Check in GM will be revamped. It will include using existing data within the primary care electronic records to identify people, not previously diagnosed with diabetes, who have risk factors which are likely to satisfy the diabetic filter so that they can be invited for screening for diabetes. Presently whether a person is invited to an NHS Health Check is dependent on the practice where the patient is registered. In future, all people who have a QDiabetes score (a measure of the risk of developing diabetes) >4%, who have not previously been diagnosed with diabetes, will be invited for a Health Check at least every five years.

About half of all new cases of T1D are in adults. About one in ten adults with T1D are misdiagnosed as T2D. Clinicians need to have a lower index of suspicion for T1D, even in persons who are overweight, and be more ready to test for urinary
ketones. If they are still uncertain about the diagnosis, they should seek urgent specialist advice.

There will continue to be active support for the developing cross-disciplinary work which includes the identification not only those at risk of diabetes but also those with undiagnosed diabetes. Whereas some signs occur even at the earliest stages of hyperglycaemia (e.g. periodontal disease), other signs are indicative of more advanced disease which may not yet have been identified (e.g. pathological changes in the eye).

If a person has an HbA1c indicating non-diabetic hyperglycaemia (HbA1c 42-47 mmol/mol) it is important that there is follow-up. People with non-diabetic hyperglycaemia are at increased risk of developing diabetes and will need further HbA1c testing. Guidance will be developed on the recommended frequency of such testing.

People with non-diabetic hyperglycaemia already have a raised cardiovascular risk and are at high risk of further declines in glycaemic control. Lifestyle intervention programmes similar to that offered to people with diabetes have benefits that include increased physical activity, weight loss and lower glucose levels. One systematic review concluded a 26% reduced incidence rate of diabetes in those that undertook the intervention.

By early 2019, the national non-diabetic hyperglycaemia lifestyle intervention programme (‘Healthier You’) will be fully rolled out in GM with up to 14,000 people a year being offered intervention (with 30% expected to take up the offer). This follows the initial pioneering work of the Salford demonstrator site and the phase 1 roll-out in Oldham, Rochdale and Bury. Localities throughout GM are co-operating in designing measures to improve uptake. The evidence indicates that the effect of these programmes wears off over time with little effect at three years if there is no longer-term follow-up. So the initial programme will be complemented with shorter annual refresher sessions to sustain improvements.

4.3 Planning for pregnancy

There needs to be measures taken to reduce the incidence of gestational diabetes, which is associated with an increased risk of adverse outcomes. Some services have provided interventions for women at high risk preconceptually whilst others have done so for women in early pregnancy. We will develop a clinical consensus to decide which women are at high-risk (e.g those with a history of gestational diabetes) to warrant such support.

Additional work will be undertaken to improve preconceptual care for women with established T1D or T2D (see below).

4.4 Health incentives

Incentives can work to improve health behaviours such as losing weight and quitting smoking but the challenge is maintaining those behaviours when the incentives stop.
Incentives are already used in GM (e.g., reduced cost of membership to weight loss classes, taster sessions for dance classes, and exercise on prescription to encourage positive changes in lifestyle). The Greater Manchester Population Health Plan 2017–2021 intends to develop and test an innovative incentives-based digital platform to support lifestyle behaviour change. There are particular challenges for people losing weight for which incentives may help. Some of these incentives can be provided by health services such as the promise to perform abdominoplasty for excessive loose skin if a person maintains weight loss for an agreed period whilst other incentives would require co-operation with the private sector such as reduced cost of clothing as a person’s size declines.

### Key actions to prevent the onset of diabetes:

- Support implementation of the Greater Manchester Population Health Plan and align with its wider strategic aim to embed a more proactive approach to person centred prevention and early intervention practice.
- Complement programmes like ‘Healthier You’ with refresher sessions to embed behavioural change.
- Encourage the use of existing patient apps to support education & care planning and develop additional app(s) as required.
- Contribute to the development of a clinical consensus to identify women of child bearing age at sufficiently high risk of developing diabetes to warrant additional support.
- Seek ways to incentivise healthy behaviours espoused in the GM population Health Plan such as exercise and weight loss.
### 5 Control of diabetes

#### 5.1 Measuring quality of care

Both good glycaemic control and reduction in blood pressure substantially reduce macrovascular and microvascular complications and reducing cholesterol reduces macrovascular complications. The National Diabetes Audit (NDA) uses the proportion of people achieving levels set out in Figure 3 to measure quality of care.

**Figure 3: Levels used to measure quality of care**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>&lt;=58mmol/mol</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>&lt;=140/80</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>&lt;5mmol/L</td>
</tr>
</tbody>
</table>

However, NICE recognises that many people with diabetes should try to achieve lower levels than those used by the NDA, for those with T2D, that can sometimes be achieved by changes in lifestyle and use of metformin therapy. At present for other people with T2D, unless there is a contraindication to metformin, intensification of medication should only be recommended for those with HbA1c >58mmol/mol. For people with T1D, some achieve very good control much below 58mmol/mol which is desirable if hypoglycaemic attacks can be avoided. This led to NICE recommending that “Diabetes services should document the proportion of adults with type 1 diabetes in a service who achieve an HbA1c level of 53 mmol/mol (7%) or lower.”

The Greater Manchester Medicines Management Group (GMMMG) will be responsible for developing local guidelines for the intensification of medication for the control of diabetes. They will also monitor and report against these guidelines with the aim of reducing unwarranted variation.

#### 5.2 Information and structured education

There should be a personalised approach for each person with diabetes. Lifestyle advice and other education relevant to diabetes should be part of the therapeutic plan from the time of diagnosis and at every stage thereafter.

There will be consistent, high quality information provided to all persons with diabetes at diagnosis and other appropriate times both verbally by clinicians and through written information. It will be available in a variety of formats and languages to meet the needs of people with sensory impairment, with learning disability or whose first language is not English. This giving of information and discussion is enhanced by attendance at structured education.

Structured education improves diabetes management and is likely to reduce diabetes complications. It leads to lifestyle changes conducive to good health, such as better nutrition and increased physical activity as well as improved compliance with medication and care processes. Structured education should be available to those newly diagnosed and existing people who have not previously attended it.
Only about one in eight of people diagnosed with T1D are reported presently to attend structured education and fewer than one in ten with T2D attend. To improve attendance, we will move towards an opt out system rather than opt in with structured education being seen as an integral part of management. Commissioners will embed this as part of the GP standards and an agreed education cycle will be shared through GP networks via tools currently available or being developed.

The time before starting structured education should be reduced so that those who feel able to do so can start structured education as soon as possible after diagnosis, or after the education programme to manage insulin treatment. Carers and people living with those with diabetes will be encouraged to attend the structured education so that they are in a better position to offer support.

The evidence indicates that lifestyle changes are not sustainable and compliance with treatment is sub-optimal without refresher courses. So, as with the non-diabetic hyperglycaemia lifestyle intervention programmes shorter annual refresher courses to follow up structured education will be an integral part of the management of diabetes.

The management of non-diabetic hyperglycaemia and T2D not requiring insulin is similar, so the same programme can be offered to both groups. For people with T2D requiring insulin, there should be a structured programme for managing insulin but other aspects of education required will be similar to that required by other people with T2D. In the longer-term, we will aim to have a combined programme for people with non-diabetic hyperglycaemia and T2D. This will increase the ability to give people a choice of time and place when selecting which course to attend. Some areas, such as Bolton, have expanded structured education to include the care processes to encourage increased attendance. Such programmes may need to be organised so that there are one or two sessions aimed at people with T2D. People with non-diabetic hyperglycaemia may decide not to attend these sessions.

There are national trials offering electronic structured education with Salford being one of the participating sites. If shown to be effective, electronic structured education will be offered to all those with diabetes but whether clinicians should still recommend face to face group structured education will depend on the relative effectiveness.

For people with T1D, there will be an education programme for initiating insulin immediately on diagnosis and managing insulin or insulin pump therapy. Good results within the SCN footprint for achieving HbA1c targets in people newly diagnosed T1D have been achieved in Cheshire. They feel their results are due to the intensity of the intervention and aiming for a slow, but steady, reduction in blood glucose. We will consider whether the adoption of the Cheshire model in other areas will improve attendance and results and, if adopted, we will audit results to ascertain whether the Cheshire results are replicated.
5.3 Continued care planning and person centred care

Increasingly, patients and clinicians in both primary and secondary care will work together in partnership to improve compliance with agreed plans and optimise outcomes through a process of Shared Decision Making (SDM). This requires sufficient time for

- Fully explaining treatment options and possible effects
- Offering choice
- Providing people with the opportunity to be involved in making decisions about their care

There will be an initial assessment and personalised care planning with a member of the care team which will include arranging follow-up appointments. Although, for most people, their care should be largely based within general practice, community diabetes nurses, working in partnership with general practice, will enhance the care of people with diabetes. The care plan will be renewed at least annually. Assessments of people’s needs should be holistic and person centred. Approaches that are person and community centred include a very broad range of practice, ranging from ‘more than medicine’ support that complements and enhances clinical care for people with long-term conditions (such as peer support) to everyday community activities that enable people to improve their health and wellbeing (such as a local football team or gardening club).

People on insulin benefit from self-monitoring. This can now be done less invasively using a flash glucose monitoring system which costs about £1K per year. People using insulin will be offered such a system for a trial period before reviewing its use and providing it in the longer term to people who seem likely to benefit. This offer will be integrated with the insulin education programme. When the flash glucose monitoring system needs to be phased in, for affordability reasons, the SCN will build a clinical consensus about who should have priority. This may be people who have experienced a hypoglycaemia, those newly diagnosed with T1D and pregnant women.

Information technology (IT) can facilitate peoples' involvement in the management of their own care. Personalised care planning will enable people to use the patient access facility of the general practice system so that they have easy access to their records. This will be complemented by supporting people with access to interactive diabetes websites that not only give up-to-date clinic results but also provides other material which supports people to manage their own diabetes. There are widely used websites such as www.mydiabetesmyway.scot.nhs.uk/ or more locally developed websites such as Salford’s www.patientview.org. There will be evaluation of systems available and a decision made about which system(s) is appropriate across GM. Whichever system(s) is used, there will be some dedicated resources to keep local information up to date such as contact details of services, news, events and patient stories.

Peer support programmes assist people with diabetes in daily management to enhance social and emotional support. Diabetes UK’s Peer Support Programme
runs groups led by trained volunteer facilitators and has the potential for members to buddy up. Considering participation in peer support will be part of the care planning process.

5.4 Reversing type 2 diabetes

A major clinical trial reported in Dec 2017 showed that almost half of people who agree to a nutrient-complete, liquid low-calorie diet for 3 to 5 months followed by foods being reintroduced along with long-term support to maintain weight loss, have a reversal of their T2D at 12 months, although we are awaiting results of longer term follow up. This intervention was delivered through GP practices, with nurses and dietitians.

Bariatric surgery leads to improvement in glycaemic control within hours of surgery. In trials of surgery, over half of patients stop medication prescribed for their diabetes as they no longer meet the criteria for a diagnosis of diabetes. Bariatric surgery is highly cost-effective (especially when undertaken early in the course of diabetes) partly as a result of reduction in medication costs. This evidence led to NICE producing new guidance in 2014 (CG189) that increased the number of people with diabetes who are eligible for bariatric surgery as long as they are also receiving or will receive assessment in a local weight management multi-disciplinary service (or equivalent).

All people with a BMI over 25 should be offered dietary intervention that has the potential to reverse diabetes. The design of such dietary intervention may need to be modified as it is a rapidly moving area of research. People who fulfil NICE criteria should also be offered the option of bariatric surgery.

GM clinical commissioning groups have not felt able to implement CG189, because of affordability of bariatric surgery and insufficient capacity in weight management multi-disciplinary services, and have based their policy on the previous NICE guidance (43). This potentially raises conflicts for people with diabetes as the NHS Health Choices website informs them that the NHS offers surgery in accordance with CG189.

GM will comply with NICE guidance when it is considered possible to do so. This will allow clinicians to offer all people with a BMI of 35 or over who have recent-onset T2D an expedited assessment for bariatric surgery and consider an assessment for bariatric surgery for people with a BMI of 30–34.9, or lower if of South Asian family origin, who have recent-onset T2D. Presently, even those who would be eligible for bariatric surgery in accordance with CG43 have to raise the possibility of the surgery themselves. Part of the implementation of CG189 will involve clinicians proactively discussing the offer of bariatric surgery enabling people to make an informed choice. As different types of bariatric surgery have different levels of effectiveness, especially in the long term, this choice will entail making an informed decision regarding the type of bariatric surgery to be undertaken. We will proactively seek to
develop local guidelines for bariatric surgery to facilitate access to surgery in line with national guidance.

There is good guidance about advice on diet immediately prior to bariatric surgery and after the operation although the evidence on the effect of this advice is not robust. However, it will be sensible to build such advice into any service for bariatric surgery.

5.5 Care processes

People with diabetes will continue to be offered a number of healthcare tests as part of their ongoing care in accordance with NICE guidance. Historically these have been referred to as the diabetes care processes. Adults should receive HbA1c, cholesterol and blood pressure measurements, in addition to having blood and urine estimation of kidney function, their eyes screened, their body mass index calculated and their feet checked. Smokers will also be offered support to quit. All these processes will happen at least annually, although it is recommended glycaemic control is checked a minimum of twice a year.

Just like adults, children should expect HbA1c testing a minimum of four times a year. They should also expect screening for coeliac and thyroid disease, their body mass index calculated and an offer of psychological support. In those over twelve years, there should be tests of kidney function, eye screening, measurement of blood pressure and a check on their feet.

Relatively very few people with diabetes have all the care processes carried out annually (Fig 4). In most cases fewer than half of adults with diabetes have the eight care processes (excluding eye screening) carried out and there appears to be a particular challenge with kidney function tests in both types of diabetes and foot surveillance in T1D.

*Figure 4: Proportion of people who have care processes carried out*

In GM, work will be done to improve the proportion of people receiving all care processes. We will build on the integrated approach, used for many people with diabetes in GM, of joint working across health sectors and disciplines which clearly allocates responsibilities for carrying out each of the care processes. This will
improve uptake and appropriate follow-up. We will enable people with diabetes to provide the data to the clinician, possibly electronically, to give more control to the patient and reduce clinician time (e.g. home blood pressure measurements and urinalysis). Other measures could include improving the correspondence to people inviting them to attend; minimising the number of visits people have to make, sometimes to different venues; increasing choice of times to attend; and virtual clinics using telephone or Skype.

It is important that action is taken following the identification of issues as a result of undertaking the care processes. For example, smokers will be encouraged to access specialist services to quit which will be available throughout GM as laid out in the GM Tobacco Strategy (http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf). This strategy also states that e-cigarettes can provide a route out of smoking. So we will explore the potential of providing starter kits for e-cigarettes for those who prefer to quit smoking by switching to vaping as well as the stop smoking aids already available.

5.6 Additions to nationally agreed care processes

Diabetes-specific emotional distress, depression and anxiety are all common in people with diabetes. Brief screening for these conditions should be an additional process undertaken annually.

Diabetic retinopathy is a leading cause of blindness in the UK and we will continue to take measures to improve attendance at National Diabetic Eye Screening Programme. People with diabetes have an increased risk of glaucoma. For the routine eye examination at an optometrist, guidance from the College of Optometrists state that risk factors for glaucoma include being “over the age of 40”. The risk increases with every decade of life thereafter”. The guidance continues that “When examining a patient who is in the at risk groups for glaucoma you must carry out relevant tests” and these include measuring intraocular pressure and assessing visual fields. It is inappropriate that people with diabetes over the age of 40 are considered in need of screening for glaucoma only if they visit an optometrist. Raised intraocular pressure is a modifiable risk factor for glaucoma and will be part of the diabetic eye screening. However, it has poor sensitivity and specificity for the diagnosis of glaucoma. So relevant pathways will be put in place to ensure people with identified raised IOP at diabetic eye screening have additional assessment to investigate potential glaucoma (including assessment of optic nerve, visual field and contact tonometry) and should be assessed for treatment to reduce IOP even in the absence of glaucomatous pathology.

In addition to the children’s programme for flu and pneumococcus, adults will benefit from having flu immunisation each year and the pneumococcal vaccine according to national guidance. However coverage could be improved with only about two-thirds of people with diabetes having the flu immunisation each year. As well as inviting people for their immunisation, advising about immunisation should be part of the discussion that takes place when undertaking other care processes.
Erectile dysfunction has an increased prevalence in men with diabetes. Even when men are affected by erectile dysfunction, they are often reluctant to mention it to the clinician. As part of undertaking the care processes, clinicians will proactively ask about erectile dysfunction.

There is a clear association between periodontal health and glycaemic control although the direction of that association is not clear. However, during consultations with patients for the care processes is an opportunity to encourage people to visit the dentist for an oral examination and dentists can encourage people with periodontal disease to be checked for diabetes.

5.7 Transition

Most people transition between the ages of sixteen and nineteen years. However, blood glucose control often deteriorates considerably in the years that follow transition with HbA1c treatment target being less likely to be reached during this period.

While the path to adulthood is a continuous one, the path through clinical services may not be so smooth. It is appropriate that children and adolescents take increasing responsibility for their condition as they grow up. It is important that this assumption of greater responsibility starts early. For example, the ‘Ready, Steady, Go’ programme prepares children with diabetes for transition starting at 11 years of age. There also needs to be a good handover of care from paediatric to adult physicians. All services for children with diabetes will adopt a systematic approach to transition in line with the GM Childrens and Young Adults Strategy.

Key actions to improve the management of diabetes:

**Structured education**
- Ensure consistent high quality information is provided to all at appropriate times in a variety of formats.
- Adopt an ‘opt out’ rather than an ‘opt in’ approach to structured education and embed this is GP standards.
- Invite carers, and people living with those with diabetes, to attend structured education.
- Ensure refresher courses are available.
- Implement new structured education opportunities through a patient diabetes app for use remotely on mobile devices.
- Offer an education programme for initiating insulin to those with T2D requiring insulin.
- Investigate the potential for the electronic delivery of structured education through mobile devices.

**Person-centred care**
- Review person centred care plans, incorporating the ‘more than medicine’ approach, at least annually.
- Offer appropriate persons on insulin the opportunity to trial flash glucose
monitoring.

- Contribute to and participate in the development of online patient access to personalised information.

**Bariatric surgery**

- Ensure clinicians proactively offer people who have diabetes with a BMI over 35 or over with recent onset diabetes the option to discuss bariatric surgery.

**Care Processes**

- Improve joint working and increase integrated care.
- Improve opportunities for people with diabetes to provide data to clinicians, including electronically.
- Provide additional support to stop smoking, including e-cigarette starter kits.

**Additional care processes**

- Include screening for diabetes-specific emotional distress, depression and anxiety.
- Include measurement of intra-ocular pressure and optic nerve damage inspection during as part of eye-screening.
- Ensure that both children and adults are advised to take up pneumococcal and annual flu immunisation.
- Ensure clinicians proactively ask men about erectile dysfunction.
- Ensure people undergoing the diabetes care processes will also be encouraged to have regular dental check-ups.
6 Prevention of complications

6.1 Impact

Complications as a result of diabetes have a profound impact on those living with them, as well as their families and their carers. Complications such as cardiovascular events, renal failure, visual impairment, erectile dysfunction, gum disease or a wound resulting in amputation can be life changing and people may require considerable support from all involved in their care. In some cases, it will be appropriate that people are offered assessment for a personalised health budget and we will proactively seek to ensure that these discussions take place.

Figure 5: Costs of diabetes complications

Based on an analysis of diabetes costs in 2010/11, around £400 million is spent each year on treating complications in GM (Fig 5). Inpatients with diabetes often exceed the NHS tariff paid to hospitals by up to 8.5% due to longer length of stay. Readmission rates are high (59% higher than in age matched populations without diabetes and there are thousands of emergency call outs for ambulance staff and presentations in accident and emergency departments). Presently a high proportion of inpatients with diabetes have medication errors during their stay in hospital (Fig 6).

Figure 6: Medication errors in GM.
We will pilot the introduction of an inpatient bundle of care to reduce harm (see box), prevent inpatient medication errors and reduce inpatient length of stay. Many people treated with insulin have greater knowledge and experience of insulin adjustment than the medical and nursing staff responsible for their care. They routinely monitor their capillary glucose and adjust the insulin dose depending on the result. Self-management of diabetes by people who are willing and able improves the safety of insulin use in hospital. Hospitals will have a policy for diabetes self-management. Self-management will be the default position for all inpatients who are willing and able to manage their condition. We will explore the option of introducing clinical decision support systems and information prescriptions to enable clinicians to respond appropriately to abnormal test results.

Diabetes nurses provide management plans, treatment advice, and support for adults with diabetes and their carers. They are also a clinical and educational resource for other health professionals. They improve patient care, including reducing medication errors, and reduce length of stay. We will aim to ensure that these nurses are employed in line with the national recommendation of one nurse per 250 inpatient beds during the lifetime of the strategy.

### The inpatient bundle of care comprises components relating to:

- Ambulatory care model
- Link to nurses
- Purple lanyards for DT
- Incident reporting response
- Timely access to nutrition
- Purple food trays
- Nutritional information
- Electronic patient tracking
- ‘Think glucose’ icon patient identifier
- MDT 7 days per week
- Safe medication management

Full details are contained in the draft diabetes service specification

#### 6.2 Cardiovascular complications

Cardiovascular disease accounts for over half of all deaths in people with diabetes. People with diabetes are about twice as likely to die prematurely from cardiovascular disease than those without diabetes. The death rate can be halved by managing cardiovascular risk factors more effectively. This will be done through the personalised care plan which will include measures such as healthy lifestyle advice, control of blood pressure and the use of statins. Measures will be taken to improve the proportion of people offered the appropriate intervention and compliance with those interventions.

Major amputation rates vary, with parts of GM up to 81% higher than the national average. When clinicians, on examining the lower limb, suspect acute limb ischemia, they will send people directly to those A & E departments which have rapid access to a vascular opinion. As the majority of amputations are preceded by ulcerations, which account for over half of hospital admissions for foot disease, any person with
wounds or ulcers to their foot will be offered an appointment with a community podiatrist within 24 hours whether during the week or at weekends. Other people with suspected peripheral arterial disease will have a specialist assessment within 28 days unless there is infection when this assessment should be done within 24 hours. A unified GM foot pathway will be developed.

The risk of developing a foot ulcer is significantly increased when a person has a callus. The main reason for people with diabetes developing a callus is peripheral neuropathy which predisposes to abnormal pressure on the foot. The skin reacts to this pressure by increasing keratinization and leading to a callus which increases the risk of ulcers. The potential reduction of ulcers if we treated calluses assertively is large but, as yet, there is a lack of robust evidence that this is effective. GM will support the recruitment of people with diabetes for suitable trials that will inform whether treating calluses assertively will reduce ulcers.

The inclusion of diabetes in the CHA₂DS₂-VASc score (used to decide which people with atrial fibrillation should be anti-coagulated) is a reflection of the increased risk of stroke faced by people with diabetes when they have atrial fibrillation. The most recent Health Technology Assessment, commissioned by National Institute for Health Research (NIHR), concludes that opportunistic screening, for the general population, is the most cost-effective approach using pulse palpation or modified blood pressure monitors. The undertaking of care processes is a suitable opportunistic encounter with people with diabetes to screen for atrial fibrillation. All people with diabetes over the age of 65 will be screened for atrial fibrillation when the care processes are being undertaken. As all people over 65 with diabetes will have a CHA₂DS₂-VASc score of at least 2, they will be prescribed anticoagulation in accordance with NICE guidance.

6.3 Renal complications

About 40% of people with diabetes will develop diabetic nephropathy. This can be reduced by good glycaemic control, blood pressure control and, for those with a diagnosis of nephropathy or microalbuminuria, treatment with ACE-I or ARB drugs. These are measured by QOF but exceptions and a top threshold well below 100% gives insufficient incentive for optimal clinical practice. There will be discussions with primary care about removing exceptions and increasing the top thresholds in exchange for increased financial incentives.

About one in eight adults have masked hypertension. This is a risk factor that is often missed. People with diabetes who are normotensive when their blood pressure is measured by a clinician will have 24 hour ambulatory blood pressure monitoring or home self-monitoring every five years.

Diabetic and renal services should work together to manage people ‘at risk’ early with the aim of preventing progression to end stage renal disease. People with diabetes and declining renal function, who may be suitable for transplantation, will be referred sufficiently early so that they can be considered for pre-emptive renal transplantation.
6.4 Microvascular complications

Eye disease, erectile dysfunction and periodontal disease may be identified as part of the care processes. When they are detected, they will lead to appropriate management or referral.

6.5 Mental health

There are interventions to tackle complications that will improve the mental health of people with diabetes with GM, such as the integrated IAPT (Improved Access to Psychological Therapies) service. People with diabetes can also suffer with eating disorders with diabulimia being especially dangerous. People with eating disorders will often require referral to specialist mental health services.

6.6 Pregnancy

NICE have produced clear guidance on good preconceptual care for women with diabetes. Some of this guidance needs to be read in conjunction with other NICE guidance. For example, the guidance on preconceptual care that advocates the “use of contraception until good blood glucose control” has to be read in conjunction with NICE generic advice on contraception that states that “women … (should be) … offered a choice of, all methods including long-acting reversible contraception (LARC)” and that long-acting contraception is suitable for women with diabetes.

General Practices should identify all women with diabetes who may become pregnant as a part of the annual care planning and support them to develop a plan for either safe, effective contraception or for pregnancy preparation as part of routine care. Once a woman with diabetes has her pregnancy confirmed there should be early referral to a dedicated multi-disciplinary team (MDT) ante-natal clinic.

Key actions to prevent complications arising from diabetes:

**Impact**
- Introduce the inpatient care bundle.
- Hospitals have a policy of diabetes patient self-management.
- Ensure the numbers of nurses employed with specific diabetes knowledge or experience are in line with national guidelines.
- Ensure patients are able to access assessment for personalised health budgets where appropriate.

**Cardiovascular complications**
- Send people with suspected acute limb ischaemia directly to A&E departments with rapid access to vascular opinion.
- Offer people with wounds or ulcers a community podiatrist appointment within 24 hours.
- Offer people with suspected peripheral arterial disease a specialist podiatrist assessment within 24 hours (if wound present) or 28 days (if no wound
Support the recruitment of people with calluses for suitable trials to assess whether assertive treatment will reduce ulcers.

Screen people with diabetes, who are not diagnosed with hypertension, for masked hypertension every five years.

Include measures such as healthy lifestyle, control of blood pressure and the use of statins in personalised care plans.

Screen people with diabetes over 65 for atrial fibrillation during the care processes.

**Renal complications**

- Hold discussions with primary care about removing exceptions and raising upper thresholds.
- Offer normotensive people 24hr blood ambulatory pressure monitoring or home self-monitoring every 5 years.
- Refer suitable people with diabetes with declining renal function for pre-emptive transplantation.

**Pregnancy**

- Ensure preconception care is integral to care planning.
- Offer women a choice of all contraceptive methods, including long-acting reversible contraception, until good blood glucose control is achieved.
7 Additional issues for consideration

7.1 High risk groups

Certain cohorts of people run a higher risk of diabetes progression and subsequent complications because they are not engaged as effectively as others. They include those with mental health problems, people from black and minority ethnic backgrounds, the lesbian, gay, bisexual or transgender community, people with sensory or physical impairments, people with learning difficulties and homeless people. Reasons for suboptimal engagement can vary within these groups from not understanding the seriousness of their condition to not having provision appropriate to their needs. The third sector will be especially important in the engagement of hard to reach groups.

Particular attention should be paid to the communities with South Asian and Afro-Caribbean origin and other high-risk groups as they have especially high prevalence of diabetes. Engaging with these communities and recruiting peer supporters from within these communities will be a priority.

The present QOF enables primary care to make exceptions and exclude people from the denominator when measuring the quality of care. One of the reasons for making exceptions is when patients do not respond to repeated invitations and these people can be some of the most vulnerable. Measurements of the quality of care provided by the National Diabetic Audit (NDA) does include people who are excepted from QOF. This data is available by practice and is a more useful measure of quality than QOF.

Over the lifetime of this strategy, we will work to make services more equitable and accessible. We will expand the information and education provided in multiple languages and formats in discussion with these communities. We will engage those at high risk of progression and complications using care calls, messaging and other methods such as health apps to check how they are managing their diabetes and to offer advice and support to reduce diabetes progression.

People with mental ill-health are at high-risk of diabetes especially people with psychosis. Efforts have begun to achieve parity of esteem so that people with poor mental health with diabetes are detected early and treated appropriately. The choice of anti-psychotic medication can increase the risk of diabetes. Further work will be done to consider diabetes when the choice of anti-psychotic is made and, if an anti-psychotic that increases the risk of diabetes is used, to minimise the dose if that is possible.

Diabetes is common in residential and nursing homes. We will work with these homes to help ensure good care of their residents eg there are clear policies on self-medication and on dealing with hypoglycaemic events.

Some people find it very difficult to control their diabetes. People with T1D diabetes that meet the guidelines will have access to insulin pumps as approved by NICE.
7.2 Unwarranted variations

Some variation in healthcare is unavoidable because of its complexity and the difficulties in controlling all the variables that contribute to it. Variation can sometimes be explained by the characteristics of the local population, individuals or by differences in the capability of healthcare professionals. Often differences occur when innovations are made but innovation is essential to drive up standards. The important thing for us to understand is whether the variation is warranted.

The term ‘unwarranted clinical variation’ has been described as ‘care that is not consistent with a patient’s preference or related to [their] underlying illness.’ This can relate to substandard care around access to services and outcomes. To limit unwarranted variation in diabetes care, we have to outline a set of minimum standards people should expect from our services.

In GM we plan to outline a set of minimum standards by:

- Developing a GM diabetes services specification covering all elements of care and;
- Supporting the service specification with agreed pathways and processes

The service specification will incorporate the NHS RightCare Diabetes pathway to facilitate a reduction in unwarranted variation. The RightCare programme can then be used to improve standards as is presently being done for blood pressure control and the management of atrial fibrillation.

The service specification will define the minimum components of quality diabetes care and should not limit local innovation. The pathways and processes aim to incorporate all necessary components of care and recommendations in this strategy, but not limit the local service models to deliver them. Combined these deliverables will support commissioners and local care organisations to review service provision and support the provision of quality diabetes care that is sustainable.

The service specification will include the agreed standards which can be audited. Clear presentation of data which shows how well services are meeting the standards and giving comparison between providers will act as a spur to improvements and help to reduce variations.

At the same time we should improve the way we evaluate diabetes health outcomes so we have a greater understanding pertaining to what is optimum, the reasons behind local variation, and what markers truly indicate a move in the right direction. Data recorded and collected should be consistent, up-to-date and enable commissioners to assist local services in need of support.
7.3 Continued learning for clinicians that support those with or at risk of diabetes

As well as educating people with or at risk of diabetes, we will ensure clinicians have the necessary competencies and skills to be able to offer effective support.

There is often an assumption that health care professionals already have these skills. However, in 2016 as part of stakeholder engagement, clinicians in GM highlighted the need to have more accessible and targeted healthcare professional training. One of the main reasons being clinical inertia; a concern highlighted in a number of diabetes studies. Clinical inertia often results in delays to treatment intensification where there is sub-optimal glucose control. This can accelerate the progression of diabetes and cause avoidable complications. Some clinicians do not feel confident or supported with complex cases and others believe the training they receive is often pitched at the wrong level and more appropriate training and mentorship would not only educate them, but help them achieve better clinical outcomes.

We will define the responsibilities of clinicians involved in diabetes care using agreed care pathways and a service specification. Those that lead the care will relay important health messages in a sensitive manner; have skills to tease out what is important to the individual; agree with the person the positive changes to be made; and signpost them to supportive tools that may help. To reduce clinical inertia, health care professionals will be offered training suitable to their needs and be supported by an infrastructure that features mentoring and partnership working with other specialists.

We will explore the potential for complementing traditional training with web-based and mobile educational programme. Such a programme for cancer (Gateway-C) has proved popular amongst primary care with over 70% of GP practices now having registered users. When appropriate, support will include involvement of community diabetes nurses working between primary and secondary care.

7.4 Improving research and innovation

Continued research and innovation is crucial to improve diabetes care especially when focussed on strengthening evidence based practice for the prevention of diabetes and its complications. Whether it is findings from clinical trials or identifying best practice locally, the information needs to be shared with peers to support continued improvement.

In GM we will continue to work with our clinical research network to improve information management when it comes to disseminating research and innovation locally. Audit data relating to clinically relevant diabetes outcomes such as CVD risk factors will be provided in a timely fashion in ways that will help improve clinical performance across the diabetes care pathway.

We will explore new ways of promoting and disseminating research and innovation not just to local academics and clinicians but commissioners, managers and people
with or at risk of diabetes. Such an approach will also aid further collaborative working and avoid repetition when it comes to service improvement.

7.5 Future planning

As new evidence emerges there will be a need to revise this strategy. Within the strategy it will be important that service redesign and implementation is a continuing process. It is vital that any future strategy development and implementation has the full involvement of service users.

Key actions to minimise the impact of additional diabetes risk factors:

**High risk groups**
- Maximise engagement with the third sector to ensure that every effort is made to access and support hard to reach groups of individuals.
- Expand the extent to which information and education is available in multiple languages and formats.
- Explore the options for engaging with those with diabetes in new ways (including electronically) and use these to provide new opportunities for self-managed care.
- Ensure diabetes is considered during the choice of anti-psychotic medication.

**Unwarranted variation**
- Introduce a GM diabetes service specification and comply with minimum standards and agreed pathways contained in it.

**Continued learning**
- Ensure clinicians have the necessary competencies to offer effective support on an ongoing basis.
- Define the responsibilities of clinicians in diabetes care.
- Offer new web-based learning opportunities for clinicians.

**Research & innovation**
- Provide diabetes audit data in a timely fashion and an accessible manner.
- Explore innovative approaches that have been delivered in other areas and replicate locally where applicable. This may be especially important in areas of high need.
- Explore new ways of disseminating research information throughout the GM diabetes care system.
SUMMARY OF REPORT:

This report describes the case for change and process undertaken to develop the GM Children’s Health and Wellbeing Framework, building on the work to date of the multi-agency GM Children’s Health & Wellbeing Board and the independencies across wider statutory bodies.

KEY MESSAGES:

The Greater Manchester Strategy, Our People, Our Place, outlined a vision for GM to be, “A place where all children are given the best start in life and young people grow up inspired to exceed expectations”. The Strategy specifically emphasised children’s early years’ experience, their being ready to start school and, subsequently being supported to be equipped for life.

The GM Health & Social Care strategic plan, Taking Charge acknowledged the contribution better health and improved provision of care services makes to successful school outcomes and successful adult lives as well as identifying specific areas of transformation to reduce avoidable hospitalisation for children, improve mental health provision and more and better community based support for children with disabilities.

The GM Children’s Health and Wellbeing Board was established by the Health & Social Care Partnership in May 2017 to provide co-ordination and oversight of children’s health and care transformation and improvements across Greater Manchester, with a focus on how health can support and contribute to the wider children’s agenda. The first phase of the Board’s work has been to develop a clear work plan centred around ten core objectives aimed at providing a comprehensive and complementary health & care contribution to the outcomes sought by the GM Children’s Board. This report describes those Framework Objectives.
PURPOSE OF REPORT:

To help co-ordinate work across all sectors to improve the health and wellbeing of children and young people across Greater Manchester.

RECOMMENDATIONS:

The GM Health and Care Board is asked to:

- Support the ten objectives currently identified within the GM Children’s Health and Wellbeing Framework and the proposed approach to phased delivery.

- Support the first wave objectives proposed, using a phased approach with system leaders to develop a mechanism for delivery and understand the resources required to support implementation.

- Support an equivalent process for the second wave and enabling objectives of detailed co-production with system leaders to determine the best mechanism for delivery, finalise the deliverables and understand the resource required to support their subsequent delivery.

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GREATER MANCHESTER
CHILDREN & YOUNG PEOPLE
HEALTH & WELLBEING FRAMEWORK
(To support the work of the Children’s Health and Wellbeing Board)
2018-2022

Taking charge
of our Health and Social Care
in Greater Manchester
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1.0 Context

Our vision is to make Greater Manchester (GM) one of the best places in the world to grow up, get on and grow old. This means a place where all children are given the best start in life and young people grow up inspired to exceed expectations.

Across Greater Manchester, to ensure children have the best start in life, we’re integrating the services provided to children from when they are born until they start school, and are working on implementing this new approach throughout the city-region. Our ambition is that all children will start school ready to learn. We’re improving parent support services and ensuring children have places to play, and we’re prioritising good air quality around our schools and pre-school sites. We’re supporting all schools and colleges to drive up achievement and progress, and working in partnership with agencies throughout the city-region to improve attendance. We’re promoting core work competencies, developing a curriculum for life, and improving careers advice so that young people leave school ‘life ready’, prepared for further study or the world of work, and have an awareness of future challenges and opportunities. We’re increasing the quality and quantity of apprentices, including higher level apprenticeships in key sectors, and making it easier for young people to apply for these opportunities. We’re also providing specialist support for those that need it; building on our experience of improving the lives of over 8,000 families across Greater Manchester by identifying needs early and providing person-centred support.

Good health in childhood is vital to achieving this ambition. We recognise that disadvantage starts before birth and accumulates throughout life, meaning that our collective actions must start at conception and be followed through the life of the child.

The foundations for virtually every aspect of development; physical, intellectual and emotional, are laid in early childhood. The earliest experiences shape a baby’s brain development, and have a lifelong impact on mental and emotional health. Evidence shows that when a baby’s development falls behind during the first year of life, it is then much more likely to fall even further behind in subsequent years, than to catch up with those who have had a better start.

We therefore want every child in GM to have the best start in life. This means that every child grows up in an environment that nurtures their development, derives safety and security from their care givers, provides ready access to high quality services and has a belief in their goals and their ability to achieve them. Our ambition is that every child in GM acquires the skills necessary to negotiate early childhood, primary and secondary school and education and employment.
We recognise, of course, that this is a time of significant constraint in public finances and resources across all organisations are exceptionally stretched. When times are tough it is even more important to pool resources and act collectively, adopting a holistic view of the child and a mindset that every child does matter.

Collaboration is part of Greater Manchester’s DNA and we are building on past progress to develop system-wide approaches to improving outcomes for children and young people. Three GM examples are ‘Making it Better’ which was a large scale service redesign of paediatric and maternity services implemented over a six year period; the GM Early Years Delivery Model; and the GM Complex Safeguarding Strategy.

All organisations delivering services for children and young people currently recognise that GM has a “once in a lifetime” opportunity to focus on improving the health and wellbeing of children, and to ensure that the models for delivering care are modern, fit for purpose, safe and sustainable for the next five years and beyond.

As a fundamental principle, there is a commitment from all organisations to work together to improve health and wellbeing throughout a child’s life course from birth to adulthood and old age.

2.0 The case for change
Greater Manchester is home to 895,000 children and young people under the age of 25 and this number is growing. The GM population under 25 is larger than the England average by 2% or 18,000 children and this population is forecast to rise to a plateau of 945,000 in 2032 – 50,000 more children or a 5.6% increase on 2018.

Growing up in Greater Manchester is more challenging than most parts of England. Greater Manchester has high rates of looked after children, poverty, mental health disorders, smoking in pregnancy, decayed teeth, obesity and lower rates of school readiness, educational attainment, levels of physical activity and, ultimately, life expectancy. Compared to the average of children in the rest of England the facts below show that in Greater Manchester

- children have a lower life expectancy (by 1.4 years for males),
- more children under 20 live in poverty (32,000 more),
- children have worse health, such as more children under 19 admitted to hospital for asthma (624 more)
- more children going to secondary school are ‘obese’ (685 more out of a population of 34,131).

Children starting school ready to learn is fundamental to supporting good outcomes later in life. Our analysis of the long term potential of Greater Manchester as a place where people can lead successful lives as part of a thriving economy, the Manchester GM Children’s Health and Wellbeing Framework – 2018-2022
Independent Economic Review highlighted early years performance as key to closing Greater Manchester’s skills and productivity gap and many health and social issues can be traced back to what happens in a child’s first years.

It remains a significant challenge for Greater Manchester that, despite our efforts, a third of our children entering primary education are not ‘school ready’. Whilst our performance has improved over recent years, the almost four percentage point gap in early years outcomes with the national average has not been eliminated and performance across Greater Manchester continues to vary considerably, being highly correlated with deprivation. Our consultation reinforced this with respondents telling us “we need equal life chances and better services for children and young people whose families are disadvantaged”.

This has been one of the drivers for the work of the GM Children’s Health and Wellbeing Board (GM CHWBB). The GM Children’s Health and Wellbeing Board was established by the Health and Social Care Partnership (HSCP) in May 2017 to provide co-ordination and oversight of children’s health and care transformation and improvements across Greater Manchester. The Board has been explicit in being open about the factors affecting the health of children and young people and constructed this framework to respond to the full range of those challenges. That work has informed the detail of this Framework to radically improve the health and wellbeing of all of our children and young people. The framework aims to ensure better co-ordination of the response to developmental delay; more reliable, earlier responses to emotional distress; harness the contribution of schools and their health and care partners to support physical and mental health of all children, and particular those with the most complex needs; to improve the management and support of children and young people with long term conditions to avoid the need for them to go into hospital; and to ensure this support assists young people into adulthood with hope.

**Fig 1: Childhood in GM at a glance**
3.0 Engaging with children, young people and families and professionals

This framework has been developed in a way that puts the voices and needs of children and young people front and centre in our work to revolutionise service provision. Some of the organisations, groups and individuals who have input to the writing of the framework include:

- Children, young people and families
- The voluntary, community and social enterprise sector especially those working with children and young people
- Public health experts
- Doctors including psychiatrists, general practitioners and hospital consultant paediatricians
- Directors of Children’s Services and lead safeguarding nurses from local authorities

• School leaders, including a local authority Director of Education
• Chief Executives of NHS Trusts
• Academic experts
• Commissioners of health services
• Business intelligence and digital directors.

An innovative “Children’s Challenge Day” was held in October 2017 where the proposed framework objectives were tested by children and young people. This ensured that the objectives and priorities are important to children and young people and address their needs. Our young people have started to develop a health and care ‘Children’s Charter’ to encompass the priorities and needs to those under 25 years, led by the GM Youth Assembly. The GM Youth Combined Authority brings together young people representative of the diverse communities in Greater Manchester, including geography and communities of interest, in particular different minority ethnic, and disability, faith, and LGBT groups. They advise the Mayor and Greater Manchester Combined Authority on key issues and the concerns of young people, and provide solutions.

“I have taken part in lots of projects and consultations around young people’s health and provided lots of information about what is important to me and other young people. We feel as service users our opinions should be heard so writing a Charter using our views is a good idea. In October 2017 at the Greater Manchester Youth Summit I ran a workshop with Lauren, we took the Charter statements and asked young people what the statements mean to them. I am looking forward to seeing how it will work and how services will change. It is important that the work we do to campaign and improve services is taken into account by decision makers.”

Jess Consterdine, Oldham Youth Council, Greater Manchester Youth Combined Authority
Fig 2: Children’s Health and Wellbeing 10 Objectives:

1. To develop all relevant plans, policies and programmes with children and young people and their families, reflecting the realities of their experiences and based upon a Children’s Charter.

2. To support the early life course of a child, starting with pre-conception right through to a child’s early years, enabling children to be school ready, especially those children with special needs.

3. To invest in mental health and resilience for children and young people, from pre-school right through to young adulthood.

4. To protect children and families at risk and strive to ensure that disadvantaged children become healthy and resilient adults.

5. To work in partnership with schools to equip them to play a pivotal role in improving children’s safety, physical and mental health and help children with special needs to achieve their goals.

6. To reduce unnecessary hospital attendances and admissions for children and young people particularly those who have long term conditions such as asthma, diabetes and epilepsy.

7. To ensure that transition of care for young people to adult services meets their needs and ensures continuity of high quality care.

8. To develop a modern, effective, safe and sustainable workforce that delivers children and young people’s services, ensuring we have the right people with the right skills and values in the right places.

9. To use the power of digital technology and a commitment to joining up services to give children, young people and their families more control over how and when they receive services.

10. To be transparent in sharing accessible information that will be useful to children, young people and their families in making choices about services and which will also help hold us to account for our performance.
4.0 Delivering the framework’s objectives

We recognise that the 10 objectives have different levels of readiness for implementation. The 10 objectives are split into 2 groups – Delivery objectives and Enabler objectives. The Delivery objectives have been further split into 2 waves for implementation based on the readiness and resource requirements of the work for implementation.

The work incorporated into Delivery Wave 1, some of which is already being implemented, centres around:

- Objective #2 – Early years and school readiness
- Objective #3 – Mental health and resilience
- Objective #6 – Preventing avoidable admissions particularly for long-term conditions (based on the May 2017 CHWBB).

The work in Delivery Wave 2 still requires additional work with GM-wide organisations to be further developed and resources for delivery and the funding sources identified. This wave centres around:

- Objective #4 – Supporting and protecting children and families at risk
- Objective #5 – Working with schools to improve all children’s safety, physical and mental health and especially those with special needs (based on the September and December 2017 CHWBBs).
- Objective #7 - Transition of care for young people to adult services (based on the March 2018 CHWBB)

The Enabler objectives are:

- Objective #1 – Including children in planning based on a Children’s Charter
- Objective #8 – Delivering a modern, effective, safe and sustainable workforce
- Objective #9 – Using the power of digital technology to join up services
- Objective #10 – Sharing transparent and accessible data to hold us to account for performance

The GM Health and Social Care Partnership will not directly be delivering this framework in its totality; more our aim is to deliver this framework in partnership with the GM system by harnessing the experience, strengths and statutory responsibilities of GM-wide groups and organisations such as:

- Children, young people, families and representatives
- The 10 local authorities and their social care and education departments
- Health organisations including commissioners, primary, secondary and tertiary healthcare providers, health researchers
- All education organisations and settings from nursery to university including Special Educational Needs and Disability
- Voluntary, community and social enterprise (VCSE) and faith sectors
5.0 Governance

The recent establishment of the GM Children’s Board will ensure we develop a coordinated approach to improving outcomes for children. The Children’s Board will oversee work on education, early years (particularly from a learning perspective), life readiness and employability through the GM Education and Employability Board. It will also ensure we bring a multi-agency focus to bear on improving outcomes for vulnerable children (including those in need of protection); children looked after; and young people who have left care through the GM Standards Board.

The GM Children’s Health and Wellbeing Board provides the co-ordination of children’s health and care transformation and improvements across Greater Manchester, with a focus on how improving children’s health can support and contribute to wider outcomes for children.
6.0 Implementation – plan on a page

A) Objective #2 – Early Years and School Readiness

Work Already Underway

- Testing a prototype for the digitisation of records in the Early Years in Salford
- Implementation of the GM perinatal and infant mental health pathway.
- A targeted programme to improve oral health in the under 5s in four priority localities. This involves Health Visitors delivering oral health improvement messages and toothbrush and toothpaste packs at 9 month and 2 year visit. Phased implementation of supervised tooth brushing scheme has started.
- Baby Clear programme to reduce smoking in pregnancy. All stop smoking services trained in the incentive scheme and implementation has begun. Cluster one baby Clear training has taken place. Cluster 2 initial meeting taken place.

Work Due to Start in Financial Year 2018/19

- Re-establish the GM EY strategy with prioritisation and investment challenge across localities
- Produce a GM outcomes framework with agreed measures across localities for the purpose of adding value to the development of young people including mental health outcomes
- Strengthen data sharing, governance and digitalisation
- Develop a high-quality workforce
- Develop an evaluation framework for interventions
- Provision of evidence-based parenting programmes across GM
- Produce consistent universal antenatal parenting classes and implement across GM
- Create/identify evidence based targeted parenting classes and implement across GM
- Co-develop risk assessment tool/approach which includes Adverse Childhood Experiences (ACEs) to support identification of those families in the antenatal and maternity period who require additional support and evidence based interventions.
- Co-produce with midwifery, early years leads, early help leads, voluntary sector and adult services the above and enable midwifery and all these services to work in an integrated way to provide support and where appropriate evidence based interventions, starting in the antenatal period - sharing outcomes especially the key high level outcome of improved school readiness.
B) Objective #3 – Mental Health and Resilience

Work Already Underway

Children and Young People Crisis Care
- Development of a ‘Reach In’ model with multi-agency partners, including health, social care, education, voluntary sector and blue light service that provides a needs-led response to crisis

Community Eating Disorder Services
- Greater Manchester has developed a core offer and standards leading to improved access and waiting times:
  - All 3 clusters seeing 100% of urgent referrals within 1 week
  - Central and East clusters seeing 100% of routine referrals within 4 weeks
  - West cluster seeing 83% of routine referrals within 4 weeks
  - All clusters above or meeting national average

GM i-THRIVE
- New Thrive care model established to promote system change
- Thrive training hub for the whole Greater Manchester workforce (including users and carers) to improve service delivery and outcomes

ADHD
- Greater Manchester wide Care Model introduced to support the needs of families with children and young people with ADHD needs

Work Due to Start in Financial Year 2018/19

Children and Young People Crisis Care
- Implementation of ‘Reach In’ community based care.
- Implementation of 4 rapid response teams and safe zones pilot across GM linked to the localities
- Implementation of in patient assessment and ‘Reach In’ centre within an alliance model of care
- 24/7 specialist expert advice, guidance and support

Mentally Healthy Schools
- 6 month rapid pilot to deliver mental health and emotional wellbeing support to schools
- Raising awareness and improving the schools’ ability to support young people and their families
- Staff wellbeing and leadership training for teachers

GM i-THRIVE
- Supporting the children and young people’s mental health and emotional wellbeing workforce
- Learn to develop and deliver services together as a single system improving outcomes for children and their carers.
- Supporting the Greater Manchester ambition of 111 CAMHS clinicians by 2021

Perinatal and Parent-Infant Mental Health
- Women and families receive the right level of help
- Swift and easy access to support for new parents and infants – 1680 more women are able to access specialist Perinatal care
Objective #6 – Preventing Avoidable Admissions

Work Already Underway
Pilot Children’s Community Hub
- Developed model for a children’s community hub
- Identified pilot site (Rochdale)

Transition
- Deep dive carried out in March 2018

Develop consistent end to end pathways for asthma, diabetes and epilepsy including prevention and transition
- Identified best practice and national guidelines
- Developed localised GM end to end treatment pathways

Refresh GM asthma standards - Support implementation in communities (including schools)
- Amended existing standards
- Developed young people’s dashboard for all GM partners to input to and access
- GM young people’s dashboard integrated into Tableau

Reduce variation in observation and assessment (O&A) units and community children’s nursing teams (CCNT)
- Baseline carried out and best practice identified

Identify best practice in reducing avoidable admissions
- Initiatives developed and shared with the GM system.
- 2 pilot localities (Salford and Oldham) identified

Work Due to Start in Financial Year 2018/19
Identify what support and resources families and children require to self-manage effectively
- Engage with VCSE to explore families’ and children’s views
- Develop further plans to identify resources and actions for implementation

Pilot Children’s Community Hub
- Pilot to be completed with evaluation by Salford University and input from Youth Combined Authority

Transition
- Map out current services for transition
- Identify best practice
- Develop, trial and evaluate Long Term Conditions (LTC) passport

Develop the role of schools in managing LTC including the role of school nurses
- Link with school nurses to develop support within schools
- Link work with emerging CCNT work

Reduce variation in observation and assessment (O&A) units and community children’s nursing teams
- Mechanisms for action to be identified

Identify best practice in reducing avoidable admissions
- Pilot bundle, evaluate and identify mechanism for action across GM system
SUMMARY OF REPORT:

To update on the current position of Palliative and End of Life Care across Greater Manchester (GM), including challenges and potential solutions to improve on the current position, and to outline the vision for a Greater Manchester Framework for Palliative and End of Life Care, where the emphasis is on choice, including place of care and death.

KEY MESSAGES:

Whilst death affects all communities the experience people have of this important life event is variable.

Approximately 1% of the population die each year. In the past year there have been 23,866 deaths in Greater Manchester. In GM 49.8% of deaths were in hospital, 23.5% in their own home, 18.7% in a care home, and 6.1% of deaths were in a hospice.

Three quarters of the total number of adult deaths are expected in the context of old age, living with multiple long term conditions, and specific illnesses. Cancer accounts for a quarter of all deaths.

Health and care costs increase dramatically in the last 90 days of life, meaning as much as 20% of all health expenditure is invested in end of life care.

Many people will die in hospital without any clinical need to be there, with surveys suggesting that most people would not choose hospital as their preferred place to die. Service users usually rate experiences in care homes and hospices higher than hospital experiences.

Existing GM activity to improve end of life care has resulted in key improvements but is relatively modest in scale and scope. All ten localities are engaged and supporting networks are in place. There are many examples of local good practice. The foundations are in place...
for a more comprehensive approach across GM that develops consistent standards building on the work done to date.

PURPOSE OF REPORT:

This report outlines an approach to develop a Greater Manchester Framework for Palliative and End of Life Care with supporting standards and an implementation plan. This will be governed by a Programme Board under the leadership of a Senior Leader.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Support the proposal for the development of a Greater Manchester Framework for Palliative and End of Life Care led by a Programme Board.

- Endorse the importance of providing effective care and support for people affected by death in Greater Manchester.

CONTACT OFFICERS:

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1.0 INTRODUCTION

1.1. Palliative care is an approach to improve the quality of life of patients and their families facing any life threatening illness, through prevention and relief of suffering by holistic assessment and treatment. End of Life Care is for patients who are likely to die within the next 12 months, with any progressive condition, such as people with dementia, Motor Neurone Disease, and chronic respiratory disease.

1.2. What problems are we hoping to solve?

1.3. There are a number of challenges within the system that contribute to the current position:
   
   - We are not always comfortable talking about death, dying and bereavement so we don’t always plan ahead in terms of wishes and preferences.
   
   - Incomplete identification and registering of those people in the last year of life within primary care leading to a lack of advance planning for future care and support needs, including the choice of place of care and death.
   
   - Incomplete and delayed information sharing between providers and poor coordination of care between teams.
   
   - Variation in the provision and timely access to Specialist Palliative Care 7 days a week.
   
   - Variable care after death processes, especially in community e.g. verification of death, variation in requirement from coroners.
   
   - Variation in bereavement support services.

2.0 PROGRESS TO DATE

2.1. The current programme of work continues to be delivered across GM, whilst the team work on the draft framework, standards and implementation plan. Key highlights are:

   - All ten localities have engaged in activity to baseline the current position of palliative and End of Life Care by against the Ambitions Framework. A GM pen picture is now available. Localities are working on local action plans in response to this.
   
   - Dying Matters Awareness Week activities are planned across GM (14 May 2018).
• An advance Care Planning and Communication Skills Training Programme is well underway across GM, and extended to VCSE, with very positive evaluation to date.

• Electronic Palliative Care Coordination Systems; working with GM Digital Collaborative to explore the blockages to IT interoperability at locality level.

• GM Hospice Group developments which includes the appointment of a project manager to work on behalf of GM Hospices, to explore the added value of Hospices to the GM provision.

• Investment from Macmillan in Wigan and Salford to enhance 7 day Specialist Palliative Care at night, weekends and bank holidays. Demonstrator sites planning well under way.

• Developing innovative education and training approaches which aim to address end of life care inequalities within vulnerable populations, e.g. those who are homeless, people with learning disabilities, prisoners and more.

2.2. Taking Palliative and End of Life Care to an elevated position across GM; Actions to date:

• During November and December 2017, a discussion paper was widely socialised with lots of comments returned and incorporated into the final version. This is informing the draft framework and standards along with the outputs from the Ambitions baseline locality visits.

• Ongoing discussions at GMHSCP regarding the application of a framework and standards within the developing LCO landscape.

• Programme Board membership in development with Elaine Inglesby-Burke, (SRFT) confirmed as the SRO, supported by Adrian Crook (Local Authority) and Gill Gibson (Commissioning).

• Cost Benefit Analysis underway, costing specific interventions applying the PHE Toolkit and supported by the Audit and Research Team at GMCA.

• Draft metrics and measurement dashboard currently in development.

• Proactively working with person and community centred approaches and Dementia United as examples of cross cutting opportunities. Workshops in place to discuss "What does a great end of life care experience look like".

• A formal submission to Transformation Funds 26 March 2018.

• Preparation underway for Dying Matters Week 14 May 2018. Lots going on across GM

2.3. What would success look like for the citizens of Greater Manchester?
• People would feel more comfortable and be more receptive to talking about death, dying and bereavement, increasing confidence to plan ahead for their own end of life preferences and choices.

• There would be an increase in the numbers of people identified as being in the last year of life, all diseases, and then registered onto the GP Practice register. At least 1% of the practice population, and including those from vulnerable populations.

• There would be more people with an Advance Care Plan, which sets out individual preferences and choices for end of life care, e.g. place of care and death.

• Those Advance Care Plans could be shared electronically within relevant teams' organisations, including out of hour's providers and the ambulance service e.g. fully functional Electronic Palliative Care Coordination Systems (EPaCCS).

• There would be more people being offered a personalised care plan with the offer of a personal health budget to support a tailored care package

• Care providers would be responsive to end of life care situations and work together to provide timely and holistic support, e.g. medicines and equipment.

• A competent and confident workforce to support people during the end of life care phase, including care after death and bereavement support.

• Access to specialist palliative care provision, 7 days a week, would be available in all localities for advice, support and as necessary intervention e.g. Hospice at Home provision.

• Accessible, timely bereavement support that can meet the needs of the local population and takes account of the cultural diversity within local populations.

3.0 RECOMMENDATIONS

3.1 The Greater Manchester Health & Care Board is asked to:

• Support the proposal for the development of a Greater Manchester Framework for Palliative and End of Life Care led by a Programme Board.

• Endorse the importance of providing effective care and support for people affected by death in Greater Manchester.
SUMMARY OF REPORT:

Greater Manchester has experienced significant challenge in relation to performance against the national four hour A&E standard during the winter months and during the last quarter of 2017/18 less than 85% of people attending emergency departments across Greater Manchester were seen within four hours.

As a result, Greater Manchester has agreed with NHS England to deliver actions to seek to ensure that at least 90% of attendees at the Emergency Department are seen within four hour by the end of June 2018, and a ‘Q1 Improvement Plan’ has been developed in partnership with all Greater Manchester localities. Early signs are positive in that performance has improved significantly in April but we still have some distance to go to reach the agreed level.

Greater Manchester has also reviewed the governance arrangements for the transformation of Urgent and Emergency Care across the region and a programme of work is currently being scoped to deliver significant change and improvement.

KEY MESSAGES:

- A Quarter 1 Improvement Plan has been produced, to achieve a position of 90% for the four hour target

- The approach to Urgent and Emergency Care reform has been revised and a new programme structure has been agreed.
PURPOSE OF REPORT:

The purpose of this report is to provide the Board with an overview of Urgent and Emergency Care (UEC) improvement working being undertaken during Quarter 1 and details revised governance arrangements for the transformation programme going forward.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Note the content of this report
- Confirm agreement with the identified approach.

CONTACT OFFICERS:

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1.0 Q1 IMPROVEMENT PLAN

1.1. Despite extraordinary levels of hard work by front line staff in maintaining a stable and safe urgent care system through the winter, acute trust sites across Greater Manchester failed to achieve the national four hour target. In March 2018, GMHSCP was asked by NHS England to develop an improvement plan to ensure that no less than 90% of people attending the emergency department across Greater Manchester were seen within 4 hours.

1.2. Key stakeholders working in UEC services in Greater Manchester met during March 2018 in order to consider and define the priority actions that needed to take place during Quarter 1 in order to significantly improve four-hour performance across Greater Manchester by June 2018.

1.3. All localities were asked to identify 3-5 areas to focus on during quarter 1 that they understood to have the greatest impact on improving urgent and emergency care. These covered areas such as reducing attendances, reducing admissions and reducing hospital length of stay.

1.4. Alongside the locality actions, the plan also sets out a list of actions that GMHSCP will deliver, for example improvements to NHS 111 services, improving ambulance handovers and improving management processes for times of peak demand.

1.5. Other areas of work that have an impact on four hour performance were also considered, such as workforce, primary care and work to reconfigure urgent and emergency care.

1.6. The plan was submitted to NHS England in early April 2018 and a process to ensure that it is regularly reviewed is in place to ensure that plans can be revised where there is poor evidence of the impact of the identified activities.

1.7. GMHSCP is also working with the North East of England Commissioning Support Unit, which has a proven track record in this area, to provide intensive intervention to systems where the challenges are most significant.

2.0 UEC TRANSFORMATION PROGRAMME

2.1. Since the publication of the GM UEC Reform in March 2017, early successes have included the agreement and implementation of three GM standards for discharge, supporting a reduction in patients whose transfer of care is delayed, significant progress with the development of Urgent Treatment Centres and the introduction of processes to stream patients to suitable alternatives to the emergency department in all localities.

2.2. A further achievement is the launch of the GM Operational Hub, which opened in November 2017. The GM Operational Hub operates 24/7 365 days a year. It has access to live information from all acute trusts across Greater Manchester relating
to activity levels and acts as a control room for high activity periods, such as winter, providing support and liaison with both local and national teams.

2.3. Moving forward, a clearly defined vision and set of aims has been developed for the GM UEC Transformation Programme. This is focused on delivering constitutional standards and best practice; improving equity of access and reducing variation in care, greater integration between services, reducing attendances and keeping patients in their usual place of residence for longer.

2.4. A measurement framework is currently in development to identify how improvements delivered by the Board can be most appropriately measured against what agreed standards.

2.5. A revised governance structure has been developed to deliver the programme. A GM UEC Improvement and Transformation Board will meet every two months, providing assurance and strategic direction to the programme. A Steering Group will meet monthly to design, oversee and review the UEC transformation work. A Professional Clinical Advisory Group will also be established, with membership drawn from professional groups and clinical staff, including social care and will be responsible for the design of clinical pathways and models of care.

2.6. The work will be delivered according to four key streams of work, these are: Stay Well (Prevention); Home First (Attendance and admission avoidance); Patient Flow and Discharge and Recovery and four working groups are to be established.

2.7. This structure is shown in the diagram below:
2.8. A key part of the Urgent and Emergency Care Programme is the development of an integrated urgent care service model. This model would bring together all existing urgent care services, including GP out of hours Services, acute visiting services, mental health crisis responses, social care, falls teams, under one provider in each locality.

2.9. The ambition is to establish up to 4 sites that would progress the development of the model at pace over the next six to eight months and a number of localities have so far expressed an interest in this.

3.0 NEXT STEPS

3.1. The inaugural meeting of the GM UEC Improvement and Transformation will take place on the same day as the Health and Care Board meeting, 11th May 2018. All work stream groups and the GM Professional Clinical Advisory Group will also meet in May 2018.

3.2. Workshop to define the improvement activities and to confirm programmes of work will take place during June 2018.

3.3. It is anticipated that an overarching UEC Transformation Plan will be drafted for sign off in June 2018.

4.0 RECOMMENDATIONS

4.1. The Greater Manchester Health & Care Board is asked to:

- Note the contents of this paper
- Agree the identified approach
SUMMARY OF REPORT:

Our Business Plan sets out the priorities for the Greater Manchester Health and Social Care Partnership for 2018-19. This is the third year of the delivery of our five-year strategic plan Taking Charge.

KEY MESSAGES:

The Business Plan reflects the work that we have done recently to prioritise those areas of work that will make the most difference to residents and patients in Greater Manchester. A draft was presented to the Health & Social Care Executive Board in April and was supported. For the Health and Care Board, we have developed an infographic and some slides to summarise the Business Plan.

PURPOSE OF REPORT:

The presentation sets out the key aims in the Business Plan and how they will make a difference to residents and patients in Greater Manchester.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Support the Business Plan

CONTACT OFFICERS:

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Greater Manchester Health and Social Care Partnership

Health & Care Board Business Plan 2018/19
11th May 2018
We have a five-year plan to transform health and social care in Greater Manchester *Taking Charge*;

- We are now moving into the third year of that plan;

- Our 2018-19 Business Plan describes what we will do in our third year – building on what we have already achieved;
Our Aims – by 2021

• 1,300 fewer people dying from cancer
• 600 fewer people dying from cardiovascular disease
• 580 fewer people dying from respiratory disease
• 270 more babies being over 2,500g which makes a significant difference to their long term health
• More children reaching a good level of social and emotional development with 3,250 more children ready for the start of school at 5.
• Supporting people to stay well and live at home for as long as possible, with 2,750 fewer people suffering serious falls.
We’re spotting and treating dementia quicker – seven more people a day are diagnosed with dementia, and getting the help and support they need.

We’re fighting cancer with a mobile screening programme and ‘cancer champions’ are out and about in communities.

Our services are rapidly improving, for example our stroke centres are top-rated and we estimate that 200 lives have been saved because of the specialist care people have received in them.

We’re creating more services closer to people’s homes, and making it easier to see medical professionals at convenient times – more people are satisfied with their GP practices and extended opening times.
Devolution difference

• Giving children a better start – we’re spending an extra £1.5m on oral health to improve children’s teeth, and getting more children ‘school ready’

• Mental health is being put on a equal footing with physical health:
  – We’re spending £74m on child and adolescent mental health and bringing more mentors into schools and training teachers on mental health
  – We’re spending a further £50m on adult mental health services
  – More people are now receiving ‘talking therapies’ and are on the road to recovery within 6 weeks of referral

• Lifestyles are being improved – for example we’re helping 115,000 smokers quit over the next three years – one in two of them would have died younger from a smoking-related condition.
Our Plan for 2018/19

- Roll out of Social Prescribing
- School flu vaccination expanded to include Year 5
- Ensure all people experiencing homelessness can register with a GP
- Specialist Children & Adolescent Eating Disorder service
- Dementia-Friendly Transport System
- Daily Mile in all Schools
- All schools to have senior Mental Health Lead
- Improving Care Home Quality
- Expand GP Access at Evenings and Weekends
- Urgent Treatment Centres in all Localities
- Resilience Hub Supporting Public & Professionals
- New Learning Disability Strategy
Our 5 Priorities in 2018/19

- New Models of Care – Local Care Organisations
- Join up Commissioning local and GM level
- Improving Urgent and Emergency Care
- Closer working between hospitals
- Innovation – Health Innovation Manchester
Next Steps

• We will work with all 33 health and social care organisations in Greater Manchester to make sure these changes happen;

• We will continue to work closely with the Mayor this year on how all of the public service in Greater Manchester can contribute to health and well-being;

• We will develop our relationship with the voluntary and community sector further;

• The main challenges will remain as finance and workforce shortages in key areas.