Greater Manchester Integrated Care Partnership

Joint Forward Plan – Draft

2023-2028

Table of Contents

CONTENTS

1 Introduction 3

2 Context 4

2.1 The GM Context 4

2.2 The composition of our Partnership 4

2.3 What the Data is Telling Us 6

2.4 What residents are telling us 7

3 Our Strategy 8

3.1 Overview 8

3.2 Our vision and outcomes 8

3.3 The Greater Manchester Model for Health and Wellbeing 9

4 What we will do - our missions 10

4.1 Our missions 10

4.2 Our ways of working 11

5 Strengthening our communities 13

5.1 Area of Focus: Scale up and accelerate delivery of person-centred neighbourhood model 14

5.2 Area of Focus: Develop collaborative and integrated working 21

5.3 Area of Focus: Develop a sustainable environment for all 28

6 Helping people stay well and detecting illness earlier 30

6.1 Area of Focus: Tackling health inequalities 32

6.2 Area of Focus: Supporting People to Live Healthier Lives 41

6.3 Area of Focus: Upscaling Secondary Prevention 49

6.4 Area of Focus: Living Well with long-term conditions 57

7 Helping people get into, and stay in, good work 67

7.1 Area of Focus: Enhance scale of work and health programmes 67

7.2 Area of Focus: Develop good work 69

7.3 Area of Focus: Increase the contribution of the NHS to the economy 70

8 Recovering core NHS and care services 72

8.1 Area of Focus: Improving urgent and emergency care and flow 72

8.2 Area of Focus: Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard 76
8.3 Area of Focus: Improving service provision and access 83
8.4 Area of Focus: Improving quality through reducing unwarranted variation in service provision 87
8.5 Area of Focus: Using Digital and Innovation to Drive Transformation 90

9 Supporting our workforce and our carers 94
9.1 Area of Focus: Workforce integration 95
9.2 Area of Focus: Good Employment 97
9.3 Area of Focus: Workforce Wellbeing 99
9.4 Area of Focus: Addressing Inequalities 99
9.5 Area of Focus: Growing and Developing 101
9.6 Area of Focus: Supporting Carers 103

10 Achieving financial sustainability 104
10.1 Area of Focus: Finance and Performance Recovery Programme 104
10.2 Area of Focus: Securing Long-Term Financial Sustainability 106

11 How We Will Deliver 107
11.1 Performance Framework 107
11.2 Assurance and Governance Arrangements 108
11.3 Commissioning 110
11.4 Locality plans 110
11.5 Implementing this Plan – Next Steps 112

Appendix 1 113
How this plan addresses the statutory requirements for a JFP 113

Appendix 2 116
Our locality plans 116

1 Introduction

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

There is a requirement for all ICSs to develop a strategy. NHS organisations and local authorities must then have regard to this strategy when making decisions about the use of health and care resources. The five-year Strategy for the GM Integrated Care Partnership (ICP) was approved in March 2023 and can be found here.

National guidance states that each Integrated Care Board (ICB) must publish a five-year Joint Forward Plan setting out how they propose to exercise their functions. This should include the delivery of universal NHS commitments address ICSs' four core purposes and meet legal requirements.

JFP Principles

Principle 1: Fully aligned with the wider system partnership's ambitions

Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments

Principle 3: Delivery focused, including specific objectives

This plan describes how GM will achieve the outcomes described in the ICP strategy. Achieving these outcomes involves *not only* integrated health and care services, *but also* action on the things that determine good lives. The strategy and plan describe a *complex system* which includes, but is not limited to, the activities under the direct influence (and resourcing) of NHS GM i.e., the 'health system'. Our ICP strategy describes our GM model for health and wellbeing which is a 'social model', including the wider determinants of health, and builds on the strong partnerships already in place with wider public services, the VCSE and our people and communities.

The Strategy was developed through extensive engagement with communities, partner agencies, practitioners and staff, across all ten localities. Its development was iterative, developing and adapting to the feedback received and ensuring it is reflective of the needs and expectations of our communities. This Joint Forward Plan is built from the results of that engagement.

2 Context

2.1 The GM Context

Greater Manchester is home to more than 2.8 million people with an economy bigger than that of Wales or Northern Ireland. Our population in the 2021 Census was estimated to be 2,867,800. This is an increase of 185,272 on the 2011 Census and represents a growth of 6.9% in ten years, higher than the growth across England and Wales (6.3%) over the same period.

There are ten councils in Greater Manchester: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. All are unitary authorities, eight are metropolitan borough councils and two, Salford and Manchester are city councils.

The Greater Manchester Combined Authority (GMCA) is made up of the ten Greater Manchester councils and the Mayor, who work with other local services, businesses, communities and other partners to improve the city-region as described in the Greater Manchester Strategy (GMS)[1].

2.2 The composition of our Partnership

The **Greater Manchester Integrated Care Partnership** (this is the name of our integrated care system) connects NHS Greater Manchester Integrated Care, the Greater Manchester NHS Trusts and NHS providers across the whole of primary care with the GMCA, councils and partners across the VCSE, Healthwatch and the trades unions.

Greater Manchester Integrated Care Partnership Board is a statutory joint committee made up of NHS Greater Manchester Integrated Care and councils within Greater Manchester. It brings together a broad set of system partners to support partnership working and it is the responsibility of this Board to develop this Integrated Care Strategy - a plan to address the wider health, and care needs of the population.

NHS Greater Manchester Integrated Care, or NHS Greater Manchester (our integrated care board) is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in

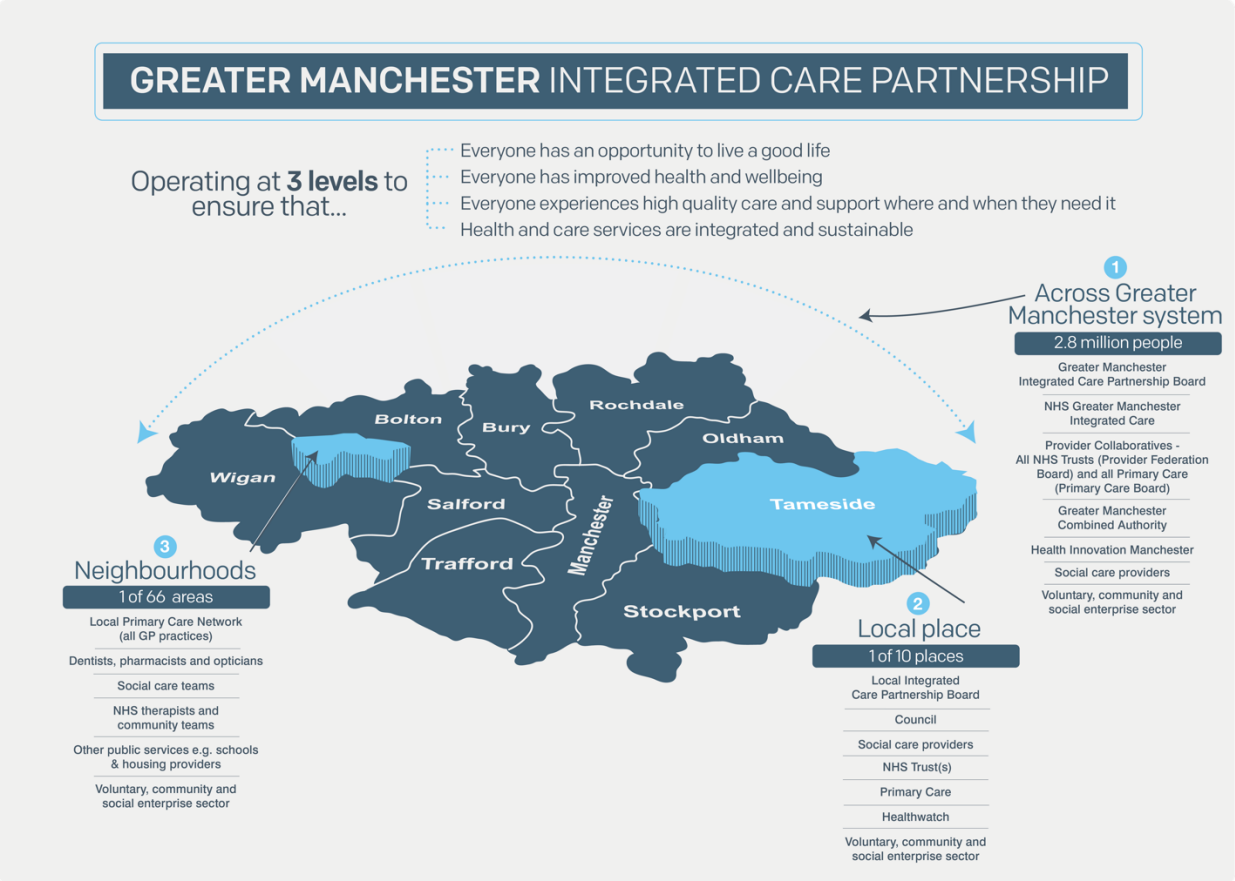
[1] https://aboutgreatermanchester.com/

a geographical area. It supports ten place-based integrated care partnerships in Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities.

Greater Manchester Integrated Care Partnership is one of 42 integrated care systems across England. It is one of the largest and one of only two which covers the same geographical area as a Mayoral Combined Authority.

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

Figure 1



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

- The Greater Manchester Provider Federation Board (PFB): a membership organisation made up of the eleven NHS trusts and foundation trusts who provide NHS funded services across Greater Manchester and East Cheshire. It includes the NHS providers of 111, 999, patient transport services (PTS), community mental health and physical health services and hospital mental health and physical health services.
- The Greater Manchester Primary Care Board (PCB) has been supporting collaboration and integration since 2015 and will continue to support the delivery of outcomes at all levels of, and across, the system, through its various programmes and its work with all 67 Primary Care Networks[2] (PCNs) in Greater Manchester.
- Greater Manchester Directors of Adults' and Children's Social Care collaborating to support transformation of social care at scale. For adult social care this also includes joint working with the Greater Manchester Independent Care Sector Network.
- Voluntary, Community and Social Enterprise (VCSE) sector providers are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE Sector represented by the Greater Manchester VCSE Leadership Group, based on a relationship of mutual trust, working together, and sharing responsibility, and providing a framework for collaboration. The VCSE sector has also established an Alternative Provider Federation as a partnership of social enterprise and charitable organisations operating at scale across Greater Manchester. It provides an infrastructure for alternative providers to engage with NHS Greater Manchester on a Greater Manchester footprint.

2.3 What the Data is Telling Us

The Greater Manchester Integrated Care Partnership Strategy gives a comprehensive picture of the key data about our system. This includes:

- Demographic information
- Information on inequalities
- Demand on health and care services
- The financial picture
- Workforce pressures.

[2]Primary Care Networks involve GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices

.

We have also drawn on our locality plans and local Health and Wellbeing Strategies which together identify the needs of our population and the plans in each locality to address these, aligned with our strategy and this plan (see section 11.4)

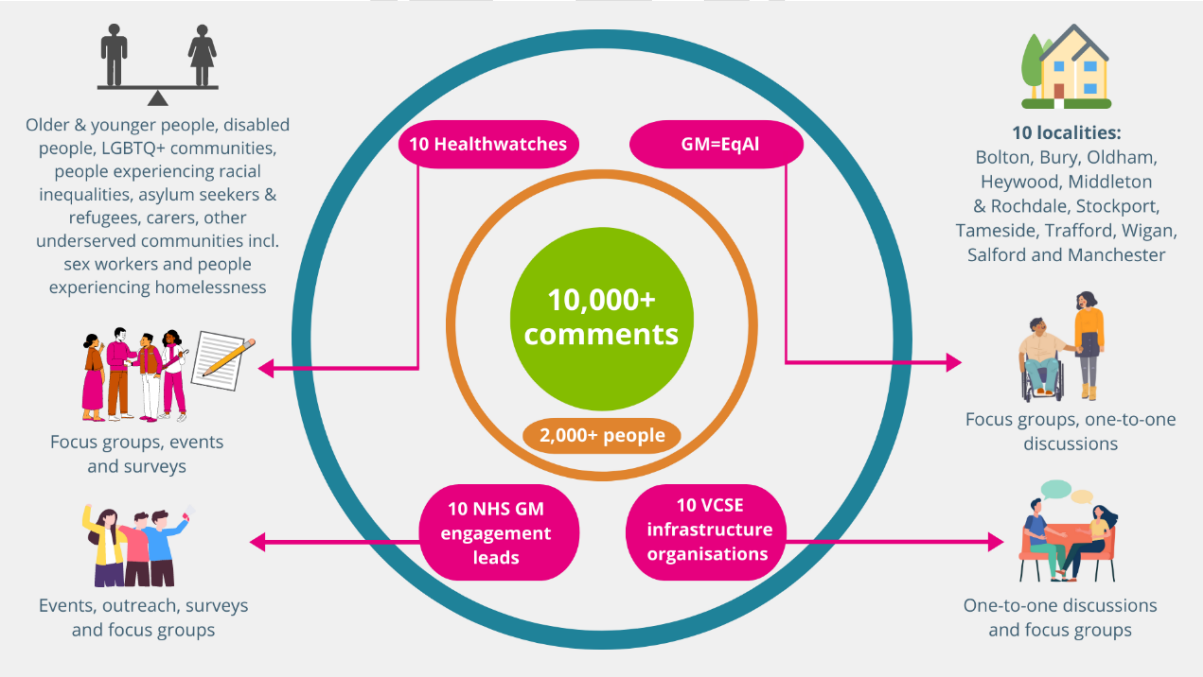
2.4 What residents are telling us

We carried out a major engagement exercise 'The Big Conversation' to inform the development of our ICP Strategy and this plan.

The Big Conversation had two phases. Phase one ran between March and May 2022 with the aim of consulting on the proposed vision and aims that had been suggested by the ICP leaders following a stakeholder engagement event they took part in. 1,332 people gave their views and consensus was most respondents agreed with the proposed aims and visions.

Phase two ran in October 2022 with the aim of ensuring the GM ICP had the insight it needed to be able to understand what matters most to communities across all ten localities - to help shape the priorities and actions for the strategy. A summary of the 'Big Conversation' is set out in Figure 2 .

Figure 2



3 Our Strategy

3.1 Overview

The Integrated Care Partnership Strategy outlined the most significant challenges facing the Greater Manchester health and care system:

- How to continue the improvements already made in GM's approach to integrated care and population health improvement
- The wider influences on health and good lives
- Economic inclusion
- Access to services, operational pressures and increasing demand
- Health outcomes and heath inequalities
- The challenge of financial sustainability

The Strategy is clear that we must both meet these immediate pressures and continue to address their underlying causes through improving the health of our population. The missions in the strategy were developed to ensure a recognition of this range of challenges.

This Joint Forward Plan will describe how we will realise these aims over the next five years – with a greater emphasis on years one to three. We will revise and update this plan each year.

3.2 Our vision and outcomes

As partners in Greater Manchester, we share the Greater Manchester Strategy (GMS) vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region.

For the Greater Manchester Integrated Care Partnership, this means we want to see a Greater Manchester where:

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

3.3 The Greater Manchester Model for Health and Wellbeing

Underpinning all our work is the Greater Manchester Model for Health and Wellbeing. This shows how we work with communities to prevent poor health and ensure support is available before crises occur to reduce demands on formal NHS and social care services. It is a social model for health and wellbeing (rather than predominantly a medical one), with people and communities at its heart.

Figure 3

Our challenge is that this Model is not universally realised across Greater Manchester. Our aim through the strategy and this supporting plan, is to confirm the actions and approaches necessary to achieve this and maximise the effectiveness of how we work together to improve our outcomes.

4 What we will do - our missions

4.1 Our missions

Our strategy sets out the following missions in response to the current challenges, within the context of our vision and outcomes

- **Strengthening our communities**

  We will help people, families and communities feel more confident in managing their own health and wellbeing. We will act on this with a range of programmes, including working across Greater Manchester to support communities through social prescribing, closer working with the VCSE and co-ordinated approaches for those experiencing multiple disadvantages.

- **Helping people stay well and detecting illness earlier**

  We will collaborate to reduce smoking rates, increase physical activity, tackle obesity and alcohol dependency. We also want to do more to identify and treat high blood pressure, high cholesterol, diabetes, and other conditions which are risk factors for poor health. Working in partnership and with targeted interventions, we will embed a comprehensive approach to reducing health inequalities.

- **Helping people get into, and stay in, good work**

  One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by expanding our Work and Health programmes, working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter[3] and developing social value through a network of anchor institutions[4].

- **Recovering core NHS and care services**

  We will work to improve ambulance response and A&E waiting times, reduce elective long waits and cancer backlogs, improve access to primary care services and core mental health services, improve quality and reduce unwarranted variation for adults and children alike.

[3] https://www.gmgoodemploymentcharter.co.uk/
[4] https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

- **Supporting our workforce and our carers**

  We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people choosing health and care as a career and feeling supported to develop and stay in the sector. We will consistently identify and support Greater Manchester's unwaged carers.

- **Achieving financial sustainability**

  Financial sustainability - 'living within our means' - requires an initial focus on financial recovery of the health system, to achieve a balanced position. We will identify the main reasons for financial challenges in the Greater Manchester health system, and implement a system wide programme of cost improvement, productivity, demand reduction and service transformation.

For each of the missions, we have set out the key areas of focus and the actions to deliver our vision and outcomes. These are described in greater detail in the next six chapters of this document. We have set out the accountability for the delivery of the missions. We describe this as:

- **Delivery Leadership** – the board/organisation accountable for driving change and improvement in the relevant part of the system. This recognises that the key responsibility for bringing together and driving delivery will sit with Locality Boards, providers and provider collaboratives
- **System Leadership** – This recognises the board/group accountable for creating the system-wide conditions, frameworks, and standards to enable delivery

4.2 Our ways of working

The way that we work together will play an important part in achieving our vision through our missions. To transform public services and integrate care we need to change the way we work with communities and fundamentally challenge our approaches to delivery. These ways of working run through all of our missions, as shown in this plan. Our outcomes cannot be achieved without us all working together.

Behaviours	We will …
Understand and tackle inequalities	✓ Take action at individual, team, organisation, and system levels, informed by data, to understand and tackle inequalities.

Share risk and resources	✓ Set out our expectations of each other, share data effectively, support joint working with shared resource and create a culture of collaboration. This must happen at every level and in every place.
Involve communities and share power	✓ Consistently take a strengths-based approach with co-design, co-production and lived experience as fundamental ingredients.
Spread, adopt, adapt	✓ Share best practice effectively, test and learn, and celebrate success, with supportive governance and resources. Adapt and implement best practice locally, in organisations and across systems.
Be open, invite challenge, take action	✓ Be open, honest, consistent and respectful in working with each other. Work on the boundaries and differences that we have in a constructive way, to support effective change.
Names not numbers	✓ Ensure we all listen to people, putting them at the centre, and personalising their care.

5 Strengthening our communities

We will help people, families and communities feel more confident in managing their own health. Our approach recognises that the organisation of the delivery of health and care services is only one of a range of contributors to the health and well-being of residents. The quality of housing, the availability of quality work, the extent to which residents are connected to their communities, and whether people feel safe also make a significant contribution.

Being deprived of these helps create and exacerbate the persistent health inequalities we see in many communities in Greater Manchester. Tackling these issues will play a key part in securing long term stability for our system – principally through keeping people well and independent in their homes and communities and reducing demand on expensive, acute services.

Our approach to this mission is underpinned by the Greater Manchester People and Communities Framework which defines our strategic approach to public engagement and involvement including key principles and commitments that support our ways of working.

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

5.1 Area of Focus: Scale up and accelerate delivery of person-centred neighbourhood model

Neighbourhood and place-based working provides the closest connection to the broadest range of factors affecting people's health and wellbeing. Most people will receive most of their day-to-day care for most of their lives in the neighbourhood or locality. The only place where local authority spend and planning, not only on care services, but also on the wider determinants of health comes together with NHS spend is at the locality level.

We have a locality model in place in Greater Manchester, comprising:

- A Locality Board to ensure the priorities are decided together in the locality and support the effective joint stewardship of public resources benefiting health
- A Place Based Integrated Care Lead with dual accountability to the local authority and to NHS GM
- A place-based provider collaborative or alliance providing comprehensive integrated care at neighbourhood and place levels
- A means of ensuring clinical and care professional input and leadership to place based working

Our localities are made up of neighbourhoods of 30,000 to 50,000 population – with Primary Care Networks at their heart. The neighbourhood model ensures that support is available before crises occur, to reduce demands on formal NHS and social care services. This is pivotal to our social model for health.

5.1.1 Action: Continue to develop Live Well and Social Prescribing

Only by working alongside people and communities to create healthier happier lives will we see sustainable improvements in the health of our population. Live Well is our programme to support this across Greater Manchester.

Every day, people help each other, and take part in activities that keep them moving, creative, and sociable – improving their physical health and mental wellbeing. Many people, particularly those experiencing inequalities, do not have the same chances to access these opportunities - this is where Social Prescribing can help.

Social Prescribing is a way for local organisations, services and professionals to refer people to a worker who acts as a 'link' between the health and care system or wider public services and the community. There are now over 220 Social Prescribing Link Workers in Greater Manchester working alongside GPs and other community

organisations. Over 30,000 people a year directly access this. Through Live Well, we are committed to expanding this offer, and to ensuring it makes a targeted difference to people who experience inequalities.

We will work with, and build, on the community-led work in all of our localities to expand the 'Live Well' offer so that all residents, particularly those experiencing inequalities, are offered the chance to maintain and improve their health, wellbeing, resilience and social connections through access to information, activities, volunteering and support. This will include:

- Expanding the offer for key groups of people, including children and young people, and people with cancer.
- Making it easier for people to get social prescribing support, through improving connections and pathways between different parts of the system. In our developing Primary Care Blueprint, we set out our intention to improve interdisciplinary referral pathways for Primary Care and enable wider Primary Care teams to refer directly into social prescribing initiatives, behaviour change services, and wider welfare support.
- Help grow more sustainable opportunities in the community, such as for green social prescribing, and creative health
- For those who need more support to live well, we will work to develop person-centred care by equipping people with skills and confidence through development of a framework, tools, and training, as well as improving expansion and quality of personal health budgets. This supports our delivery of the comprehensive model of personalised care.
- Implementing the Greater Manchester Creative Health Strategy, helping spread the use of creative health approaches as tools to address health inequalities by growing and sharing the evidence base, supporting skills and knowledge development of the creative health workforce and helping health and care professionals to understand and access creative health approaches for the people they support.

Measuring our delivery

- Increase in social prescribing activity
- Increase in Social Prescribing Link Workers and other community connectors
- Proportionate investment in social prescribing and allied activity compared to deprivation index
  Improvements in wellbeing as measured through the ONS survey
- Community wellbeing measured through GM resident survey

Accountability

- Locality Boards
- Live Well Steering Group
- Primary Care System Board
- Population Health Board

5.1.2 Action: Coordinate our response to poverty

Poverty is the single biggest determinant of health outcomes and health inequalities. Building upon a 'deep dive' into poverty and health that was undertaken by the GM Population Health Board, the GM Integrated Care Partnership approved a range of actions aimed at addressing this issue.

A key feature of this response has been the development of a strategic partnership with Greater Manchester Poverty Action and tapping into their nationally recognised expertise to support NHS GM to establish and approach which can serve as an exemplar to other ICBs.

Our focus is on completing the ongoing strategic review of the role of NHS GM in tackling poverty, including:

- Reviewing the current NHS GM response to poverty against existing examples of good practice and the recommendations made by the Kings Fund in their publication – 'The NHS's Role in Tackling Poverty'
- Assessing the feasibility of NHS GM developing an anti-poverty strategy and adopting and implementing the socio-economic duty, a tool by which public bodies can ensure decisions they consider the needs of people experiencing poverty.
- Complete the ongoing test and learn activity around health and care workforce training and development around Poverty Awareness and Poverty Literacy and use the findings from this to implement a scaled-up programme of training and development across the GM health and care workforce.
- Complete the ongoing proof of concept activity exploring the application of 'poverty proofing' methodology in health and care (with an initial focus on pregnant women during pregnancy and 12 weeks post-partum) in the 20% most deprived areas of GM) and use the learning from this to develop a GM approach

Measuring our Delivery

In the long term, the impact of our activity will be measured by:

- A reduction in the gap in life expectancy and healthy life expectancy between the most deprived and least deprived areas of Greater Manchester.

In the shorter term, the impact of our activity will be measured by:

- 500 NHS GM or provider staff completing poverty awareness training by the end of 2023/24 and at least 50% of all NHS GM staff completing poverty awareness training by the end of 2028/29.
- % of GM residents worried about the impact of cost of living on their lives (GM Residents Survey)
- Excess deaths associated with fuel poverty / cold homes

Accountability

- Locality Boards
- Population Health Board
- Reform Board

5.1.3 Action: Expand Community-Based Mental Health Provision

As part of our neighbourhood model, we will expand provision of multi-disciplinary, strengths-based teams for mental health connecting to community-based care. We will aim to build resilience in people and communities and intervene earlier before people reach a point of crisis.

We need to have a shared language around how to address the mental health challenges we face as a city-region. Our approach is based on addressing historic under-investment in mental health, learning disability and autism (see section 8.3.3)

Our Mental Health and Well Being Strategy sets out our aim to provide clear, accessible care pathways for people, integrating mental wellbeing, social care and physical health. We will further integrate mental health offers into Early Help, family support, housing and schools.

In GM and in line with the Community Mental Health Transformation Framework, we are working across all ten localities to develop new and integrated models of primary and community mental health care which will support adults and older adults with severe mental illnesses and reach over 20,000 more people. A key area of work is scaling up the Living Well model across all GM localities which had been successfully piloted in Salford and Tameside between 2018-2021.

Over the next five years, we will:

- Continue to develop, embed and enhance Living Well models and integrated specialist community pathways in each of the ten localities
- Engage in meaningful co-production and co-design with people with lived experience and wider stakeholders
- Improve the quality of person-centred care by developing our multi-agency teams
- Working with a shared practice model that is strengths based, trauma-informed and solutions focused
- Providing increased access to evidence based psychological therapies, social support and community connections

Measuring our Delivery

- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Number of women accessing specialist community perinatal mental health services
- NHS Talking Therapies access: number of adults entering NHS funded treatment
- Access and waiting times for Children and Young People (CYP)
- Improving access (CORE 20 PLUS 5 groups) for CYP with long-term conditions to MH services including Child and Adolescent Mental Health Services (CAMHS), Eating Disorders and talking therapies.
- Better support offer for CYP with mental illness/ emotional/behavioural needs presenting in acute settings – including growing the number of mental health champions in acute settings

Accountability

- Locality Boards
- GM Mental Health System Board

5.1.4 Action: Living Well at Home

Adult Social care in Greater Manchester is rooted in the power of co-production with people, carers and families to enable better outcomes for people. The primary focus is on supporting people to live well at home, as independently as possible, making sure that the care and support people experience is built on their own strengths and those within the community, and is of the best quality.

The key elements of the programme are:

Workforce

- RECRUIT-implementation of the GM Care academy, delivery of the GM Social Care Workforce strategy, the GM International Recruitment Programme implementation, and the recruitment strategy for social workers and nurses
- RETAIN - expand blended roles to enhanced care workers, expand the person-centred care and support Trailblazer
- GROW – continual professional development training for nurses and Occupational Therapists (OTs), succession planning, leadership development and mentoring

Market Development and Sustainability

- A diverse and sustainable market with great quality and supports better outcomes and better lives
- Continuous improvement of the quality of social work
- Better commissioning models that support better outcomes and attract the best providers to the market

Digital

- Explore more collaboration, focussing where we can pool funding to deliver shared outcomes
- Improve number of providers using digital social care records as set out in our digital strategy (see section 8.5.1)
- Better utilisation of technology enabled care solutions

Safeguarding

- Working in partnership across all aspects of safeguarding to enable the best outcomes for people, especially in relation to complexity, prevention and sharing learning

Learning Disability

- Development of 3-year LeDeR (Learning Disabilities Mortality Review) strategy
- Develop apprenticeships programmes
- Continue roll out of the Keyworker workstream
- Roll out PACT and Riding the Rapids training
- Continue to implement the GM justice plan
- Continue to the roll out of the CYP Keyworker workstream
- Review advocacy – GM exemplar model

Measuring Delivery

- Workforce – increase in recruitment and retention of individuals successfully employed through the developing GM care academy
- Market shaping – more people living well at home (reduction in long term residential care)
- Quality – either a maintenance of existing or improvement of Care Quality Commission (CQC) ratings for providers, LAs and GM ICS (new single assurance framework)

Accountability

- Locality Boards
- GM Directors of Adult Social Care

5.1.5 Action: Take an inclusive approach to digital transformation to ensure equity for all

GM has significantly advanced the use of digital approaches across health and care, but there are still many people who cannot easily access or benefit from digitally enabled services and tools. In an increasingly digital world, people who are digitally excluded are at risk of worse access to services and poorer health outcomes, deepening inequalities.

People who are most likely to experience digital exclusion are:

- People living in deprived areas
- Inclusion health groups including people who are homeless, rough sleepers, asylum seekers and the travelling community.
- Protected groups according to age, disability and ethnicity.

A lack of digital access and skills can have a huge negative impact on a person's life. As many as 1.2m residents in Greater Manchester could be excluded in some way to access the benefits digital brings.

The GM Digital Inclusion Action Network (DIAN) has been established by the Greater Manchester Combined Authority to ensure digital inclusion is built into the transformation of public services, place-making and economic growth. It is focused primarily on getting all under-25s, over-75s and people with disabilities online.

NHS GM will continue to work in partnership with the DIAN and Health Innovation Manchester to build inclusion into the design and development of digitally enabled services and pathways, develop targeted approaches for key communities and boosting digital capabilities and awareness of inclusion barriers.

Measuring our Delivery

- Develop and deliver a series of pan-GM projects to address digital exclusion in key service areas including virtual wards, digital GP practices and the use of remote monitoring technologies
- Monitor uptake and access to digitally enabled services according to key demographics, including over-75s, under-25s and people with disabilities
- Develop and deliver a programme to improve health and care staff awareness of digital inclusion and build skills needed to spot and support people who may be impacted – number of staff participated, % increase in awareness and competence

Accountability

- GM Digital Inclusion Action Network
- GM Health and Care Digital Transformation Board

5.2 Area of Focus: Develop collaborative and integrated working

5.2.1 Action: Embed the VCSE Accord

Voluntary, Community and Social Enterprise (VCSE) sector providers are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE sector.

The VCSE Accord delivery plan for 2023 to 2026 sets out the future of the Accord over the next three years. The central themes of delivery are:

- Scaling up the VCSE role in addressing inequality, population health delivery models, and in creating a more inclusive economy
- Supporting the effective Commissioning and Investment of GM VCSE action
- Helping to develop a resilient 'VCSE Ecosystem' in the face of current challenges
- Ensuring powerful VCSE representation and voice, and
- Finding ways to support Greater Manchester's 75,000-strong VCSE workforce, 500,000 volunteers and 300,000 informal carers

Measuring our Delivery

- Three VCSE data targets met: contributing to system, access to collective data and VCSE intelligence built into decision-making
- Propositions for VCSE role in addressing wider determinants of health built into GM programmes and asks and VCSE at the heart of social and economic action in all ten localities and at GM-level
- Co-design and Co-production via VCSE sector defined and resourced
- VCSE accessing funding and investment across GM and across VCSE sector (equalities, providers, grassroots)
- All employees in the VCSE sector receive at least the Real Living Wage
- VCSE workforce at all levels (including leadership and management) is reflective of the diversity of the communities of Greater Manchester

Accountability

- VCSE Leadership group

5.2.2 Action: Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage

Through the Devolution Trailblazer Deal in early 2023, the Government confirmed its support for GM's ambition to develop a city region-wide approach to supporting people and families experiencing multiple – social, economic and health –disadvantages. To support this work, the Government has agreed to review the secondary legislation that underpins pooled and aligned budgets (section 75 of the National Health Service Act 2006), with a view to amending the scope and simplifying the regulations where needed.

Demand on public services, including health and care, is often driven by cohorts of residents who are in contact with multiple agencies – for instance, people with drug and alcohol problems; people who are homeless; people with a range of complex long-term conditions who frequently present to acute services through A&E and other routes.

They are among the most vulnerable in our communities, and often experience entrenched disadvantage, long term unemployment, trauma and health inequalities. The most at-risk adults and children and young people in this situation are estimated to cost the public purse five times more than the average citizen per year.

These plans will support our aim to move from a system characterised by responses to cycles of chronic illness and exacerbation to one focused on a model that keeps people well at home and in their communities. They build on learning and effective approaches from the Supporting Families (Troubled Families) programme, Rough Sleeper Initiative, Housing First, Changing Futures and Working Well.

Measuring our Delivery

For the identified cohort:

- Reduction in A&E attendances
- Reduction in Non-Elective Admissions
- Reduction in Mental Health Crisis Presentations

Accountability

- Locality Boards
- Reform Board

5.2.3 Action: Embed the GM Tripartite Housing Agreement

The home is a driver of health inequalities. Inadequate housing causes or contributes to many preventable diseases and injuries. Direct effects of an inadequate home on a person's health can include heart attacks, stroke, respiratory disease, flu, falls and injuries, hypothermia and poor mental health. Poor housing is estimated to cost the NHS at least £1.4 billion per year in first year treatment costs alone.

The GM Tripartite Agreement 'Better Homes, Better Neighbourhoods, Better Health', is a collaboration between Greater Manchester Housing Providers, Greater Manchester Combined Authority and NHS Greater Manchester Integrated Care to deliver positive change across the city region. The Agreement sets out a collective vision to work alongside local people, neighbourhoods and stakeholder organisations to create lasting solutions to complex issues and challenges centred on housing and health.

Measuring our Delivery

- Increase supply of supported and specialist homes to support delivery of health and care system priorities
- Integrating housing pathways and models of joint working into place-based delivery via PCNs

- Delivery of the action plan on Damp, Mould and Condensation
- Delivery of the GM Good Landlord Charter to drive up standards in rented homes
- Activity to make our homes warmer and reduce fuel poverty, including domestic retrofit measures, delivery of Truly Affordable Net Zero homes, NHS GM Warm Homes pilots
- Action against the GM Healthy Homes framework to deliver consistent Home Improvement Agency services and policies
- Private rented sector interventions, including Good Landlord Scheme
- Responding to homelessness and rough sleeping - including embedding Inclusion Health principles in commissioning and delivery and ongoing health system investment

Accountability

- Locality Boards
- Population Health Board
- Tripartite Agreement Core Group

5.2.4 Action: Giving every child the best start in life

Greater Manchester is passionate about ensuring that all our children and young people get the best start in life and are cared for, nurtured and supported to grow up well and achieve their ambitions in life.

The specific health case for investment in children is extremely strong. The life course costs of late intervention have been estimated at £17bn across England and Wales (including nearly £4bn borne by the NHS).

GM partners (health education, voluntary, criminal justice sectors, GMCA and local authorities) have adopted a system-wide approach, delivered through a combined Children and Young People Plan. Further information on our work with children and young people can be found in the mission for helping people stay well and detecting illness earlier (section 6).

In the next five years, we will:

- Address inequalities within maternity services through delivery of the Greater Manchester and Eastern Cheshire Maternity Equity and Equality Plan 2022-2027 (see section 6.1.1).

- Fully embed the Smoke Free Pregnancy (SFP) programme into the mainstream maternity journey to achieve the high-level performance seen pre-pandemic (see section 6.2.1)
- Standardise pathways to prevent alcohol harm in pregnancy across all the GM maternity providers
- Continue rolling out the 'As Soon as You're Pregnant' campaign to encourage early booking and to increase timely uptake of screening tests, including those for sickle cell and thalassaemia
- During 2023/24, establish a GM advisory group to lead on the co-design of a framework for food and healthy weight that outlines priorities and sustainable investment for city-region action to build and scale good practice in maternity and early years (year 1) and for school aged children (years 2-5) through a whole family, whole-system approach
- Co–design with partners a plan to consolidate and roll out further a comprehensive approach to oral health improvement incorporating dental services and community based approaches
- Ensure effective health contribution to the implementation of the GM Children and Young People Plan, including working towards a shared vision of family help where families can get the help they need from the right places and people in their communities including health professionals.

Measuring our Delivery

- SATOD (Smoking at Time of Delivery) rate to be reduced to 4% or less by 2026
- School readiness: Increase in the percentage of children achieving a good level of development at the end of reception
- Reduction in the infant mortality rate
- 83% of children to reach the expected level of development by 2024
- Improved access to speech and language therapy services
- Increase the uptake of funded childcare and early education places for 2-year-olds by April 2024
- Decrease in proportion of children 0-5 years old with dental decay
- Increase in the prevalence of breast feeding

Accountability

- GM Children and Young People's Board
- Population Health Board
- Locality Boards
- GM Maternity Board

5.2.5 Action: Ageing Well

The pursuit of an age-friendly Greater Manchester is in line with the UN Decade of Ageing and the WHO (World Health Organisation) Age-friendly cities and communities programme. Our approach focuses on improving financial security, tackling inequalities and creating places for people to age well through healthy, active and connected lives. We do this by championing the voice of older people, challenging ageism, growing the GM age friendly movement and delivering changes across our city region to improve later life.

A unique cross-sector Ageing Hub partnership brings together the Greater Manchester system leadership at the Ageing Hub Executive Group and a range of task groups, to collectively deliver on the strategy, supported by the Ageing Hub team at GMCA. The Ageing Hub works alongside the 10 districts of Greater Manchester to integrate age-friendly approaches at a neighbourhood, district and Greater Manchester level.

The Greater Manchester Ageing in Place Pathfinder is a £4 million investment (2022-25) by partners, led by GMCA, in eight neighbourhoods to create strong and supportive neighbourhoods to improve connection, health and wellbeing of residents over 50 years of age.

Measuring our Delivery

- Number of neighbourhoods with identifiable Ageing Well Action Plans

Accountability

- Greater Manchester Reform Board
- Ageing Hub Executive Group

5.2.6 Action: Increase identification and support for victims of violence in all health care settings

We are working collaboratively with partners to develop community-led, whole system approaches to violence reduction, to strengthen early intervention programmes and to embed trauma-responsive health and well-being pathways for victims of violence in all health care settings and for people in contact with the criminal justice system.

Health services can provide a safe space for disclosure of domestic or sexual violence and abuse – and we must tackle the variation in provision that can lead to unidentified and unmet need. We will:

- Increase identification and support for victims of gender-based violence in health care settings, including development of primary care and sexual health services pathways
- Implementation of Sexual Assault Referral Centre pilot to develop integrated pathways for victims of sexual assault who have complex mental health problems
- Develop community-led solutions to violence reduction through culture and sport
- Develop trauma-responsive approaches for victim support in health care settings, including delivery of the Violence Reduction Community Navigator pilots
- Developing tailored health and well-being pathways for women in contact with police, custody, court and probation services and on release from prison.
- Develop trauma responsive care in line with GM system plans to become an Adverse Childhood Experience (ACE) and Trauma Responsive system. In 2023-2024, Localities will lead on implementation of the GM ACE and Trauma framework through co-design of community development plans in targeted neighbourhoods to improve community resilience and create a social movement for change
- In 2024/25, learning from these pilots will inform proposals to scale and spread these models and to establish clear referral pathways in all health and care settings for victims of violence in response to legal duties (Serious Violence Duty and Domestic Abuse Act) and to fulfil the NHS commitments in the GM Gender Based Violence Strategy[5].

Measuring our delivery

- Referral from health and care settings into domestic and sexual violence advocacy services
- Referrals from urgent and primary care into the Violence Reduction Community navigator programme
- Number of trauma leads and champion roles across third and public sector organisations
- Number of trauma/ACE recognised trainers and professionals working in the health and care system
- Trauma/ACE embedded within communities of practice at neighbourhood, Locality and GM level

[5] Gender Based Violence Strategy - Greater Manchester Combined Authority (greatermanchester-ca.gov.uk)

Accountability

- Population Health Board
- Locality Boards
- GMCA Gender based Violence Board and Violence Reduction Board

5.3 Area of Focus: Develop a sustainable environment for all

5.3.1 Action: Delivering the NHS Green Plan

Climate change is the greatest global health threat facing the world in the 21st century, but it is also the greatest opportunity to redefine the social and environmental determinants of health (Lancet Commission, 2009).

In May 2022, we published our Green Plan 2022-2025, aligning priorities and carbon budgets with the national NHS Delivering a 'Net Zero' National Health Service report and the GMCA 5 Year Environment Plan. Two overarching goals are outlined:

- To achieve a net zero NHS GM Integrated Care Carbon Footprint by 2038 – this target is the science-based approach outlined in the GMCA 5-Year Environment Plan. We will seek assurance that providers are delivering against their own plans, whilst focusing on priorities that we can deliver most effectively by working together.
- To achieve a net zero NHS GM Integrated Care Carbon Footprint Plus by 2045 – this is a national NHS target to eliminate the carbon impact of the goods and services we buy. We will work closely with national and regional partners to achieve this

Over the next five years we will focus on delivering and scaling up activities outlined in the Green Plan, refreshing this as necessary to ensure it remains current, and maximising the opportunities from collaboration.

We will:

- Ensure all Trusts have robust travel plans in place and work closely with Local Authorities and TfGM (Transport for Greater Manchester) to improve access to sites by active travel and public transport,
- Consider carbon emissions from procurement
- Harness the carbon reduction opportunities presented by digital transformation
- Engage the system-wide workforce with the net zero agenda by developing comprehensive training, awareness and behaviour change programmes

- Embed net zero into commissioning processes and across more clinical services
- Work closely within the NHS GM Anchors Network to drive a more strategic and aligned focus across trusts and localities
- Ensure appropriate prescribing by supporting social and low carbon options, with support for patients to reduce medicines waste

Measuring our delivery

- Total carbon footprint
- Fleet composition and emissions by organisation
- Inhalers carbon footprint
- % Virtual appointments across both primary and secondary care
- Increase in active and sustainable travel by staff and patients (as demonstrated through % modal shift in survey responses)

Accountability

- Population Health Board
- GM Net Zero Delivery Board

6 Helping people stay well and detecting illness earlier

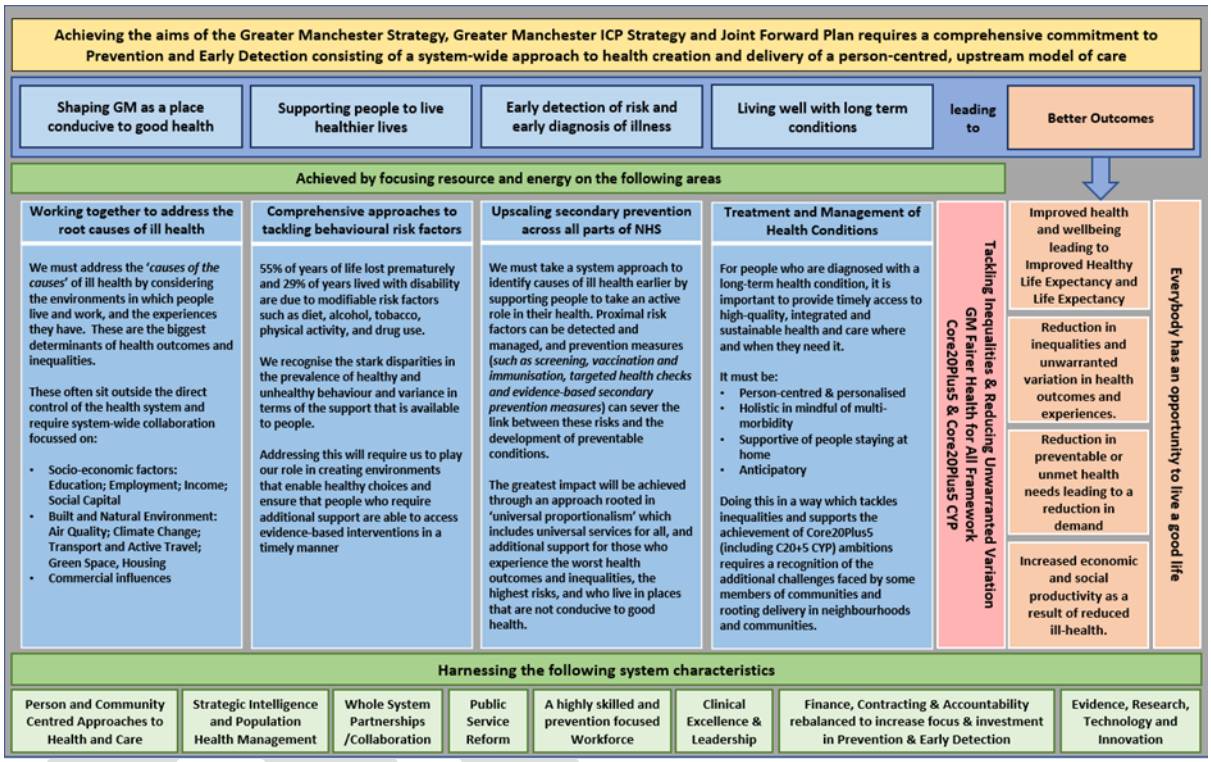
There is a strong rationale for the NHS to increase its focus on prevention and improving population health outcomes. For the past decade, improvements in life expectancy and healthy life expectancy have stalled, and inequalities in health have widened.

Life expectancy and healthy life expectancy for people born in GM is significantly lower than the England average. Importantly, much of this burden of poor health and early death (borne disproportionately by the most deprived and marginalised communities) can be attributed to conditions that are preventable through coordinated action across the health and care system.

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

The complexity and breadth of activity that is required to drive change through prevention and early detection is set out in our GM Framework for Prevention (Figure 3):

Figure 3



For the purposes of the framework, we have used the broader definition of secondary prevention, used by the UK chief medical officers, to include "evidence based, preventive measures to help stop or delay disease, taken during an interaction between an individual patient and a clinician" [6].

Our framework has four distinct areas of focus:

1. Tackling inequalities and reducing unwarranted variation through Core20Plus5 and the GM Fairer Health for All Framework
2. Supporting people to live healthier lives by implementing comprehensive approaches to tackling behavioural risk factors for illness.

[6] Restoring and extending secondary prevention | The BMJ

3. Upscaling secondary prevention across the NHS (including the early identification of risk and diagnosis of illness, and the effective management to prevent progression).
4. Supporting people to live well with long term conditions through the equitable, effective, and efficient management of diagnosed health conditions

We need to put in place more upstream models of care and integrated neighbourhood models that better address the needs of those at higher risk of illness, and those not currently in contact with services. This will require increased population health management capability.

Secondary prevention must be an integral part of all patient care pathways. All medical and allied professionals have an opportunity to 'make every contact count'. Prevention activities also need to be extended to population groups with historically low uptake, and those not in contact with NHS services, to ensure delivery within communities and neighbourhoods.

As set out in the GM Prevention Framework, the NHS also has an important role to play in working across the system with partners to address the root causes of ill health (relating to factors such as poverty, education, work, and housing), and to shape GM as a place that is conducive to good mental and physical health.

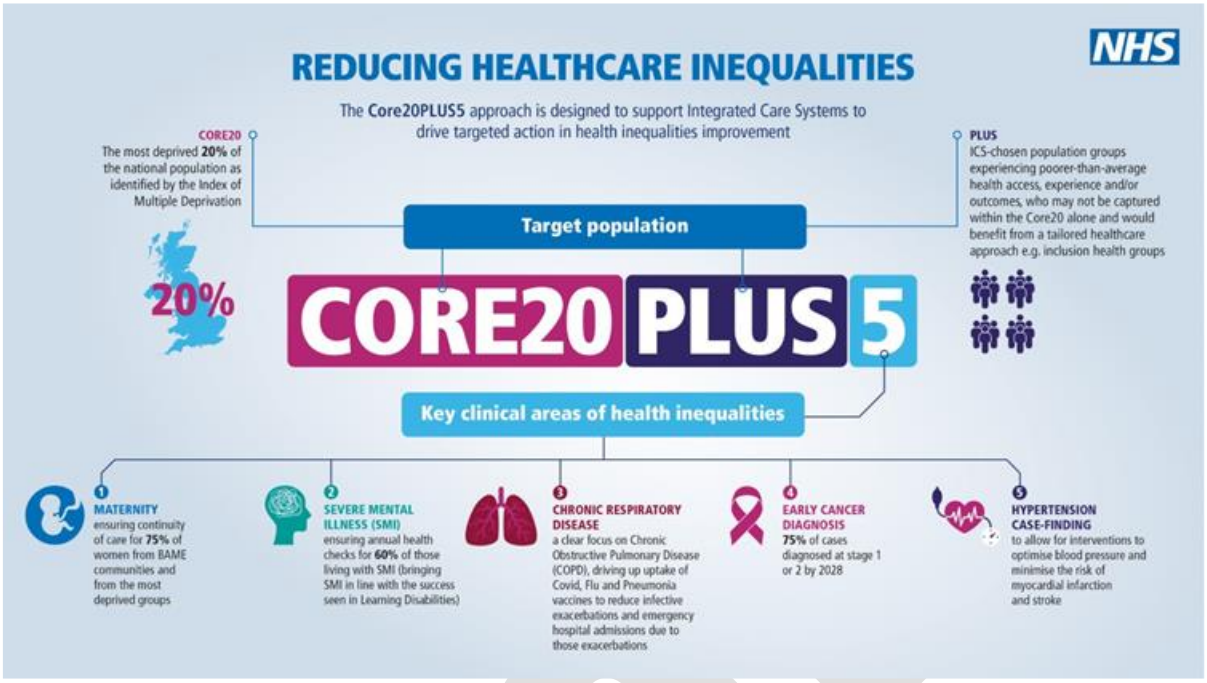
6.1 Area of Focus: Tackling health inequalities

6.1.1 Action: Delivery of CORE20PLUS5 (adults)

The CORE20+5 framework for adults (Figure 4) outlines the key clinical areas that should be targeted to reduce health inequalities.

Of the five clinical areas of health inequalities, severe mental illness annual health checks, chronic respiratory disease, early cancer diagnosis and hypertension case finding are covered in section 6.3

Figure 4



Maternity

We have developed a Maternity Equity and Equality Action Plan. The plan has been carefully co-designed and co-produced with the people we serve.

It is an ambitious and dynamic plan that contains 36 Interventions and 363 individual actions with particular focus on those areas that make the biggest impact:

- Preconception care
- Early access to antenatal services
- Enhanced Midwifery Continuity of Carer
- Personalised Care and Support Planning
- Black & Asian Maternity Equity Standards
- Universal & Targeted vitamin D supplementation
- Embedding of Saving Babies' Lives Care Bundle, including the Smokefree Pregnancy programme
- Addressing raised BMI
- Establishment of Family Hubs across GM

Our staff from ethnic minority background are representative of our local populations and will have the same opportunities and experience as others

In 2022 the GM Equity and Equality steering group was established which brings together clinical, VCSE, education colleagues to oversee and deliver the Maternity Equity and Equality Action Plan.

The group have already delivered on improvements identified in the plan including the development of Black and Asian Maternity Equity Standards, public facing information materials, working with Maternity Action to support pregnant women at work and the commencement of a student mentor scheme

Cancer

GM Cancer Alliance established a Cancer Health Inequalities Working group in 2021, and it leads on the health inequalities work programme for the cancer system in GM.

Examples of work that have taken place in or are underway include:

- A report commissioned by the Cancer Alliance and undertaken by GMCVO into the inequalities in cancer prevention, diagnosis and care
- A review of GM Cancer's User Involvement Programme assessing what a successful and effective programme looks like and how can it be more diverse and work for everyone

The strategy and implementation plan for 2023-24/5 was approved by the GM Cancer Board in May 2023.

Key priorities are:

- Make health inequalities everyone's business. For the cancer system to achieve its overall goals around early diagnosis, operational performance and personalised care and treatment, health inequalities must be addressed
- Better use of data, understanding health inequalities in the cancer system and the impact we are having
- Target all cancer innovation and improvement to tackle health inequality groups as set out in CORE20PLUS5
- Funding of two Health Inequalities pieces of research, one to look at how inclusive our cancer research population is and one to increase up take from our ethnic minority communities in cancer clinical trials

Measuring our Delivery

- Ensuring Continuity of Maternity Care for 75% of women from BAME communities and the most deprived groups
- Achieve 75% of cancers being diagnosed at stage 1 or 2 by 2028

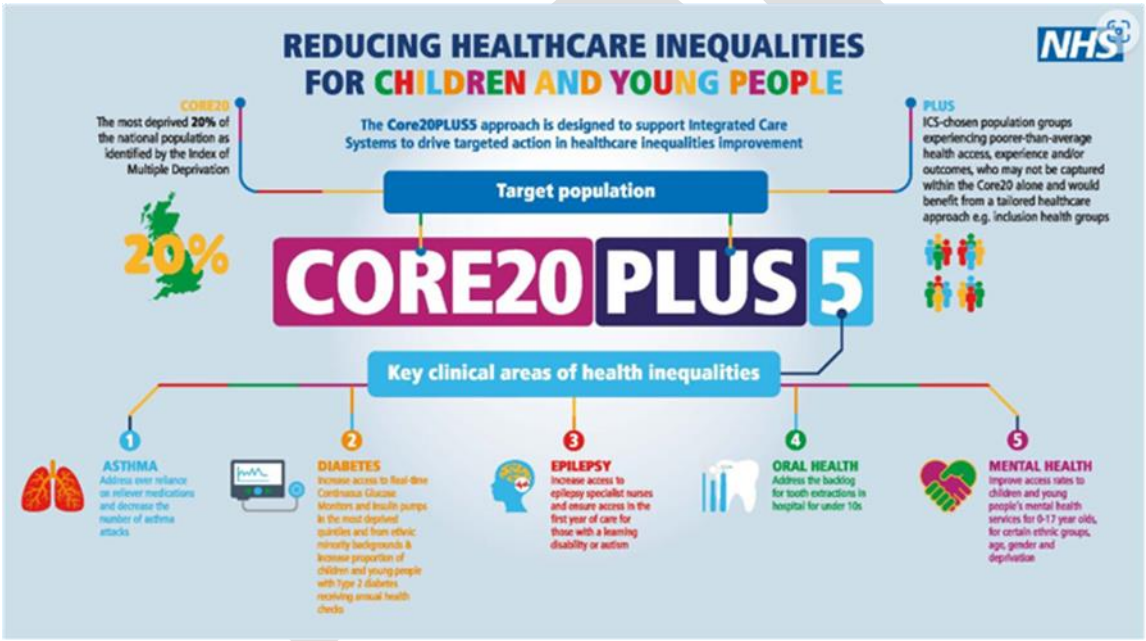
Accountability

- Locality Boards
- Clinical Effectiveness and Governance Committee (CEG)
- Population Health Board
- Quality and Performance Committee
- GM Cancer Board
- GM Maternity Board

6.1.2 Action: Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)

The national CORE20PLUS5 framework for children and young people (CYP) outlines the key clinical areas relating to secondary prevention that should be targeted to reduce health inequalities (Figure 5).

Figure 5



Over the next five years, we will:

- Build on the existing partnerships and cross-sectoral leadership in GM, through the newly established GM Childrens Board, to enable a social model of care for CYP so that equity, inclusion, and sustainability are at the heart of all care pathways.
- Asthma - Test out population health approaches to asthma prevention and management through asthma friendly schools' pilots, programmes to develop CYP

asthma peer mentors in primary and secondary schools and integrated care pathways

- Diabetes – Implement a whole system approach to enabling CYP and their families to eat well, move more and achieve a healthy weight
- Epilepsy – Review access to Epilepsy Specialist Nurses and epilepsy tertiary services
- Dental and Oral Health – Reduce tooth decay in children by delivering a GM Oral Health Improvement Programme to increase the number of children brushing their teeth every day in early years setting, in schools and at home; and increase the access to dental services for children by increasing the number of routine and urgent dental spaces available; increasing the dental practices that are in the Child Friendly Dental Practice (CFDP) Network; developing the dental care pathway for looked after children; and by increasing the number of sessions for children who need dental extraction(s) in a hospital setting.
- Mental Health – increase access to community and crisis services through support teams working with education settings and implement a core mental health offer for Cared For/Care Leavers including Speech and Language support and Trauma Informed Care

Measuring our Delivery

- A reduction in avoidable admissions and emergency attendances for relevant clinical conditions
    - Reduction in rate of emergency admissions for asthma for CYP aged 18 years and under from 180.1 per 100,000 population to 137.12 per 100,000 in line with the North West average by March 2024.
    - Reduction in rate of emergency attendances at hospital for asthma for CYP aged 18 years and under
    - Reduction in rate of emergency hospital admissions for diabetes for CYP aged 18 years
    - Reduction in rate of emergency attendances at hospital for diabetes for CYP aged 18 years and under
    - Decrease in rate of epilepsy-related emergency admissions for CYP aged 18 years and under from 31.98 per 100,000 population
    - Reduction in rate of emergency attendances at hospital for epilepsy for CYP aged 18 years and under from 163.4 per 100,000 population
- Digital inclusion plans implemented with routine monitoring.
- Increase in healthy weight prevalence for Y6 pupils across GM from 58.4% (latest GM data for 2021/22) to 60.8% (latest England average for 2021/22).

- Reduction in prevalence of overweight (including obesity) for Y6 pupils across GM from 40% (latest GM data for 2021/22) to 37.8% (latest England average for 2021/22).

CYP Asthma

- Year on year reduction in prescription of oral steroids

CYP Diabetes

- Increase access to CGM (Continuous Glucose Monitoring) from 10.9% to 20.9% in the most deprived quintile
- Increase access to insulin pumps from 23.5% to 27.7% in the most deprived quintile
- Minimum of 60% of CYP with diabetes received all 7 care processes.

CYP Epilepsy

- % of children and young people with epilepsy, with input by epilepsy specialist nurse within the first year of care (Minimum 85%)
- % of children and young people with epilepsy after 12 months where there is evidence of a comprehensive care plan that is agreed between the person, their family and/or carers and primary and secondary care providers, and the care plan has been updated where necessary. (Minimum 74%)
- % of children and young people meeting defined criteria for paediatric epilepsy surgery
- Referral criteria with evidence of epilepsy surgery referral (Minimum 50%)

CYP Oral Health

- Increase the number of settings recruited to the GM Oral Health Improvement Programme
- Reduce the waiting times for proportion of children waiting in excess of 18-weeks for dental extractions in a hospital setting
- Increase proportion of children and young people (aged 0-18-years) accessing routine and urgent NHS General Dental Service

CYP Mental Health

- Improved access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- The Greater Manchester Assessment and In-reach Centre (GMAIC) available 7 days a week with a 24/7 consultation service to support the wider system with young people presenting in crisis to urgent and emergency settings.

- GM-wide, 24/7 single point of access for all CYP crisis services to improve accessibility and system navigation for referrers and specialist pathways to support looked after young people experiencing emotional distress

Accountability

- Children's System Board
- Population Health Board
- Mental Health and Wellbeing Board
- Quality and Performance Committee
- Clinical Effectiveness and Governance Committee (CEG)

6.1.3 Action: Implementing a GM Fairer Health for All Framework

Health inequalities mean that some groups have significantly worse health outcomes and experience than others. These inequalities are avoidable, unfair, and systematic. Reducing health inequalities is a priority for NHS GM and we continue to work in partnership across the NHS, local government, and voluntary sector to take comprehensive approaches to address the socio-economic causes of poor health.

We have been working with system partners and communities to codesign a Fairer Health for All Framework to ensure that health equity and equality and sustainability are embedded systematically at the heart of our decision making, system leadership and governance.

The Fairer Health for All Framework (Figure 6) outlines our priorities for coordinated action to reduce inequalities across the life course through a set of shared principles:

Figure 6

Our key delivery actions are:

- To complete the codesign and launch of the Fairer Health For all Academy to provide learning and development opportunities focusing on health equity and population health approaches. Priority learning and development programmes in 2023/24 include: a fellowship programme for people working in the VCFSE sector, primary and secondary care, and establishing at least three communities of practice supporting Live Well, Population Health Management and integrated neighbourhood working.
- To further develop VCSE-primary care partnerships to address the CORE20PLUS5 clinical priority areas. In 2023/4, as part of the implementation of the primary care blueprint we will synthesise the learning from the CORE20PLUS5 community connector pilot led by the Caribbean African Health Network and the VCSE-PCN partnership pilots into a series of practical guides and tools
- To continue to build and sustain our adaptive capability (analysis, people, and systems) within NHS GM for population health management and strategic intelligence (see section 6.1.4). In years 1 and 2, we will complete development of the GM health and care intelligence hub, capture best practice for population health management, establish a strategic intelligence business 'unit' and design and implement development programmes to enhance capability where we can have the greatest impact aligned to CORE20PLUS5 clinical areas and primary care blueprint priorities.

Measuring our Delivery

- Narrow the gap in healthy life expectancy between men and women living in GM and between all ten Localities and the England average
- Reduction in avoidable mortality
- Reductions in health inequality in the onset of multiple morbidities

Accountability

- Population Health Board

6.1.4 Action: Monitoring and targeting of unwarranted variation in outcomes

Pivotal to the whole system approach to reducing health inequalities is access to cross-sectional data through the GM Advanced Data Science Platform (ADSP) which is enabling a system level view on key priorities and inter-sectional understanding of protected characteristics, thus improving our accuracy and completeness of data sets on patient ethnicity, disability and other protected characteristics. The ADSP has been created to ensure that we have a wide range of interoperable and specialist capabilities to support the generation of actionable insight for clinicians and multidisciplinary teams and intelligence to support service optimisation and population health.

Cross-sectoral intelligence (data and insight from public and VCSE partners accessed via the GM Health and Care Intelligence Hub), facilitates a shift in how we understand health inequalities across the life course and for people with multiple conditions to inform allocation of resources according to need and the identification of segmented performance and quality targets for communities and neighbourhoods. This cross-sectoral approach is facilitated through a GM VCSE intelligence group, and investment in VCSE capacity and skills to collate and analyse data and insight.

The GM Health and Care intelligence hub is a web based portal that is being co-designed to bring together data, community insight, web-based tools, guidance, shared learning and workforce development resources to support people working in health and care to better understand health inequalities and variation in care in their areas and implement upstream models of care.

These technologies enable the development of a record-level longitudinal linked dataset which combines primary, secondary, mental health, social care and community data held in our GM shared care record with other health and care data that is available nationally and via local flows from providers, such as our live A&E or

daily hospital discharge data. Using this combined data, we can support clinicians to identify and enrol individuals onto acute and chronic disease remote monitoring programmes; mitigate risks of health deterioration; and support the identification of appropriate population level or prevention interventions. The insight from the advanced analytic capabilities of the ADSP can be written back into the health and care workflow through the shared care record.

Measuring our Delivery

- Continued development and application of the record-level longitudinal linked dataset across health and care

System Leadership

- Population Health Board

6.2 Area of Focus: Supporting People to Live Healthier Lives

We know that if Greater Manchester was a place that enabled people to smoke less, drink less alcohol, do more exercise, and eat better food, it would have a major impact on health and wellbeing. There are also stark disparities in the prevalence of healthy and unhealthy behaviour and variance in terms of the support that is available to people, which in turn drives unacceptable levels of health inequality. We also know that unhealthy behaviours are a symptom of the presence of deep-seated societal and commercial causes of poor health.

6.2.1 Action: A renewed Making Smoking History Framework to deliver our smokefree ambition

GM is committed to becoming the first global city region to be smokefree and since 2017 has been delivering the evidence-based Making Smoking History (MSH) Strategy.

Reducing smoking prevalence is integral to GM's approach to tackling inequalities. Becoming a smokefree city region by 2030 creates a unique opportunity to reduce health inequality and increase healthy working life expectancy with ONS estimating that overall healthy life expectancy would increase by just over 6 years for men and 7 years for women if GM becomes smokefree by 2030 (a prevalence of <5%).

An updated Making Smoking History (MSH) five-year framework will be published in Autumn 2023. The refreshed framework will further strengthen our reputation as national leaders in tobacco control through a strong commitment to innovation and

research and delivering behaviour change. Over the next five years we will deliver our **GMPOWER** approach:

- **G**rowing our social movement with communities to create change culture, denormalise smoking and turn off the tap of new young smokers. This includes working with housing providers and communities re smoke free homes
- **M**onitoring and evaluating prevalence through the national Smoking Toolkit Study and through increasing research collaboration with GM academia.
- **P**rotecting people from secondhand smoke. Work will continue through the WHO Bloomberg Partnership for Health Cities to deliver more outdoor smokefree spaces.
- **O**ffering every smoker support to quit, targeted at the most disadvantaged. This includes comprehensive programmes within acute and community services (CURE, Smoke Free pregnancy, SMI mental Health, Targeted Lung Health Checks), as part of a wider model of support delivered through pharmacy, community, and digital.
- **W**arning of the dangers of tobacco through insights driven, multi-media behaviour change
- **E**nforcing regulation across the full range of tobacco and nicotine regulation including action to protect young people from vaping products
- **R**aising the price of tobacco is achieved both through advocacy for national tax increases and GM coordination of a Tackling Illicit Tobacco programme.

Measuring our Delivery

- Reduced smoking prevalence in overall population – GM and locality targets
- Reduced smoking prevalence in Routine and Manual groups - GM and locality targets
- Reduced smoking at time of delivery/during pregnancy (see section 5.2.4) .
- SOF metrics for NHS LTP Treating Tobacco Dependency Programmes

Accountability

- Population Health Board

6.2.2 Action: Reducing Harms from Alcohol

Alcohol is a significant cause of health harms and Greater Manchester residents experience this disproportionately, which culminates in demand for health and care services.

Reducing alcohol harm at a pace which meets our ambitions will require a scaling up and acceleration of our current whole system efforts and extensive collaboration with a range of partners. Our approach will be anchored in the findings of the GM Big Alcohol Conversation.

Over the next five years we will:

- Develop the independent evaluation of an evidence-based and co-produced NHS GM plan to tackle the health harms associated with alcohol, as a constituent part of a refreshed overarching GM Drug and Alcohol Strategy
- The development of this plan will be underpinned by a strategic evidence and research partnership with the NIHR Applied Research Collaboration (Greater Manchester); comprehensive primary research into the alcohol consumption behaviours of children and young people in Greater Manchester; and focused engagement with high-risk cohorts
- Commission a community-led 'Ambition for Alcohol' aimed at accelerating a social movement for change in Greater Manchester
- Build on our activity to date on tackling the harms associated with alcohol consumption in pregnancy by fully implementing the NICE Quality Standards for Foetal Alcohol Spectrum Disorder (FASD)
- Continue to monitor and evaluate our existing Alcohol Care Teams (ACTs) and improve quality, and reduce variation through the development of a GM Community of Practice

Measuring our Delivery

The impact of our activity will be measured by closing the gap to the national average for:

- Alcohol specific mortality
- Admission episodes for alcohol specific conditions
- Admission episodes for alcohol specific conditions – Under 18s

Accountability

- Population Health Board
- Drug and Alcohol Programme Board

6.2.3 Action: Enabling an Active Population

Greater Manchester Moving is our social movement of people, communities, and organisations, from every sector and place across the city region, with a shared goal of enabling Active Lives for All, aligned behind the knowledge and belief that:

- Moving matters to us all
- We need to design movement back into our lives
- Everyone has a role to play

'GM Moving in Action 2021-31' sets out our collective strategy and whole system approach for achieving this mission, making it easier for people to move more and a natural part of how we all live, travel, work, and play.
Approximately 30% of the GM population are still not experiencing the health benefits of physical activity and the patterns in the data reflect the social determinants of health and point to a need for culture, systems, and behaviour change. We have identified where GM Moving can support the missions of the ICP strategy These are outlined below and will be the focus of our collective efforts in this area in the next three to five years.

- While You Wait – supporting people waiting for hospital treatment
- Deconditioning and Falls Prevention
- Mental Health and Wellbeing
- Health inequalities and SEND (Special Educational Needs and Disability)
- Live Well
- Health and Care Workforce Wellbeing
- Priority Clinical pathways (Respiratory, CVD and Cancer)
- Healthy Active Places
- Women's Health

We will:
- Embed GM Moving (movement, physical activity, and sport) across the health and care mode through a universal and targeted approach to tackle inequalities in inactivity
- Continue to connect with national and international networks such as the Active Partnership Network and the Global Community of Practice, to learn from, and share our understanding of whole system approaches to physical activity

Measuring our delivery

- Reduce inequalities by increasing physical activity rates amongst the groups most likely to be physically inactive, with a specific focus on lower socio-economic groups; culturally diverse communities; disabled people; people with long-term health conditions

- Reduce whole population inactivity rates as measured by the active lives survey and close the gap to the national average

Accountability

- Population Health Board

6.2.4 Action: Promoting Mental Wellbeing

It is our ambition to create a unified, integrated, and equitable system that will help to realise a mentally healthy city region in which every child, adult, and place matters. We aim to achieve this through our new GM Mental Health and Wellbeing Strategy.

The strategy recognises a need to focus on early intervention and prevention. Poor mental health and ill health has its roots in our experiences and opportunities in early life and throughout the life course. We know that some individuals, communities, and cohorts are at greater risk and are underserved by the support that exists.

Our key workstreams include:

- Tackling inequalities through the allocation of grant funding to the VCSE sector to focus on those individuals, communities, and cohorts who are at greater risk
- Delivering training and development to boost the understanding, confidence and skills of the wider health and social care workforce in relation to responding to poor mental wellbeing and building positive mental wellbeing
- Raise population level awareness to enable more people to identify and access timely self-help, support and services if required that will improve outcomes and reduce the need to access clinical support. A GM Mental Wellbeing e-module will be built and tested in 2023/24
- Continue to deliver workforce training, such as Connect 5, that is based on best practice and trauma informed evidence to inform and support our workforce to deliver better mental wellbeing outcomes for population

Measuring our delivery

- Improved wellbeing, satisfaction, worthwhile, happiness and anxiety as measured through the national ONS survey questions and the supplementary data provided by the quarterly GM Residents Survey
- 10% reduction in population reporting they do not know how to access timely self-help and further support by the end of 2023/24 and a 100% reduction by the end of the 5-year period meaning that every person in GM knows how to access self help and support if they require it

Accountability

- GM Population Health Board
- GM Mental Health Programme Board

6.2.5 Action: Food and Healthy Weight

Obesity and poor diet are linked with numerous health conditions. In GM, nearly two-thirds of adults (65.8%), and 40% of children in year six, are classified as overweight or obese (significantly higher than the England average)[7].

There is a strong relationship between obesity and deprivation, and rates are higher in some ethnic minority groups. Creating opportunities for people to be a healthy weight requires a whole system approach, and policies and programmes at neighbourhood, city-region, national and international levels. We will:

- Initially focus on supporting a whole system approach to food and healthy weight for pregnant women, children and young people and families
- Further develop primary care pathways into weight management services that align the local well-being offer with the national digital weight management programme.

Measuring our Delivery

- Increase in healthy weight prevalence for Y6 pupils across GM from 58.4% (latest GM data for 2021/22) to 60.8% (latest England average for 2021/22).
- Reduction in prevalence of overweight (including obesity) for Y6 pupils across GM from 40% (latest GM data for 2021/22) to 37.8% (latest England average for 2021/22).
- Reduce the prevalence of overweight and obesity in adults

Accountability

- GM Population Health Board

6.2.6 Action: Eliminating New Cases of HIV and Hepatitis C

GM has some of the highest diagnosed prevalence rates of HIV in the country, and over a third of diagnoses are made at a late stage. Preventing HIV and hepatitis C

[7] Obesity Profile - Data - OHID (phe.org.uk)

virus (HCV) infection, diagnosing it early, engaging people in care and starting treatment at an early stage are all critical to preventing the associated health consequences and premature death, and for preventing onward transmission.

Towards Zero – the HIV action plan for England outlines plans to reach zero new transmissions of HIV by 2030, with an interim target of an 80% reduction in HIV transmissions by 2025. For GM, this means a target of less than 35 new diagnoses a year by 2025. NHSE has also set out their ambition to eliminate HCV by 2025; five years earlier than WHO targets. In 2018, the Mayor of Greater Manchester and all 10 Council leaders signed the Paris Declaration and Greater Manchester joined the Fast-Track Cities Initiative, committing to achieve the UNAIDS targets for HIV (which GM has now reached and exceeded).

In the same year, a transformation programme ('ending all new cases of HIV in Greater Manchester within a generation' - HIVe) was launched. Over the next five years, we will:

- Continue to support the delivery and development of HIV and HCV opt-out testing at Manchester University Foundation Trust and scope out the feasibility of extending routine testing to other blood born viruses and areas
- Support mobilisation and development of HIV and HCV opt-out testing at Salford Royal Hospital.
- Continue investment and activity in the HIVe programme, and co-design of proposals for the next phase. This will be informed by community insights work, commissioned during to identify populations not reached by HIVe activities to date, and to identify the barriers and facilitators to accessing care and support

Measuring our Delivery

- The proportion of eligible people attending participating emergency departments who are tested for HIV and/or HCV on an opt-out basis
- The proportion of people newly diagnosed with HIV/HCV through opt-out testing, or who are identified as not currently engaged in care, who are contacted and offered an appointment with a specialist
- The proportion of people seen by a specialist who are offered community/peer support at their first appointment
- Reduction in the proportion of people diagnosed late with HIV (people first diagnosed in the UK).
- Increase in the proportion of people living with HIV who have a diagnosis.
- Maintain or increase the proportion of people diagnosed with HIV who are on treatment.

- Maintain or increase the proportion of people on treatment who are virally supressed.

Accountability

- GM Population Health Board
- GM BBV Opt Out Testing Steering Group

6.2.7 Action: Increasing the uptake of vaccination and immunisation, particularly amongst groups with the lowest uptake and the worst health outcomes.

High immunisation rates are key to preventing the spread of infectious disease, the associated complications, and premature death[8]. However, there are avoidable inequalities in immunisation rates between population groups, and the likelihood of complete and timely vaccination is influenced by variables such as where people live, their socio-economic status and their ethnic group[1].

Since the COVID-19 pandemic, vaccine uptake rates for routine childhood programmes have fallen globally. Coverage for the measles, mumps, and rubella (MMR) vaccination programme in the UK has also fallen to the lowest level in a decade. Uptake of the first dose of MMR by two years of age, and uptake of both doses of MMR by five years of age is below the 95% threshold across GM and has dropped in almost all locality areas compared with pre-pandemic.

Over the next five years, we will:

- Finalise and implement the GM winter vaccination strategy for COVIOD and flu once the upcoming national immunisation strategy is published
- Aligning with national plans, bring forward the second dose of the MMR vaccine from 3 years 4 months to 18 months of age (implementation by 2024/25) to improve coverage
- Review, refresh and then implement (Q2-4 2023/24) the GM measles and rubella elimination strategy action plan in collaboration with stakeholders across the system
- Commission behavioural insight work to understand the motivators, drivers, situational changes, nudge factors and steps that lead to positive attitudinal and change in members of communities where vaccine uptake is low and implement strategies to effect change.

[8] PHE Immunisation Inequalities Strategy (publishing.service.gov.uk)

- Improve population health management capability re immunisation data (systems, analysis and people), including enabling the flow of routine immunisation data from the GM Care Record into the GM Data Warehouse and development of data dashboard.

Measuring our Delivery

- Achieve and sustain ≥ 95% coverage with two doses of the MMR vaccine in the routine childhood programme (<5 years old)
- Increase the proportion of people over 65 receiving a seasonal flu vaccination to ≥ 85
- Demonstrate improvements in flu and COVID-19 uptake, and reduce inequalities in uptake in specified cohorts

Accountability

- GM Population Health Board
- Screening and Immunisation Oversight Committee

6.3 Area of Focus: Upscaling Secondary Prevention

Secondary prevention refers to a wide range of the activities included throughout this mission: from supporting people to take an active part to improve their own health by promoting healthier behaviours; to earlier detection and diagnosis of illness; to high impact interventions for the prevention and treatment of cardiovascular disease, diabetes, and respiratory disease

6.3.1 Action: Early cancer diagnosis through screening and early detection

Cancers are a significant driver of avoidable mortality. Effective cancer screening programmes and other activities that increase the proportion of cancers diagnosed at an early, more treatable stage have a central role to play in reducing premature mortality and morbidity.

The NHS Long Term Plan outlines the ambition for 75% of people with cancer to be diagnosed at an early stage (stage 1 or 2) by 2028. Research shows that eliminating

socioeconomic inequalities in stage at diagnosis across several different cancers could result in a 4% shift to early-stage cancer diagnosis[9] .

Over the next five years, we will implement improvements to cancer screening programmes to improve access and maximise uptake. These include:

- Continue staged roll-out of the NHS Bowel Cancer Screening Programme to younger age groups in line with the NHS Long Term Plan ambition to lower the starting age to 50. During 2023, we will continue the rollout to 54-year-olds, and then progress to 50- and 52-year-olds in 2024/25
- Remodel regional breast screening services for GM to deliver the infrastructure and integrated models of care to provide a high quality, efficient, sustainable service for all patients
- Implementing 5-year screening intervals for women aged 25 to 49 testing HPV negative on a routine screen
- Support increased uptake of cervical screening through the continued involvement of GM providers in the HPValidate study of self-sampling tests
- Commission a piece of city region-wide bowel, cervical and breast screening behavioural insights work to improve understanding of the barriers and motivators to accessing cancer screening for populations across GM. This will be completed in Q1 and 2 of 2023/24 and inform a GM wide communications campaign and future commissioning approaches

We will implement the GM Cancer Alliance 2023-24 programme of work on early diagnosis. This is overseen by the Early Diagnosis Programme Board. The work includes:

- Patient and public awareness to promote timely presentation – ongoing programme of communication with locality support and involvement. Funding to be allocated to support this in 2023-24, at a GM and locality level
- Primary Care Pathways – primary care engagement and education to support delivery of the Early Diagnosis Primary Care Network Direct Enhanced Service. Testing new referral pathways, including the national pharmacy referral pilot – GM is one of three national pilot sites
- GP Direct Access Diagnostics – ensuring GP have access to the appropriate range of pre-referral diagnostics and encouraging use of the established 'non-specific symptoms' (NSS) pathways.

[9] Socio-demographic variation in stage at diagnosis of breast, bladder, colon, endometrial, lung, melanoma, prostate, rectal, renal and ovarian cancer in England and its population impact - PubMed (nih.gov)

- Targeted Lung Health Checks (TLHC) – continued delivery and further expansion of this programme across Greater Manchester. This project is supported by additional targeted funding allocated to the Cancer Alliance
- Cancer Screening Programmes – joint work with the NHSE/I Screen and Immunisation Team and colleagues in primary care to improve uptake of the three cancer screening programmes and reduce inequalities in access, experience and outcomes.

Measuring our delivery

- Increasing and maintaining breast cancer screening coverage to ≥70%
- Increasing and maintaining cervical screening coverage (under and over 50) to ≥80%
- The proportion of eligible people invited to participate in the bowel cancer screening programme, in all age groups, achieves the national achievable standard (60%)
- The proportion of participants with an abnormal FoBT (Faecal Occult Blood Test) result who go on to have a diagnostic procedure achieves the national acceptable standard (82%)
- Increase the proportion of people with cancer diagnosed at an early stage (1 or 2) to ≥75% by 2028
- Meet the Faster Diagnosis Standard (FDS) Standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

Accountability

- Population Health Board
- Cancer Board
- Locality Boards
- Primary Care System Board
- Screening and Immunisation Oversight Committee

6.3.2 Action: Early detection and prevention of Cardiovascular Disease

We will improve earlier detection of undiagnosed illness and earlier identification will enable earlier initiation of treatment. Given the inequity in health outcomes we currently see across GM, these key activities will focus on reducing inequalities in access and experience of healthcare and in reducing unwarranted variation in earlier diagnosis rates.

Earlier diagnosis of CVD

Whilst Cardiovascular disease (CVD) Prevention involves optimising and streamlining clinical pathways and areas, the underlying complexity and overlap with social and wider determinants of health means that a concerted system wide response is required. This needs to be combined with new ways of working with and for our communities: starting to change the dialogue from one about patients to *people*.

CVD has been identified as the single biggest area where our NHS can save lives over the next 10 years. The NHS Long Term Plan aims to prevent up to 150,000 heart attacks, strokes, and cases of dementia over 10 years. Key areas of focus include:

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

Modifiable risk factors explain 90% of CVD incidence and up to 80% of premature deaths from CVD are preventable[4]. Many people are living with common, treatable risk factors that significantly increase the risk of developing CVD:

- High blood pressure affects 1 in 4 adults, of whom half are undiagnosed or not receiving treatment. In GM, only 61% of adults with hypertension are treated to target.
- Nearly half of adults have cholesterol above recommended guidelines. In GM, 62% of people with no CVD, but a QRISK (Heart Attack and Stroke Risk Calculator) score of 20% or more are on lipid lowering therapy
- An estimated 1.4 million people have atrial fibrillation (AF), of whom almost 500,000 are undiagnosed and untreated10. In GM, around 89% of adults with AF and a CHA2DS2-VASc (Score for AF Stroke Risk) score of 2 or more are currently treated with anticoagulants

In general, GM figures are lower or worse than the England average, with variation between local authority areas in terms of both the prevalence and management of these risk factors.

NHS health checks are a crucial part of our prevention plans. We will continue to drive uptake of health checks across GM by:

[10] Prevalence | Background information | Atrial fibrillation | CKS | NICE

- Focusing NHS Health Check recovery on high-risk priority groups and explore mixed models of delivery to increase engagement
- Maximise impact of the programme by increasing prescribing of hypertensives and statins, referral into prevention programmes and links into wider welfare and support
- Increase take-up of the programme with a particular focus on populations with low uptake and higher CVD risk
- Explore a GM training approach which supports consistent and high-quality delivery and performance with a strong focus on effective behaviour change which is strength based and aligns to approaches to social prescribing and personalised care.

We will improve the identification and treatment of people with Hypertension by:

- Community pharmacy blood pressure case finding service. We have 456 community pharmacies providing a blood pressure (BP) case-finding service. These will be supported by the development of guidance for primary care around collaborating with community pharmacies.
- Supporting opportunistic blood pressure screening across all health and social care settings, making every contact count. Following the national rollout of the BP@home scheme, GM distributed over 10,000 BP machines across GP surgeries throughout so that patients can record their own blood pressure and send their readings to their GP practice to review

Measuring our delivery

- Reduction in prevalence gaps across our localities
- Reduction in inequalities in outcomes
- Improvement in the expected vs recorded prevalence of illnesses across differing socio-economic and ethnic groups
- Increased use of Community Pharmacy blood pressure case finding service
- Increased recorded prevalence of NDH (Non-Diabetic Hyperglycaemia) diabetes, hypertension, high cholesterol, obesity and behavioural risk factors

Accountability

- GM CV Prevention and Cardiac Board
- GM Clinical Effectiveness Group
- Locality Boards
- Primary Care System Board

Lipid management: Improve the identification and treatment of people with high cholesterol

Currently in GM we have approximately 11,000 patients who have had a CVD event, known to need basic statin medication to manage their cholesterol but who are not receiving this medication (cohort 1), plus a further 8,000 patients who are maximised for statin medication and yet their cholesterol levels remain unmanaged (cohort 4). These two cohorts are the two highest risk patient cohorts for our populations in terms of developing further cardiovascular events (such as a stroke or a heart attack). Our key actions in this area include:

- Development of a GM bespoke risk stratified case management tool Enabled on the Greater Manchester Shared Care Record, allowing system level data insight – shared with localities
- Development of lipids educational and training resources, including webinars, case management tool, medication pathway.
- An enhanced clinical pharmacist third-party review service for primary care supporting the optimisation of lipid lowering therapies for high-risk patients.

Measuring our delivery

- Improvements in the numbers of patients across the highest risk cohorts who are initiated on therapy against pathway criteria 1 and 4
- We conservatively estimate that optimising these patients will realise a 17% reduction on Major Adverse Cardiovascular Events (MACE) + events, 15% in MACE events and a total of 1,067 non-fatal events avoided
- Improvements in the proportion of patients who are optimised against the Accelerated Access Collaborative medication pathway

Accountability

- GM CV Prevention and Cardiac Board
- GM Clinical Effectiveness Group
- Locality Boards
- Primary Care System Board

6.3.3 Action: Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry

There are thousands of people in GM who have COPD but are undiagnosed. NHS RightCare estimate this to be around 19,000. Spirometry is essential for the diagnosis of respiratory conditions such as COPD and asthma. Limited spirometry has been

provided across Greater Manchester since COVID-19 due to infection prevention and control measures. Spirometry restart is necessary for the diagnosis of patients presenting with new symptoms but also to catch up on the 'backlog' of people who have been unable to access spirometry over the past three years. Spirometry provision will be embedded in the community so it can be aligned with Community Diagnostic Centres (CDCs).

Our focus is on achieving the following outcomes:

- To increase the number of people accurately diagnosed with COPD, asthma
- To increase the proportion of people diagnosed with COPD confirmed using post bronchodilator spirometry that is quality assured
- To increase the proportion of people with COPD who are diagnosed compared to predicted prevalence
- To reduce the risks related to inappropriate treatment of individuals misdiagnosed, and the associated medicines waste and environmental impact

Measuring our delivery

- Decrease Backlog in Spirometry
- Reduce respiratory referrals into secondary care
- Increase in diagnostic spirometry for children
- Increase the number of people who have been diagnosed with Asthma/COPD and have a quality assured spirometry on record

Accountability

- Primary Care System Board
- GM Clinical Effectiveness and Governance Group

6.3.4 Action: Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness

Learning from lives and deaths - people with a learning disability and autistic people (LeDeR) is an NHS England service improvement programme. Its purpose is to improve the quality of health and social care for people with a learning disability by requiring a review of the care received by a person after their death. The drivers for LeDeR were, and still are, the persistence of significant health inequalities and higher rates of morbidity and mortality between the general population and people with a learning disability. The role of health checks is key in supporting earlier access to healthcare and earlier detection of unmet health needs.

People with severe mental illness (SMI) face health inequalities and live on average 15 to 20 years less than the general population. They are less likely to have their physical health needs met, including identification of health concerns and appropriate, timely screening and treatment.

The CORE20PLUS5 Framework sets out the ambition for at least 75% of those living with a Learning Disability and at least 60% of those living with SMI to receive an annual health check.

Over the next five years we will:

Improve Learning Disability Annual health checks (AHC) uptake, quality and impact

- Work with General Practice to increase the numbers of people with Learning Disability on the General Practice Learning Disability register so as to reduce the numbers of those 'missing' from the register
- Increase both the uptake and quality of LD Annual Health Check (AHC), including provision of meaningful Health Action Plans (HAP) to meet (or exceed) national target of 75%
- Obtain strategic Intelligence through the development of GM LDA dashboard
- Develop and provide quality information for people with Learning Disability, families, health, and social care providers.
- Comprehensive training packages for stakeholders.
- Deliver health cafes, providing a structured platform to share accessible evidenced based information to people with Learning Disability

The above with be co-produced and co-delivered with experts by experience. We will obtain agreement for an annual audit cycle from all partner agencies and feedback from Experts by Experience

Increase Severe Mental Illness Annual Health Checks

- Continue to co-produce and embed innovative models to improve access for SMI patients and their physical health checks using principles of Making Every Contact Count
- Focus on patient engagement and completion of recommended physical health assessments with follow-up, involving delivery of or referral to appropriate NICE-recommended interventions
- Ensure patients are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvements in their physical health through personalised care planning. This will also address the full needs of the person taking steps to

combat loneliness, isolation and promoting wider engagement in self-care, exercise, healthy eating and lifestyle

- Ensure that primary care teams continue to carry out annual physical health assessments and follow-up care for patients who are not in contact with secondary mental health services and patients with SMI who have been in contact with secondary care mental health teams for more than 12 months and /or whose condition has stabilised
- Ensure that secondary care teams continue to carry out annual physical health assessments and follow-up care for patients with SMI under the care of a mental health team for less than 12 months and/or whose condition has not yet stabilised

Measuring our delivery

- Achieving 75% uptake rate for annual health checks for those with Learning Disability across NHS GM
- Increase in those from ethnically diverse communities on register and having an LD AHC/HAP
- Increase in young people aged 14-25 on GP register and having an LD AHC/HAP
- Increase in LeDeR reviews identifying positive impact of AHC/HAP (and decrease in those not having one)
- Achieving 60% uptake rate for annual health checks for those with Severe Mental Illness across NHS GM

Accountability

- The GM LD&A delivery Group
- The GM Good Health Group
- The GM LDA Strategic Group
- GM Mental Health Board
- GM Clinical Effectiveness and Governance Group

6.4 Area of Focus: Living Well with long-term conditions

We have described the actions to prevent the worsening of disease, particularly of CVD, Diabetes and Respiratory disease. We now move focus to consider how we can support those with established long-term conditions to live well. The focus on prevention at every stage of the patient journey is to improve health and reduce severity of illness and to shift the balance away from care in hospitals towards care at home, with appropriate support (see section 5.1.4)

6.4.1 Action: Managing Multimorbidity and Complexity

Multimorbidity is a term used to describe the presence of two or more long-term health conditions, and includes both physical and mental health conditions, ongoing conditions such as learning disability, symptom complexes such as frailty or chronic pain, sensory impairment such as visual loss and alcohol/substance misuse[11].

Over the next five years, we will:

- Obtain the data to understand the prevalence of those living with multimorbidity in Greater Manchester, with a particular focus on identifying inequity and unwarranted variation
- Develop a strategic multi-morbidity approach to long term conditions, which will include person centred care and shared decision making
- Establish a systemwide approach to Chronic Musculoskeletal Conditions (including back pain), Chronic Pain and Chronic Fatigue

Measuring our delivery

- We will design/develop an approach to multimorbidity in years 1-2 of the Joint Forward Plan
- We will evidence delivery of this over years 3-5

Accountability

- GM Clinical Effectiveness and Governance Group
- GM Population Health Board

6.4.2 Action: Optimising treatment of long-term conditions

The focus here is the optimal treatment of the three main conditions driving preventable disability and mortality - cardiovascular disease, diabetes and respiratory disease

Cardiovascular Disease

Following a cardiac event, such as a heart attack, research shows that cardiac rehabilitation has a positive impact on wellbeing and quality of life and can also reduce the risk of being re-admitted into hospital with subsequent cardiac events.

[11] Recommendations | Multimorbidity: clinical assessment and management | Guidance | NICE

Measuring our delivery

Our aims are:

- 85% of eligible Acute Coronary Syndrome patients attending cardiac rehab
- 33% of eligible and newly diagnosed Heart Failure patients completing a personalised cardiac rehabilitation programme by 2028/29

Accountability

- Quality and Performance Committee

Improving access to diagnostics for people with Heart Failure

People with Heart Failure are often admitted to hospital due to limited access to diagnostics and treatments in the community. Improving access could prevent up to 230,000 hospital admissions and 30,000 deaths from heart and circulatory diseases over the next decade in England.

We will use digital services to support improvements. These include:

- GM heart failure digital care plan. We are working together to transform care planning in HF to a standardised digital heart failure care plan that can be utilised across care settings via the GM Care Record. It will support patients to be managed more effectively within the community while also empowering patients to take greater control and be more informed. It is currently being piloted in Rochdale and Tameside with a view to spread across the whole of GM.
- Remote Monitoring for Heart Failure. We are testing out a remote monitoring platform that allows people with heart failure to be monitored remotely

Measuring our delivery

- Roll out of standardised digital heart failure care plan

Accountability

- Quality and Performance Committee

Improving survival rates for Out of Hospital Cardiac Arrest

Cardiopulmonary resuscitation (CPR) is attempted in nearly 30,000 people who suffer out-of-hospital cardiac arrest (OHCA) in England each year, but survival rates are low and compare unfavourably to other countries.

Many lives can be saved if:

- CPR and early defibrillation are undertaken promptly and more often
- The whole pathway of care from successful resuscitation to subsequent rehabilitation were improved.

We will work with the British Heart Foundation to roll out training initiatives to support education on the use of defibrillators.

Measuring our delivery

- Our ambition in GM is to increase the survival rates for our patients to 25%.

Accountability

- Quality and Performance Committee

Diabetes

Over 170,000 people are living with Diabetes in GM and many others are at risk of developing the condition. We developed the GM Diabetes Strategy in 2018 and the GM Diabetes Board reviewed and refreshed the strategy in 2022.

Our main areas of delivery include:

- Structured Diabetes Education is being in adapted to offer it in more culturally appropriate formats for different communities (South Asian, Black and Afro-Caribbean, Deaf people, visually impaired people)
- The Manchester Amputation Reduction Strategy (MARS) is being developed and rolled out in more localities around GM to offer more integrated wound care in a more timely fashion to help prevent amputations
- The nationally commissioned BHS Type 2 Diabetes Pathway to Remission (formerly known as low-calorie diet) is being offered across GM, providing a 12 week total diet replacement course under clinical supervision
- Healthier You, the national diabetes prevention support offer, is being offered across GM with 14,000 places available each year
- A Diabetes Transition Strategy is being developed to set out the GM vision for improved transition for children living with diabetes into adult care services
- Diabetes My Way (www.diabetesmyway.nhs.uk) provides self-management support for people living with diabetes in GM by providing access to their own GP diabetes data dashboard, personalised advice, digital structured education, and support resources
- Healthcare professionals working with diabetes patients have been offered training and education in the areas of motivational interviewing and shared decision making to increase attendance rates at structured diabetes education

Measuring delivery

Using the GM Diabetes Intelligence Dashboard, we will measure key metrics at practice, PCN, locality and GM level, including:

- The prevalence of diabetes in GM
- Number of referrals and programme starts in the National Diabetes Prevention Programme
- Number of patients completing all 8 diabetes care processes (and individual care processes)
- Number of patients achieving all 3 diabetes treatment targets (and individual treatment targets)
- Number of patients attending structured diabetes education
- Number of referrals and programme starts into the NHS Type 2 Diabetes Pathway to remission programme
- Number of diabetes patients living with additional risk factors and/or other long-term conditions

Accountability

- GM Diabetes Board
- GM Clinical Effectiveness and Governance Group

Respiratory Disease

In GM in 2019, 26.78% of all respiratory hospital admissions were due to influenza or pneumonia. Influenza and pneumonia are one of the highest areas of spend due to non- elective admissions (source NHS RightCare).

The uptake of influenza, covid and pneumococcal vaccination varies across GM localities and across risk groups and all age groups. Increasing uptake rates of these vaccinations for people with respiratory disease, will lead to avoidance or reduction in severity of winter respiratory illness for the individual and reduce avoidable unplanned admissions to hospital.

We will work with vaccination and immunisations teams (as described in section 6.2.7) to deliver a comprehensive and targeted offer of vaccination for those with respiratory disease

Measuring our delivery

- Reduction in hospital admissions due to influenza and pneumonia

Accountability

- Quality and Performance Committee

COPD

Prevention of COPD by supporting people to stop smoking and earlier detection of COPD through quality assured Spirometry is considered in section 6.2.1 of this plan. Once COPD has been diagnosed, the priority turns to enabling a good quality of life by preventing progression and complications. Respiratory conditions are long-term conditions, with stable periods and exacerbations, and many patients experience deterioration over time. This means the access to services is an important aspect of care.

We plan to enhance and expand the Pulmonary Rehabilitation (PR) programme across GM. We have established a GM PR collaborative to reduce variation in offer, standards and access to PR across Greater Manchester. Over 2023/24, we will roll out the standardised PR educational booklet; work with community teams to provide early education sessions; continue to work towards national accreditation.

We will explore community based and led rehabilitation/ patient expert education group models and will work with other rehabilitation groups (e.g., cardiac rehabilitation) to provide a person-centred cross-cutting offer which encompasses other rehabilitation and chronic disease education.

Measuring our delivery

- Achieve nationally recognised accreditation standards for all pulmonary rehabilitation services
- Reduction in waiting times for PR
- Increase in choice of delivery of PR

Accountability

- Quality and Performance Committee

6.4.3 Action: Role out the Manchester Amputation Reduction Strategy (MARS) across NHS GM

The Manchester Amputation Reduction Strategy (MARS) is an example of a 'whole systems' approach to a single clinical problem: *How do we reduce lower limb amputations secondary to chronic disease across Greater Manchester?* A multi-disciplinary team with expertise across Public Health, community, hospital, finance,

digital, strategy and academia came together to co-design a solution with sustainability and scalability at its heart. Its' philosophy is that better outcomes result from the 'aggregation of marginal gains' which are only possible in a complex system if cultures across organisational boundaries are better aligned.

The work began by encapsulating the entire patient journey in one diagram and understanding amputation inequalities across regional, gender, ethnic and diabetes groups. An amputation is often the result of an ulcer that is inadequately treated which itself is often the result of chronic disease that is, itself, poorly managed made more difficult by variations in service provision and access which together are likely to be leading to the locality, gender and ethnic inequalities we see across the region.

MARS has 4 programmes of work being developed and becoming ready to scale up;

- *'**Move More':*** Improve physical activity in the general and ulcer population by linking Public Health services with clinical pathways both face to face and digitally
- ***'Reduce Inequality more':*** Level up access for all lower limb ulcers to the diabetes standard
- ***'Diagnose more':*** Raise capabilities and confidence of community nursing and podiatry teams to perform more non-invasive vascular assessments
- ***'Make every contact count more':*** Use Public Health Screening programmes e.g., aneurysm screening to case-find undiagnosed conditions of concern e.g., depression, hypertension and peripheral arterial disease

Measuring our Delivery

- Enable equity of access to community podiatry services by patients with foot ulcers regardless of diabetes status
- Raise uptake levels of screening from areas with high levels of deprivation and ethnic minorities
- Raise capability of community nursing and podiatry teams to perform and interpret non-invasive lower limb vascular assessments and reduce referrals into vascular surgery by 25%

Accountability

- Cardiac SCN
- Clinical Effectiveness and Governance Committee (CEG)
- Locality Boards
- Population Health Board

6.4.4 Action: The GM Dementia and Brain Health Delivery Plan

Dementia is a priority for Greater Manchester. Our vision and shared ambition is to improve the experience of being diagnosed and living with dementia and make GM the best place to live for all those affected by Dementia.

Our Strategic Aims are:

- Improving connections, quality of care and experience for everyone affected by dementia
- Promote brain health and help prevent avoidable cases of dementia, supporting wellbeing and independence
- Design, develop and facilitate education and training across all sectors
- Increase access to benefits of dementia research through awareness, involvement and participation

We are working hard to increase the dementia diagnosis rate (DDR) to pre-pandemic levels. The Greater Manchester DDR is currently above the national target (66.70%) with an average of 70% in 2022/ 2023. This is key to supporting people to live well at home for as long as possible and avoid care home or hospital admission.

Measuring our Delivery

- The longer-term ambition is for GM to recover pre-pandemic levels which reached 76% in 2018/2019. Immediate target to reduce variation across GM; to ensure that all boroughs have recovered the dementia diagnosis rate of 66.7%

Accountability

- Dementia United Board

6.4.5 Action: Taking an evidenced based approach to responding to frailty and preventing falls consistently across GM

Frailty is an increasingly problematic long-term health condition characterised by declining resilience and increased vulnerability to events associated with, but not specifically caused by, ageing.

We have launched the Greater Manchester Falls Collaborative to oversee and deliver the priorities for falls prevention, integration and reconditioning.

Over the next five years, we will:

- Develop GM strategy and standards focused on ageing well, identify and reduce of unwarranted variation, improve key clinical outcomes and improve patient experience for older people
- Review the Framework for Resilience and Independent Living to produce a GM Frailty Prevention and Care Strategy and an agreed set of frailty care standards for implementation to drive frailty care quality improvement.
- Develop a frailty care outcomes framework dashboard. This will be designed to support place-based teams allowing them to review, develop and quality improve services to achieve better care for local people as they age

Measuring our Delivery

- New care home admission
- Death in unplanned settings including in hospital
- ED attendance and admission resulting from a fall and/or fracture

Accountability

- GM Ageing Well Steering Group
- GM Clinical Effectiveness and Governance Group

6.4.6 Action: Anticipatory care and management for people living with, deteriorating and dying from life limiting illness

Individuals who are experiencing a life limiting illness should be supported to live as well as they can before they die. They should be empowered to make important decisions about their care and wishes. They should be treated with dignity, respect and conversations about their condition and care should be open and honest. Appropriate and culturally sensitive care should be available to all those who need it.

It is recognised that the majority of an individual's care in the last year of life will be. provided in their usual place of care. However, many people in Greater Manchester die in hospital. Dying in hospital is usually the least preferred place to be.

Our focus is on:

- Delivering a palliative and end of life care transformation programme
- Ensuring that care is available to all those needing it, prioritising quality of life and living and dying well within existing legal frameworks

We will develop and implement:

- A quality improvement plan against the GM Commitments and the National ambitions self-assessment
- The increased use and reporting of IPOS (Integrated Palliative Care Outcomes Scale) across Greater Manchester ensuring the transformational programme is in line with individuals' needs

Measuring our Delivery

- The availability of 24 hour/7 day a week specialist palliative care services in Greater Manchester
- Reduction in inappropriate admissions to secondary care in the last 90 days of life
- Increased use of the EPaCCS (Electronic Palliative Care Coordination System) Summary on the Greater Manchester Care Record
- Increased identification of people with palliative and end of life care needs

Accountability

- GM Palliative and End of Life Group
- GM Clinical Effectiveness and Governance Group

7 Helping people get into, and stay in, good work

One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by enhancing the Education, Work and Skills system, working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter and developing social value through our network of anchor institutions.

Helping people get into, and stay in, good work Delivery Leadership: Locality Boards System Leadership: Population Health Board; GM Good Employment Charter Board, GM Employment and Skills Advisory Board	
Areas of Focus	**Actions**
Enhance Scale of Work and Health Programmes	Expansion of our Working Well System
Develop Good Work	Working with employers on employee wellbeing through the GM Good Employment Charter
Increase the contribution of the NHS to the economy	Developing the NHS as an anchor system
	Implementing the Greater Manchester Social Value Framework

NHS GM and the GM Combined Authority have been able to draw from shared evidence generated through publications such as Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives (2021), the GM Independent Prosperity Reviews (2019 and 2022) and the Greater Manchester Local Industrial Strategy (2019) which all reinforce the connection between health and an inclusive economy.

7.1 Area of Focus: Enhance scale of work and health programmes

7.1.1 Action: Expansion of our Work and Health Models

Jointly developed by GMCA and NHS GM, the Working Well System Model has been in place since 2018. A co-investment approach aims to support the long term unemployed and people with health conditions or disabilities into sustainable 'good work' across the city-region.

Within the 2023 Devolution Trailblazer agreement, there is a commitment to a co-design approach for all future DWP contracted employment support programmes in the city-region, with an assumption of a GM footprint and a delegated delivery model. This will allow GM to further shape and define the Working Well system, and bring the additional resource and opportunity created by the introduction of the UK Shared Prosperity Fund (replacing European Social Fund) for those not in employment or training, over 50s and those with complex needs.

NHS GM and the Combined Authority will work together in 2023/24 to redefine and advance our future model including for the Working Well model, as well as the Working Well: Specialist Employment Service (SES) comprising Supported Employment (SE) for people with a learning disability and/or autism, and Individual Placement and Support (IPS) for both people with severe mental illness and those referred through the Primary Care route.

7.1.2 Action: Expansion of our Working Well System

Working with GMCA, NHS GM will continue to evolve the Working Well System to ensure as many residents as possible are supported towards and into employment providing the right support at the right time to enable positive work outcomes. As funding and programme opportunities become available, a data and evidence led approach will be applied to ensure maximum impact. New services to be in place in 2023/24:

- Working Well: Individual Placement and Support in Primary Care service funded by the Department for Work & Pensions (DWP), to provide support for 1,500 GM residents running to March 2025. Delivery will take place in co-locations with a range of primary and community NHS health services and professionals. Participants will come from two distinct cohorts: out of work participants who require assistance and support to move into competitive employment; and in work participants who are off sick or struggling in the workplace due to their disability / health condition
- A Working Well: Early Help service building on leaning from our first pilot and further testing an early intervention primary care referral model for individuals with health conditions or disabilities at risk of falling out of work
- A programme of work delivered in partnership with The Health Foundation will improve health and reduce inequalities through scoping a system wide approach to addressing increasing economic inactivity resulting from poor health in those aged 50-64
- A response to the Joint Work and Health Unit's new Work Well Hub and Partnership programme. The Hubs are expected to link jobcentres, health services and other local organisations and provide wraparound support for jobseekers, those on benefits and those at risk of falling out of work due to their health conditions.
- Additional commissioning linked to the UK Shared Prosperity fund is likely to focus on economically inactive people with complex needs (all age groups) many of which are likely to relate to health conditions. This programme will be delivered from late 2023 and aims to support over 8,000 people towards employment over coming years.

Measuring our Delivery

- Number of people supported into work
- Number of people supported to remain in work
- Number of people supported whose health conditions improve

Accountability

- Locality Boards
- Population Health Board
- GMCA Employment and Skills Advisory Partnership / new Integrated Education, Skills and Work Governance Board

7.2 Area of Focus: Develop good work

7.2.1 Action: Working with employers on employee wellbeing through the GM Good Employment Charter

The Greater Manchester Good Employment Charter aims to develop diverse, equal and truly inclusive working conditions across Greater Manchester. By promoting the benefits of equality, diversity and inclusion in the workplace, we aim to support employers to create workplaces that embrace the characteristics of good employment in ways that ensure fair pay, opportunity and progression to all. This will include adoption of the Real Living Wage (RLW)

This action applies to all Greater Manchester employers, in partnership with GMCA, but also includes health and care organisations. Our key actions in this area are set out in the Supporting our Workforce and Carers Mission.

Measuring our Delivery

- Number of Health and Care organisations achieving Charter Accreditation

Accountability

- People Board

7.3 Area of Focus: Increase the contribution of the NHS to the economy

7.3.1 Action: Developing the NHS as an anchor system

The Health Foundation describes anchor institutions as large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve[12]. This agenda is also linked to the 'fourth purpose' of ICSs, unlocking the NHS's social and economic potential.

These anchor organisations are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community. By strategically and intentionally managing their resources and operations, anchor institutions can help address local social, economic and environmental priorities in order to reduce health inequalities.

In Greater Manchester, we will move from an institutional perspective to one more akin to a social movement. The next stage of our journey will be to develop a more strategic and aligned focus on what it is the ICS wants to change, developed in partnership with the range of other anchors in the system, all pulling and participating in the same strategic direction for the economy.

This work will be developed by a GM NHS Anchors Network with representation from each trust as well as each locality. Agreed short term priorities for the GM Anchors Network include:

- Develop and implement vision, strategy and targets
- Develop and implement local supply chain opportunities
- Develop and implement collaborative approaches to the development of effective local employment pathways

Measuring our Delivery

- To be confirmed through GM Anchors Network development

Accountability

- Population Health Board
- Provider Federation Board

[12] The NHS as an anchor institution (health.org.uk)

7.3.2 Action: Implementing the Greater Manchester Social Value Framework

The GM Social Value Framework sets out how our city region will deliver social value through commissioning and procurement activities. It sets out the outcomes that GM is collectively working on to make an impact through the policy, including supporting more people into work; a reduction in poverty and health inequalities; and avoiding acute problems by investing in prevention.

Our key actions as NHS GM:

- Embedding Procurement Policy Note 06/20 (taking account of social value in the award of central government contracts) into business-as-usual activity
- NHS GM Integrated Care and Provider Trusts formally adopt GMCA approach to lever more social value from public sector spending
- Agree and embed standard social value evaluation questions with model answers for procurements
- Implement standard approach to measurement and reporting on social value delivered:
- Evaluate the impact of a 20% (or higher) social value weighting for procurements
- Identify relevant categories and/or contracts for local supply chain development

Measuring our Delivery

- Improvements against Social Value Reporting Tool metrics – being developed at national level

Accountability

- Population Health Board

8 Recovering core NHS and care services

Improving access to high quality, core services and reducing long waits is the main issue raised by Greater Manchester residents participating in the Big Conversation and this will be delivered through our approach to the recovery of services. The impact of the COVID-19 pandemic was huge and exacerbated many of the challenges which were already influencing delivery of core health and care services.

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

8.1 Area of Focus: Improving urgent and emergency care and flow

The GM Urgent and Emergency Care (UEC) Plan is based on a set of improvement priorities linked to the themes in the national UEC recovery plan.

8.1.1 Action: Access to urgent care in the community

Responsive urgent care services in our neighbourhoods and communities are a vital part of our system. Our priorities for these community-based services are:

- Fully implementing Urgent Treatment Centre (UTC) models consistently across GM. There are currently 10 accredited UTC sites open across GM that adhere to the guidance
- Improving 111 access and flow through reviews of community services and Directory of Services (DoS) accessibility
- Improving referral pathways for 999 access and response. Building on existing good work with North West Ambulance Service (NWAS) and system partners to increase “Hear and Treat” and “See and Treat” rates
- Continued GM Clinical Assessment Service (CAS) development, reviewing appropriate code sets and increasing options for 111 and 999 based on clinical appropriateness

Measuring our Delivery

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
- Reduction in A&E attendances
- Reduction in Ambulance conveyances

Accountability

- UEC Board
- Locality Boards
- PFB

8.1.2 Action: Admission/Attendance Avoidance

Admission/Attendance Avoidance includes initiatives to ensure the expansion of out of hospital services to avoid an admission or attendance. These include:

- Same Day Emergency Care (SDEC) – working with system partners on improving direct access pathways for NWAS and primary care. Reviewing consistency of models across GM, supporting improvement, and overcoming barriers to make the most effective use of the services
- Urgent Community Response (UCR). All localities have plans to offer full geographic coverage for a minimum of 08:00 – 20:00 7 days a week for UCR.

Where demand necessitates, there is flexibility for longer operating hours and covering all 9 clinical conditions or needs, including level 2 falls. This is done by ensuring there are multi-disciplinary teams operational during the required times

- Our localities are aiming to increase referrals in from 111 and 999. The NW regional team are working with NWAS and the DoS team to produce a standardised code set for across the region to ensure consistency of approach

Measuring our Delivery

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Reduction in non-elective admissions
- Reduction in A&E Attendances

Accountability

- UEC Board
- Locality Boards
- PFB

8.1.3 Action: Improving Discharge

Improving Discharge and Flow focuses on reducing Length of Stay (LoS) and supporting patients leaving hospital in a timely manner including:

- In-hospital flow – working with providers to support flow improvement initiatives, benchmarking and sharing best practice
- Evidenced-based audit work to support improvement
- Out of Area (OOA) placement discharge improvement

We have been working with partners to introduce new schemes and enhance existing models to improve Discharge and Flow. Specific areas of focus include:

- Setting up a directory in GM of contacts, and a national directory, and streamlining these through localities
- Ensuring points of escalation are in place through the relevant groups including acute and mental health discharges
- Review of systems and processes across GM, further embedding of escalation processes
- Review of other ICS Transfer of Care Hubs, working closely with social care

The GM Directors of Adult Social Services have led on the development of additional schemes to support winter and surge capacity engaging all GM partners in the decision making. This includes the GM Independent Provider Network.

Measuring our Delivery

- Reductions in Length of Stay
- Reductions in the number of patients in hospital beds with no criteria to reside
- Reduce adult general and acute (G&A) bed occupancy to 92% or below
- Increasing the number of patients being discharged to their usual place of residence

Accountability

- UEC Board
- Locality Boards
- PFB

8.1.4 Action: Increasing ambulance capacity

Several "alternative to transfer pathways" are in place across Greater Manchester. These pathways include direct referrals into two-hour UCR and other community services, as well as the falls lifting services, which are relieving some of the pressure on ambulance services. There is a dedicated mental health triage function developed between Greater Manchester Police (GMP), NWAS and mental health providers.

GM actions include:

- Ensure pathways to other services are clear on the DoS and Service Finder.
- Monitor ambulance referrals to other services - ensure consistency during busier and lighter periods
- System review of pathways across localities ensuring sufficient capacity is in place

Measuring our Delivery

- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24 with further improvement towards pre-pandemic levels in 2024/25

Accountability

- UEC Board

8.1.5 Action: Improving emergency department processes

We are working with partners to standardise care at the ED front door, including for mental health patients. Our focus is on improving patient flow in and out of hospitals, including embedding fully functional bed management and the GM system control centres.

Work to improve and standardise Same Day Emergency Care (SDEC) is part of this improvement plan, ensuring patients can access SDEC services as an alternative to the Traditional ED process, through referral from their GP or from NWAS. Our key priorities include:

- Ensure consistency of approach across each ED to avoid inequity of service
- Ensure systems can cope with the operational and monitoring challenges on a day-to-day basis
- Further development of the SCC (System Control Centre) and embedding of a sustainable model across the whole system

Measuring our Delivery

- Improving A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Reducing 12hr waits in the Emergency Department

Accountability

- UEC Board
- PFB

8.2 Area of Focus: Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard

The GM elective recovery and reform strategy has six pillars (Figure 7) and addressing health inequalities is embedded as a priority through the programme supported through board level equalities champions. Each recovery pillar also has an equality impact assessment

Figure 7

8.2.1 Action: Integrated Elective Care

The Integrated Elective Care Pillar aims to support the early stages of a patient pathway. The Integrated Elective Care Pillar will support the Primary Care and Secondary Care interface principles through improving utilisation and implementation of referral optimisation initiatives. This pillar of work will also support the system in delivering outpatient recovery and transformation initiatives to improve efficiency and patient experience including increased use of advice and guidance and Patient Initiated Follow Up (PIFU).

Measuring our Delivery

- Utilisation of advice and guidance
- % patients moved to PIFU pathways
- New to follow up outpatient appointment ratio

Accountability

- GM Elective Recovery and Reform Board

8.2.2 Action: Improving productivity and efficiency

Driving productivity and efficiency to release the capacity required to increase elective activity, reduce long waits and improve patient safety, outcomes and experience.

Plans are underpinned by a systematic data-driven approach for identifying productivity opportunities with the highest impact on improving elective care and reducing inequalities. This is supported by the adoption of GIRFT (Getting it Right First

Time) and Right Care principles to reduce unwarranted variation and improve GM performance. The programme will focus on reducing DNAs; improving theatre utilisation; increasing day case rates; specialty specific focus on ophthalmology and orthopaedics

Measuring Delivery

- Increase in high volume low complexity procedures
- Theatre utilisation
- Day case activity as a percentage of overall activity
- Reduction in on the day cancellations
- Improvements in DNA rates

Accountability

- GM Elective Recovery and Reform Board

8.2.3 Action: Development of Surgical Hubs

Maximising the use of surgical hubs will ensure capacity for elective activity is protected and drive down the overall wait list in GM. GM has a number of hubs in place with plans for more to come on line in the next few years. We are also engaging with the national surgical hub accreditation process which focuses on performance, utilisation and patients experience in hub settings. One of our GM hubs is currently going through national accreditation process with more to follow. The use of surgical hubs through the pandemic has highlighted the importance of protecting elective activity and ensuring beds are available.

- We have developed a weekly GM surgical hub capacity report to review surgical hub utilisation and proactively manage surgical hub capacity using the 6-4-2 model, supporting the GM mutual aid approach, and the delivery of national targets.
- GM surgical hub sites will continue to work towards the achievement of 85% day case activity in 2023/24, and the development of Standard Operating Principles for all GM hubs will reduce variation and improve equity of access to hub capacity for patients across GM
- Plans to extend GM surgical hub sites in 2023/24 will increase the provision of elective capacity, particularly for children and young people, and surgical hub sites will work towards gaining national GIRFT (Getting it Right First Time) accreditation.
- A GM wide communication and engagement approach for both patients and staff will support these developments

To support digital activity, we have an identified digital lead on the GM Elective Board with links back to the GM Chief Digital Officers network. This will enable us to identify digital opportunities relating to the pillars of the Elective Recovery Strategy.

Measuring our Delivery

- Meet the 85%-day case and 85% theatre utilisation national expectations, using GIRFT and moving procedures to the most appropriate settings
- Number of patients treated in surgical hubs
- Productivity of surgical hubs

Accountability

- Elective Care Recovery and Reform Board
- PFB

8.2.4 Action: Improved utilisation of the independent sector

Working with independent sector (IS) providers is critical to supporting our work to reduce the overall wait list and in particular those who have waited the longest. This programme of work will focus on a demand and capacity model for those patients that have waited over 65 weeks.

We will work in collaboration with IS providers to develop and implement a joint standard operating procedure and access policy for IS activity.

Measuring our delivery

- Utilisation of available independent sector capacity
- Number of long waits with IS providers
- System spend against plan on IS activity

Accountability

- Elective Care Recovery and Reform Board

8.2.5 Action: Improving how we manage our wait list

We will work collaboratively to eliminate long waits over 78 and 65 weeks by the end of June 2023 and March 2024 respectively. This will be undertaken in an equitable way through targeted support and a focus on choice. In addition, we will further

develop the While You Wait website to support people while they are on the wait list and through our work on the Myrecovery app.

We will agree and implement a consistent GM access policy and will pilot a GM approach to risk stratification and clinical prioritisation to support inclusion and reduce inequalities.

Through the Wait List Management Programme, we will also pilot alternative approaches to support patients through our Care Navigation Hubs.

Measuring our delivery

- Overall GM referral to treatment (RTT) wait list
- Number of patients waiting over 78 weeks
- Number of patients waiting over 65 weeks

Accountability

- Elective Care Recovery and Reform Board

8.2.6 Action: Recovering children and young people's elective services

Our focus on Children and Young People will consider five key areas of work: additional capacity opportunities; consistent clinical prioritisation; improved referral pathways; revised specialty pathways and shared productivity and efficiency opportunities.

Improvements have already been driven through our work on Walk In Walk Out approach to increasing day case activity and surgical hub funding has been allocated to children and young people. Recovery is however slower for children and young people, which is also being seen across the country. As a result, this is a particular focus as part of our cross-cutting work on health inequalities.

Measuring our delivery

- Overall number of children and young people on the RTT wait list
- Number of children and young people waiting over 65 weeks
- Activity relating to children and young people as a proportion of overall activity

Accountability

- Elective Care Recovery and Reform Board

8.2.7 Action: Reducing waiting times in cancer

Cancer Alliance planning requirements aim to improve performance against the Cancer Waiting Times standards with a specific focus on delivering the Faster Diagnosis Standard (FDS). This requires 75% of patients to have cancer confirmed or excluded within 28 days.

The target of 75% is for March 2024 with incremental milestones at the end of each quarter at system and provider levels. There is a requirement to reduce the volume of patients from a two week wait referral source who are on an active PTL (patient tracking list) beyond 62 days. The target set by NHSE is 1,051 by the end of March 2024. GM has set a stretch target of 761.

To achieve this, our key areas of focus are:

- GM system wide action plan
- Focused work on first attendance 'offer' and 'day 7'
- Best Practice Timed Pathway (BPTP) project delivery and compliance monitoring
- Roll out of tele-dermatology and Faecal Immunochemical Testing (FIT) and compliance monitoring
- Continued education and support to primary care
- Collaborative work with elective programme on referral options (urgent non-cancer capacity)
- Consolidation of oncology appointments (single queue)
- Ongoing work to improve waiting times for diagnostics and reporting for patients on suspected cancer pathways.
- Mutual aid offer for specialist surgery
- Embed faster diagnostic standard (FDS) principles in all site-specific pathways
- Roll out and compliance with personalised stratified follow-up (PSFU) to release clinical time to be re-invested pathway improvement

Measuring our Delivery

- Reduce the volume of patients on active PTLs over 62 days. NHSE target 1051 by end March 2024. GM target 761
- Meet the Faster Diagnosis Standard (FDS) Standard by March 2024 so that 75% of patients have cancer confirmed or excluded by day 28 of their pathway. Achieve the milestone targets of 67.5% end June 2023; 70.0% end September 2023; 72.5% end December 2023

Accountability

- Cancer Board
- Locality Boards
- Primary Care System Board

8.2.8 Action: Improving Diagnostics

GM trusts have each developed plans to achieve the ambition of 95% diagnostics tests within six weeks for all relevant modalities by March 2025. These have been brought together into a single plan for GM and approved by the regional team. The trajectories in these plans will achieve 87% within six weeks by the end of March 2024. This is being set as the target for the 2023/24 plan. Key risk areas within the plans have been highlighted and mitigating actions are being put in place.

The Endoscopy network have finalised a set of productivity KPIs as a starting point to extensive improvement and standardisation work in this area. The Theatre Rooms In Virtual Environments (THRIVE) tool is being rolled out at most GM sites to support this.

Endoscopy workforce scoping and review was undertaken in late 2022 with a workforce plan in development. This will which address workforce gaps and retention and drive up activity levels. It is planned to have at least one room at each site working a 6/7-day week giving the potential to increase activity significantly. Capital schemes are planned to build additional room capacity at specific sites.

At system level, the Community Diagnostic Centre (CDC) programme will create additional capacity across GM and short form business cases (SFBCs) have been submitted from all localities. GM will implement the CDC programme to create essential new diagnostic capacity within localities as soon as practical once capital and revenue funding is agreed.

We have plans to improve the productivity of pathology and imaging networks through digital diagnostic investments and optimal rates for test throughput and the expansion of diagnostic capacity including through the CDCs programme. Specifically, the introduction of PACS (Picture Archiving Communications System) based reporting by March 2024 across all organisations will facilitate delivery of a minimum 10% efficiency in reporting by 2024/5.

In addition, the introduction of MRI (Magnetic Resonance Imaging) accelerator technology will increase productivity of MR scanner throughput for image acquisition.

The implementation of digital pathology across all cellular pathologies in GM by end of 2023/4 will facilitate a minimum 10% efficiency gain in reporting by 2024/25.

Measuring our Delivery

- Deliver the ambition of 95% diagnostics tests within 6 weeks for all relevant modalities by March 2025
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
- The implementation of digital pathology across all cellular pathologies in GM

Accountability

- Diagnostics Board
- PFB

8.3 Area of Focus: Improving service provision and access

8.3.1 Action: Improving Access to Primary Care

In organising primary care, we always seek to balance convenience and continuity of care between online or face to face appointments according to the patient's wishes and needs. Our Primary Care Blueprint (currently being finalised) will describe how we will approach this.

The pandemic brought change and in some cases transformation to demand, access and capacity. The Primary Care delivery model had to change overnight with a short term reduction in capacity and more access being delivered online. The opportunity to move to digital solutions where appropriate was accelerated and now needs to settle into a more measured way of understanding how digital can support Primary Care services and citizens alike.

It is important to reflect that demand, access and capacity is different in the four disciplines of Primary Care and in some cases demand and access are merged due to the open-door nature of services. It is also important to acknowledge the role of preventative, screening, and wellness services which fundamentally change the shape of demand into services, keeping citizens well, supporting early diagnosis and promoting self-care.

Primary Care, and particularly general practice has had the advantage of the Additional Roles Reimbursement Scheme (ARRS) initiative. This has brought many

more clinicians and support workers into Primary Care Networks, increasing workforce and the opportunity to offer flexible solutions to patients and more capacity into neighbourhoods. For this opportunity to work well we must integrate not only across Primary Care disciplines but also with the wider public sector, voluntary sector, and the business community to make the most of our workforce, local services, and buildings.

We will seek to secure additional capacity when periods of surge demand occur, which we assess through our framework for reporting pressures. Primary care providers will enable the spread of access to online advice on symptoms and self-care.

Our key aims on improving access across primary care are:

- Ensuring same day urgent access to Primary Care where clinically warranted and agreeing an appropriate response at first contact for all non-urgent requirements
- Removing the “8 am rush” in General Practice, via a support programme which will include investment in the telephony infrastructure, encouraging optimal use of the NHS App and a programme of development support for PCNs and practices
- Delivery of a Dental Quality scheme which will seek to improve access to NHS Dentistry across GM. NHS Greater Manchester and primary care providers are engaging on options to address the current issues surrounding access to NHS dental services and to develop a dental access plan
- Building on the core Community Pharmacy Contractual Framework to develop and deliver pharmacy services to improve access and reduce health inequalities – for example, in developing a harmonised GM Minor Ailments scheme

Measuring our Delivery

- Number of general practice appointments per 10,000 weighted patients
- Percentage of patients describing their overall experience of making a GP appointment as ‘good’
- Continue on the national trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

Accountability

- Primary Care System Board

8.3.2 Action: Digital transformation of Primary Care

Practices and Primary Care Networks have been on an accelerated journey of the deployment of digital tools from the start of the COVID-19 pandemic. Digitisation in General Practice broadly meets foundational requirements. However, there remain outstanding challenges to optimise the use of the digital technology. This involves a focus on workforce and connecting existing systems to truly integrate care across care settings.

Practices and PCNs are facing more aggregate demand and an increase in non-patient-facing workload. Change is required to manage demand and capacity efficiently with digital tools, delivering effective digital access for patients, alongside traditional routes – all to support the best possible experience and outcomes for patients.

Our Digital First Primary Care Programme is supporting the Primary Care Recovery Plan with digital access for capacity and demand management – measured by dashboards that provide evidence on benefits of using digital solutions. This will include supporting practices with Virtual Contacts, Digital Care Navigation and Triage to enable easier digital access to help tackle the 8am rush and assessment of need or signposting to appropriate services on first contact

Measuring our delivery

- Standardising practice websites across GM with consistent messages to meet national standards for accessibility and quality of information provided
- Promoting usage of NHS App across GM for particular use cases
- Every PCN to have a named person as a Digital Change Champion with support from Digital Facilitator or Digital Change Manager
- Deployment of GM Care Record to Community Pharmacy to improve medication safety, save time for pharmacists and practices and support decision making for enhanced services
- GM Care Record Realising Potential Programme to increase usage and utility including training and communications across care settings; clinical documents sharing; data feeds completion and data quality improvement
- Integrated Care Planning – adoption of the GM Care Record (GMCR) as the single platform for multi-agency integrated care planning - including EPaCCS (Electronic Palliative Care Communications System)
- Cloud-based telephony functionality for practices will help them offer a more reliable service and facilitating PCN hub delivery both in hours and out of hours

Accountability

- GM Health and Care Digital Transformation Board
- Primary Care System Board

8.3.3 Action: Ensuring universal and equitable coverage of core mental health services

We will support people with mental health needs through improvements in crisis services working with GMP and NWAS. We will also work in partnership to support people with a serious mental illness to access housing and employment. We must tackle long waiting-times in mental health as a priority.

We will adopt a proactive approach to supporting children and young people to reduce the impact of mental health problems and specifically to improve the pathway for eating disorders.

We intend to increase our longer-term baseline investment in mental health services, recognising that demand now is substantially above pre-pandemic levels, and that Greater Manchester has historically under-invested in mental health, learning disability and autism compared to other areas. This has resulted in significant variation in the availability of services across Greater Manchester, which must be properly resourced going forward through an agreed investment plan.

This is consistent with seeking parity of esteem for mental health services with physical health services and will be challenging for our system in terms of allocating limited resources. Recognising the starting position, our ambition would be to move Greater Manchester to the middle quartile of expenditure per capita with consequent improvements in access and outcomes across the life of this plan.

Measuring our Delivery

- Work towards eliminating inappropriate adult acute out of area placements
- Move Greater Manchester to the middle quartile of expenditure per capita on mental health

Accountability

- Mental Health Board

8.3.4 Action: Digital transformation of Mental Health Services

We have made progress in provision of digital tools to support mental health patients Fundamental risk factors for mental health patients are related to social challenges, and physical health.

In accordance with NHSE requirements, GM Provider Trusts are working towards implementing the Electronic Patient Record meeting the Minimum Digital Foundations by the end of 2025 across all their hospital sites.

Measuring our delivery

- Integrated Shared Care Record - increasing usage of the GM Care Record across all care settings; redefining and implementing a consistent data set for Mental Health feeding into the GMCR

Accountability

- GM Health and Care Digital Transformation Board
- Mental Health Board

8.4 Area of Focus: Improving quality through reducing unwarranted variation in service provision

8.4.1 Action: Improving Quality

Our quality strategy describes the collective ambition of GM Integrated Care to improve people's experience through the delivery of good quality, safe and effective care. The national principles for quality are fundamental to our approach:

1. A shared commitment to quality
2. Population-focused
3. Coproduction with people using services, the public and staff
4. Clear and transparent decision-making
5. Timely and transparent information-sharing
6. Subsidiarity

The actions needed to embed these principles into our system, with clear responsibilities, are completed or on track (as of June 2023) and detailed in the GM quality strategy.

In year 1 (2023/4) the focus will be on developing the quality priority workstreams and finalising the emerging quality governance assurance processes – putting the foundations in place. Our priority actions are:

a) Ensuring good governance of Quality Assurance for the ICB and a common understanding of quality data.
b) Establishing and embedding our integrated care system wide priorities for areas of quality improvement
c) Establishing and embedding locality quality arrangements for areas of quality improvement
d) Demonstrating where initial improvements have been made by measuring our progress as a system.
e) Confirming that the quality ambitions for years 2- 5 meet the triple aim of improving health and wellbeing, quality of care and are an efficient/sustainable use of resources

These actions are undertaken in the appropriate part of the system – the ICB, localities, system subject leads. Engagement on the strategy made clear that its implementation will be achieved through a series of improvement actions that contribute to the overall shared purpose. The delivery and coordination of the individual components of the quality strategy will be managed by the Quality Strategy Delivery Group.

Our shared purpose for 2023/24 is:

- Setting system-wide quality priorities
- Setting outcomes that are measured to inform improvement
- Setting the expectation of all those involved in providing care access across the system

For years 2-5 (2024/5 and onwards), our shared purpose will be:

- Improved standards
- Improved quality
- Improved population health and wellbeing through the reduction of inequalities

Safeguarding

The ICB has a statutory responsibility for safeguarding which is enacted via the NHS GM Chief Nurse and supported by the Deputy Chief Nurse and Associate Director of Safeguarding. Statutory safeguarding responsibilities are delegated to the Associate Director of Quality and Safety in each of the GM localities and delivery of the statutory functions are undertaken by the locality Designated Teams.

NHS GM can demonstrate that there are appropriate safeguarding governance systems in place for discharging statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014
- Children Act 1989 and 2004
- Children and Social Work Act 2017
- Working together to Safeguard Children 2018

NHS GM will undertake their statutory duties across the GM Safeguarding Children Partnerships as one of the equal and joint statutory partners (Local Authority, ICBs and Chief Officer of police) and as a statutory partner for the GM Adult Safeguarding Boards. The ICB will ensure that the delivery of safeguarding aligns with the NHS Safeguarding Accountability and Assurance Framework (2022)[13].

It is the responsibility of the ICB and each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect. NHS GM Safeguarding will encompass an all-age and a Think Family model supporting an integrated safeguarding partnership approach.

Measuring our Delivery

- Through metrics developed as part of the Quality strategy

Accountability

- Quality and Performance Committee

8.4.2 Action: NHS at Home – Including Virtual Wards

We recognise the potential and importance of developing new models of care enabled by technology to provide care to people in their own homes and place of residence as an alternative to a hospital bed.

The virtual wards programme has an aim to deliver between 40-50 virtual wards beds for per 100,000 adult population. This equates to between 1,110 to 1,250 for Greater Manchester. GM is now projecting to deliver approximately 1,095 beds by March 2024.

[13] B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf (england.nhs.uk)

The current virtual ward average length of stay is approximately 7 days, equating to a conservative estimate of 1,960 bed days saved each week. This will increase throughout 2023/24.

The GM virtual wards model comprises four networks working across the city-region to achieve adoption and spread at scale, equity of access for patients and reduce unwarranted variation. All sites have now mobilised standard clinical pathways for acute respiratory infection and frailty virtual wards (step-up and step-down) co-produced with senior clinical leaders, alongside a clear set of operating principles and standards.

The expansion of the programme through 2023/24 and beyond will focus on:

- New pathways – heart failure, end of life, post-op, general medicines
- Optimising admission avoidance and increasing referrals
- Enabling patient flow between virtual ward networks
- Optimising non-clinical activity at scale

Measuring our Delivery

- Deliver 1,095 virtual ward beds by March 2024, achieving 80% occupancy from September 2023 onwards
- Adoption and spread of all agreed pathways across all sites, supporting flow across the system

Accountability

- UEC Board
- NHS at Home Programme Board

8.5 Area of Focus: Using Digital and Innovation to Drive Transformation

8.5.1 Action: Implementation of Health and Social Care Digital Strategy

To deliver on our strategic vision and support the ambition for Greater Manchester to become a world-leading digital city region we need to embrace digital transformation opportunities across the health and care system. We want to be a truly digital health and care system, leveraging partnerships across academia and industry with one of the largest life sciences clusters in the country.

However, there are many areas of our health and care system which remain paper-based or operate on clunky, outdated systems that are not connected to each other.

This impacts on the quality and standard of care and the experience of people using our services. There is an urgent need to get the basics right alongside our ambition to develop leading-edge approaches.

Our five digital transformation ambitions are to:

- Deliver integrated, coordinated and safe care to citizens
- Enable staff and services to operate efficiently and productively
- Empower citizens to manage their health and care needs
- Understand population health needs and act upon insights
- Accelerate research and innovation into practice, as a globally leading centre

We have developed the GM Digital Maturity and Investment Framework in each care setting to understand our status and next priorities. This strategy presents three layers of activity required - to digitise, integrate and innovate.

Measuring our Delivery

- A joint delivery plan targeting the priority capabilities across all major delivery partners is being developed. Progress is measured through a) digital maturity scores per capability (assessed annually in each care setting), b) delivery of milestones and c) programme level benefits evaluation
- Social care - increasing uptake of Digital Social Care Records by independent social care providers (from ~50% to 80% by March 2025) and deployment of the GM Care Record to independent social care providers
- Secondary Care - In accordance with NHSE requirements, GM Provider Trusts are working towards implementing Electronic Patient Record meeting the Minimum Digital Foundations by the end of 2025, across all their hospital sites

Accountability

- GM Health and Care Digital Transformation Board

8.5.2 Action: Driving transformation through research and innovation

Greater Manchester is regarded as one of the most active, diverse and growing health innovation ecosystems due to our concentration of advanced health and care, academic, life sciences and digital sectors.

Health Innovation Manchester (HInM), now in its sixth year, continues to work on behalf of GM health, care and academic system partners to discover, develop and

deploy innovation aligned to the needs of GM citizens and supporting economic development across the city region.

Through the course of 2023/24, HInM will be working with GM system partners to develop a new three-year strategy, building on the research and innovation assets of the system and aligned to the new ICP strategy missions, as well as GM economic growth ambitions.

For the final year of the current three-year strategy, the innovation priority projects for 23/24 are:

- Enhanced diagnostics accelerator - this £15.1m programme will deliver novel diagnostics in cardiovascular, respiratory and liver disease, specifically addressing communities most at need. The programme will drive better access to care and improve clinical outcomes for local people, as well as increasing impact from GM academic activities and creating new market opportunities for local industry partners
- GM Care Record optimisation and development of the Secure Data Environment (SDE) - the GM Care Record is a direct care and innovation asset which is already funded by GM system partners. We will accelerate our activities to maximise the benefits from the platform
- Deployment of proven innovation - we are in the final stages of agreeing the initial set of deployment at scale projects with system partners, based on proven solutions that meet key system challenges, population health needs and contribute to tackling inequalities.
- Continued expansion of virtual wards and NHS at Home –this will include the rollout of further virtual ward pathways, supporting providers to optimise admission avoidance and further developing this model of care
- Strategic industry partnerships - we will continue to deliver our industry strategy and our pipeline of proven innovations, secure additional resource for local innovation deployment, and bring benefits to industry which will encourage further investment and collaboration
- Academic partnerships - we will continue to make develop our university and NHS research assets so that we can improve our innovation pipeline and achieve greater local impact from investment to the GM academic infrastructure.

GM Health Innovation Accelerator

GM is one of three UK city-regions to be awarded funding as part of the Government's levelling up white paper to launch 'innovation accelerators' to advance R&D in key areas.

The GM health innovation accelerator will focus on tackling some of the most challenging disease areas through early diagnosis using novel approaches and holistic treatment aligned to people's specific needs. It will focus on enhanced diagnostics and genomics, delivered through a partnership between Health Innovation Manchester, Manchester University NHS Foundation Trust, and the University of Manchester. Further significant investment has also been leveraged through partnerships with businesses in life sciences, digital and creative industries

Measuring our Delivery

Each innovation project is delivered through a structured innovation pipeline method and approach, including a PID, benefits realisation plan and logic model outlining the following deliverables:

a) Inputs – funding, costs and resources

b) Activities – the key tasks and milestones

c) Outputs – measurable/quantifiable results

d) Outcomes – what the innovation led to, short medium-term consequences

e) Impacts – longer term wider contextual changes

Accountability

- Health Innovation Manchester Board
- GM NIHR Infrastructure Oversight Board
- GM Health and Care Digital Transformation Board

9 Supporting our workforce and our carers

We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people to choose health and care as a career and to feel supported to develop and stay in the sector.

Supporting our workforce and our carers Delivery Leadership: NHS GM People & Culture Function, NHS GM, NHS Trusts, Primary Care providers, Local Authorities, Social Care Providers, VCSE Organisations System Leadership: GM People Board	
Areas of Focus	**Actions**
Workforce Integration	Enable leaders and staff to work across traditional boundaries to support service integration
	Share best practice and develop tools to support a dynamic system culture
Good Employment	Increase in Good Employment Charter Membership and payment of Real Living Wage
	Improve access to staff benefits and flexible working
	Share best practice and resources to support managers
Workforce Wellbeing	Take action on the cause of staff sickness and improve wellbeing support
Addressing Inequalities	Building a leadership culture committed to addressing health inequalities
	Adapt the recruitment process to provide alternative entry routes for diverse talent
Growing and Developing	Develop our Greater Manchester careers approach to attract and support career development
	Develop and deliver the Greater Manchester retention plan
	Embrace digital innovation to improve the way we work – starting with HR digitisation
Supporting Carers	Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

We have set out a shared ambition for the health and care workforce in our People and Culture Strategy 2022-2025. The People and Culture Strategy is summarised in Figure 8:

Figure 8

9.1 Area of Focus: Workforce integration

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

9.1.1 *Action: Enable leaders and staff to work across traditional boundaries to support service integration*

- Co-create a culture of collaboration, including development of ways of working which are adopted at all levels such as our system boards and wider leadership development
- Promote the development of neighbourhood based integrated health and social care roles, including the expansion of the blended roles programme
- Make it easier for our workforce to move across different settings, including the expansion of the GM passport across health and care settings
- Work with our regulators to develop standards around integration

Measuring our Delivery

- Increase in number of integrated learning environments within nursing, AHP (Allied Health Professional) and medical education programmes
- Total number of senior leaders participating in system integration development programme
- Increase in number of integrated health and social care roles, including blended roles programme. Increase in number attending our workforce summits and post event evaluation
- Increase in number using the digital training passport

Accountability

- People Board
- Locality Boards

9.1.2 *Action: Share best practice and develop tools to support a dynamic system culture*

- Continue to share best practice and ways of working to support integration and collaboration, through toolkits and events such as the Workforce Collaborative Summit
- Establish a system induction toolkit that can be incorporated into place and organisation inductions to provide useful context around how our system works and supports the development of a system culture
- Establish a system staff survey to improve our understanding of our workforce experience across the sector
- Develop a plan for cross system mentoring and coaching

Measuring our Delivery

- Total number of organisations incorporating system induction piece into their induction programmes
- Survey measuring perceived integration/survey of leaders feeling able to work across boundaries

Accountability

- People Board
- Locality Boards

9.2 Area of Focus: Good Employment

9.2.1 Action: Increasing membership of the GM Good Employment Charter and payment of the Real Living wage for health and care organisations

- Increase in Good Employment Charter membership and payment of the Real Living Wage. Supporting organisations to achieve Charter membership will also improve employment standards across all areas covered by the Charter, including security, flexible working, employee engagement, recruitment, people management wellbeing provision and inclusion
- Establish a Good Employment Charter definition for good leadership – piloting in NHS Greater Manchester and sharing best practice with the system
- Work with partners to help embed good employment practices in our commissioning and contracting of services
- Share best practice and resources to support managers to be the best they can be and explore a core development programme for managers – including line management and clinical supervision
- Deliver the Greater Manchester Champion Awards to celebrate collaboration and good practices
- Continue to work in close partnership with trade unions, supporting ongoing engagement between unions and employers in the event of industrial dispute

Measuring our Delivery

- Increase in Good Employment Charter membership
- Good Employment Charter Steering Group engagement on perceived change in the system
- Increase in the number of health and care employers paying the Real Living Wage

Accountability

- People Board
- Locality Boards

9.2.2 Action: Improve access to staff benefits and flexible working

- Improve access to staff benefits, starting with the Blue Light Card
- Support our net zero ambitions by promoting active travel and improving access to electric cars and cycle schemes

Measuring our Delivery

- Improvement of the wider employment standards included in the Good Employment Charter, such as increase in access to flexible working

Accountability

- People Board
- Locality Boards

9.2.3 Action: Share best practice and resources to support managers

- Coordinate action to tackle violence and bullying experienced by our workforce in their place of work
- Improve workforce engagement and access to flexible working by sharing good practice

Measuring our Delivery

- Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from managers
- Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from patients/service users
- Staff survey engagement theme score (Out of 10)
- Aggregate score for NHS staff survey questions that measure perception of leadership culture

Accountability

- People Board
- Locality Boards

9.3 Area of Focus: Workforce Wellbeing

9.3.1 Take action on the cause of staff sickness and improve wellbeing support

- Supporting workplaces to keep people well to reduce workforce sickness levels
- Improve access to existing resources so that all our people can get the support they need for maintaining good wellbeing
- Improve infrastructure and systems for absence management to support effective workforce planning
- Take a more standardised approach to occupational health in secondary care
- Establish occupational health and Employee Assistance provision for NHS Greater Manchester and look to extend this where possible in primary care, social care and the VCSE sector
- Support organisations and networks to embed good wellbeing cultures and practices
- Establish a workforce wellbeing oversight group - with the power to act on system themes
- Identify Wellbeing needs/gaps and working with partners address them together at a Greater Manchester level

Measuring our Delivery

- Sickness absence rates
- Leaver rate

Accountability

- People Board

9.4 Area of Focus: Addressing Inequalities

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

9.4.1 Action: Building a leadership culture committed to addressing health inequalities

- Develop and implement a Greater Manchester Workforce Disability Equality Scheme

- Delivery of the national Stepping Up programme at scale
- Develop a culture of services across Greater Manchester addressing wellbeing inequalities experienced by specific groups
- Develop and implement an Equality, Diversity and Inclusion Framework for inclusive leadership

The work of the Fairer Health for All leadership academy (section 6.1.3) will also contribute to this action.

Measuring our Delivery

- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age
- Reduction in the disproportionality in disciplinary investigations by people with protected characteristics

Accountability

- People Board

9.4.2 Action: Adapt the recruitment process to provide alternative entry routes for diverse talent

- Implement the #InclusiveHR initiative to create more representative and inclusive People and Culture services
- Adapt the recruitment process to provide alternative entry routes for diverse talent

Measuring our Delivery

- Proportion of staff in senior leadership roles who are from a) a BME background or b) are women or c) are disabled
- Increase representation of people with protected characteristics at all levels, within the NHS that will be particularly at entry levels at Band 2, Band 5 and Junior Medical Grades
- Number of organisations that have adapted their recruitment processes to attract diverse talent and impact this has had on those recruited

Accountability

- People Board

9.5 Area of Focus: Growing and Developing

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

9.5.1 Action: Develop our Greater Manchester careers approach to attract and support career development

- Develop our Greater Manchester careers approach to reach into our communities and engage with school leavers as well as those looking for a new career
- Develop our talent pool to ensure it is diverse and meets the needs of our system
- Develop the Social Care Careers Academy to support growth, retention and development of the social care workforce
- Building on the findings from research into the workforce development needs of the VCSE sector, support workforce development within the VCSE sector to create a more sustainable, resilient and integrated workforce
- Work closely with HEE (Health Education England) to create more development opportunities and enable people to have the protected time to participate
- Use the work within the People and Culture Strategy to build a strong narrative on why people should want to work in health and care in Greater Manchester
- Support Greater Manchester People Teams to develop by creating a development plan for our HR and OD colleagues

Measuring our Delivery

- Increase the number of people engaged through GM careers activity
- Increase in the size and diversity of the GM talent pool
- Increase in perceived access to development opportunities through staff surveys
- Increase in utilisation of CPD (Continuing Professional Development) funding to support development

Accountability

- People Board
- NHS Provider Trusts
- Locality Boards

9.5.2 Action: Develop and deliver the Greater Manchester retention plan

- Develop and deliver the Greater Manchester retention plan: focusing on the experience of our health and care people and integrated roles
- Provide a single point of contact for matching workforce and employers through a GM platform.
- Targeted action on nursing, midwifery and AHPs – including student recruitment, placement capacity and promotion of working in GM
- Recruit and retain key primary care roles including GPs, nurses, community pharmacists, NHS dentists and dental nurses working in partnership with HEE
- Support primary care employers to utilise Additional Roles Reimbursement Scheme (ARRS) funding and strengthen the multi-disciplinary approach in primary care
- Support providers with the delivery of the Sustainable Services programme – managing workforce shortages by developing new ways of working to support the system to continue to provide valuable services

Measuring our Delivery

- Increase in student numbers in nursing, midwifery and mental health
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- FTE doctors in General Practice per 10,000 weighted patients
- Direct patient care staff in GP practices and PCNs per 10,000 weighted patients

Accountability

- People Board
- NHS Provider Trusts
- Locality Boards

9.5.3 Action: Embrace digital innovation to improve the way we work – starting with HR digitisation

- Improving workforce data within primary care to support better workforce planning
- Provide a single point of contact for matching workforce and employers through a GM platform
- Embrace digital innovation to improve the way work in a more efficient way, with a focus on digital literacy and exploring different ways of working

- A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on community services, the social care workforce and unwaged carers

Measuring our Delivery

- Increase number of programmes supporting workforce digitisation

Accountability

- People Board

9.6 Area of Focus: Supporting Carers

We recognise the enormous pressures faced by carers, making life harder for the people they are trying to support. As an Integrated Care Partnership, we need to take action to create the conditions to allow our people to provide the best possible care – including our paid and unwaged workforce.

9.6.1 Action: Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

- Implementation of GM Carers' Charter and the Greater Manchester Working Carers' Toolkit
- A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on unwaged carers
- Support for unpaid carers funded through the Better Care Fund (BCF) enabling people to stay well, safe and independent at home for longer
- Embed Carers Exemplar Model consistently across GM
- Further develop and promote tools and opportunities for supporting working carers
- Launch best practice for carers in ethnic minority communities
- Develop products to support primary care to identify and signpost carers

Measuring our Delivery

- 10,000 uses of SNOMED CT (an electronic health record) contingency code for carers in 22/23 (10% of 24/25 target below per region)
- 2,000 young carers identified by uses of SNOMED CT in 22/23 (10% of 24/25 target below per region)

Accountability

- GM Directors of Adult Social Care

10 Achieving financial sustainability

Financial sustainability - 'living within our means' - requires an initial focus on financial recovery to achieve a balanced position. We will identify the main reasons for financial challenges in Greater Manchester, and implement a system wide programme of cost improvement, productivity, demand reduction and service transformation.

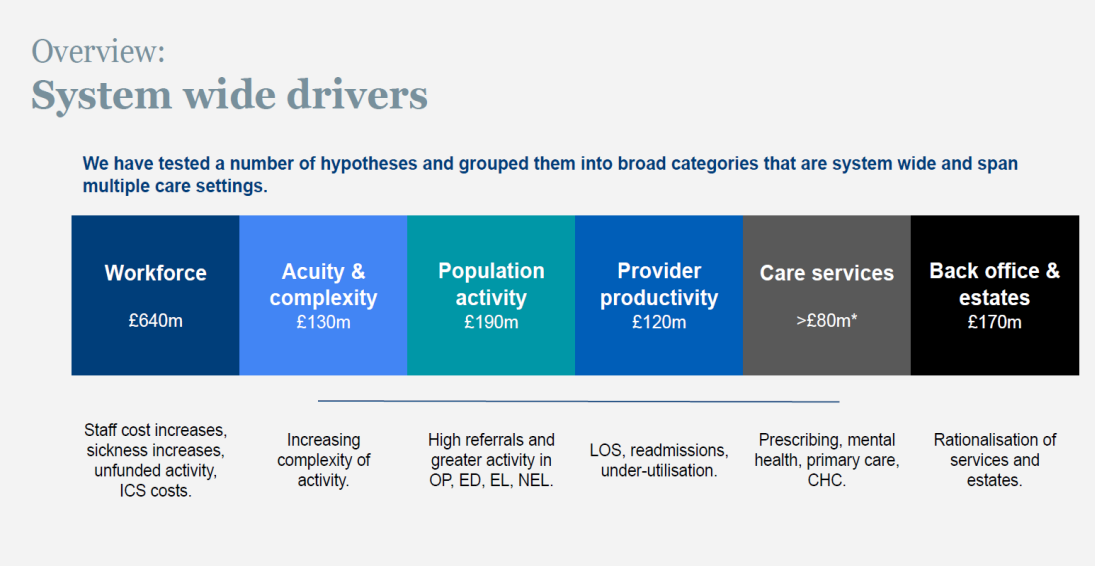
The Greater Manchester system has both an efficiency and a productivity challenge. NHS GM inherited a system structural budget deficit (commitments over revenue) of over £500 million (out of a total budget of £6.5 billion) on its establishment on 1st July 2022. This reflects the ongoing cost of additional resources (mainly workforce) put in place during the COVID-19 pandemic. One of the national requirements of an ICB is to bring the system into balance

Achieving financial sustainability Delivery Leadership: Locality Boards; PFB System Leadership: Finance and Performance Recovery Board	
Areas of focus	**Actions**
Finance and Performance Recovery Programme	System recovery programme based on drivers of operational and financial performance
Developing Medium Term Financial Sustainability Plan	Development of three-year financial plan

10.1 Area of Focus: Finance and Performance Recovery Programme

Our system is under significant financial and operational pressures with the position having worsened due to the impact of COVID-19. To build the foundations for long-term sustainability we will put in place a recovery programme covering both finance and performance. The first step we took in early 2023 was to deepen our understanding of what is driving our current challenges. Figure 9 shows one of the outputs of this exercise with the drivers set out in broad system categories.

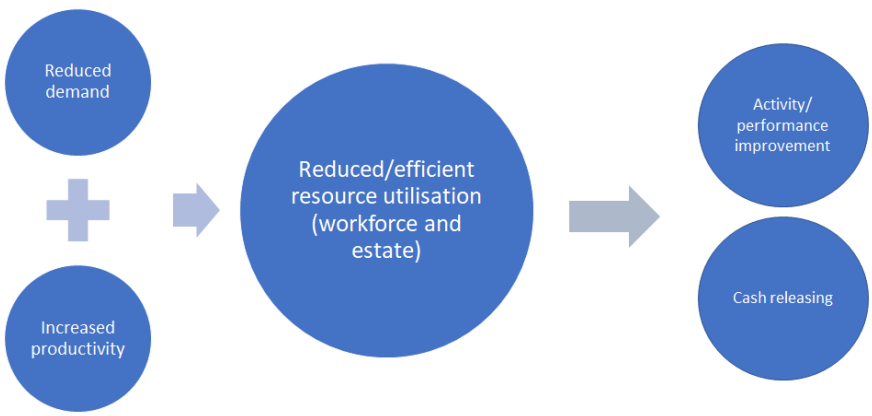
Figure 9



**Currently only includes medicines management, delayed discharges, CHC and small MH opportunities. It is likely that this number will grow when further analysis is undertaken.*

As part of our approach, we need to better understand and act on our performance on productivity (which has declined since 2019/20) Improved productivity will create activity or cash benefits (Figure 10).

Figure 10



Measuring our Delivery

- Return of System to Recurrent Financial Balance

Accountability

- Finance and Performance Committee

10.2 Area of Focus: Securing Long-Term Financial Sustainability

It is recognised that GM needs to move into a more sustainable position in terms of finance, performance and service sustainability. Specifically, that the system can plan and deliver financial and performance objectives without a sense of crisis or non-recurrent interventions. This is more than a single year task.

10.2.1 Development of three-year financial plan

Stakeholders from across the ICS have identified 13 improvement opportunities following the diagnostic into GM's drivers of operational and financial challenge. Reforming how the system operates in these areas will be key to our securing long-term transformation and financial sustainability.

Theme	Transformation Opportunities
Workforce	1. Identify opportunity to 'right size' the workforce across GM 2. Plan to identify shared services business model across corporate functions
Acuity and Complexity	3. GM System High Impact Care model 4. Digital Health Model
Population Activity	5. System review of volume of Outpatient referrals
Provider Productivity	6. Reduce DNAs through patient engagement 7. Reduce Non-Elective Length of Stay 8. Improve Outpatient Performance 9. Improve Theatre Throughput
Care Services	10. Mental Health Operational Processes and Demand and Capacity Review 11. Discharge to Adult Social Care Process Review
Corporate Functions and Estates	12. Optimised Estate 13. Maximise value of tech assets and licenses

This work will support the GM system moving to a multi-year planning cycle. Within this, we propose to start the planning process much earlier in the financial year – allowing us greater scope to align our approach across the system; confirm our priorities; and mitigate key risks. This will also support greater integration between NHS and local authority planning – including our approach to budget setting. Our approach would be to set out our plans and then make any adjustments to these based on the national NHS guidance.

Measuring our Delivery

- Return of System to Recurrent Financial Balance

Accountability

Finance and Performance Committee

11 How We Will Deliver

11.1 Performance Framework

The ICP strategy contains four high-level outcomes (what we are aiming to achieve) and six missions (what we will do – our actions) which will together lead to the outcomes. This relationship is shown in the table below:

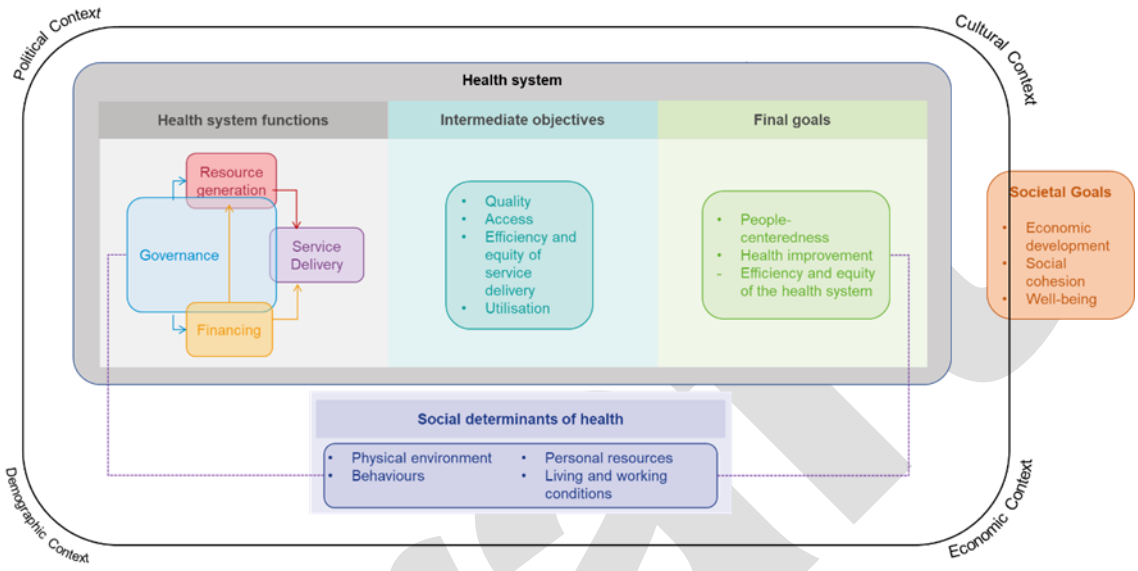
Health and care services are integrated and sustainable	Everyone experiences high quality care and support where and when they need it	Everyone has improved health and wellbeing	Everyone has an opportunity to live a good life
Achieving financial sustainability • Delivery of a balanced recurrent ICB and system financial position ***Supporting our workforce and our carers*** • Increase in Good Employment Charter membership from the health and care sector • Number of health and care organisations paying the RLW	***Recovering core NHS and care services*** • Year-on-year improvement in meeting national targets for core services • Equitable service provision across all areas in Greater Manchester	***Helping people stay well and detecting illness earlier*** • Life Expectancy and Healthy Life Expectancy • Avoidable mortality rates • Reductions in health inequality in the onset of multiple morbidities • Physical activity • Smoking prevalence • Obesity	***Helping people get into, and stay in, good work*** • Number of people starting work • Number of people staying in work ***Strengthening our communities*** • Reduced anxiety • Improved life satisfaction • Feelings of safety

Both the outcomes and the missions are interlinked and depend on each other. We have developed a framework for performance to be assured and assessed and accountability to be clear. This framework applies to both the activities under the direct influence and resourcing of NHS GM and the social determinants of health. Both are essential to improving the health of our population and delivering our strategy.

Our approach is based on a revised version of the framework selected by the University of Manchester research team for their analysis of the effects of health and social care devolution and the World Health Organisation (WHO) Health System Performance Assessment (HSPA) framework

This framework shows how the health system – its functions, intermediate objectives and final goals - and the social determinants of health act together to influence societal goals, within a political, socio-economic, demographic and cultural context. This is illustrated in Figure 11.

Figure 11



NHS England requires reporting against the objectives it sets for the NHS in England (NHS Oversight Framework metrics). For 2023/4 there are 56 measures across the domains defined by NHSE as:

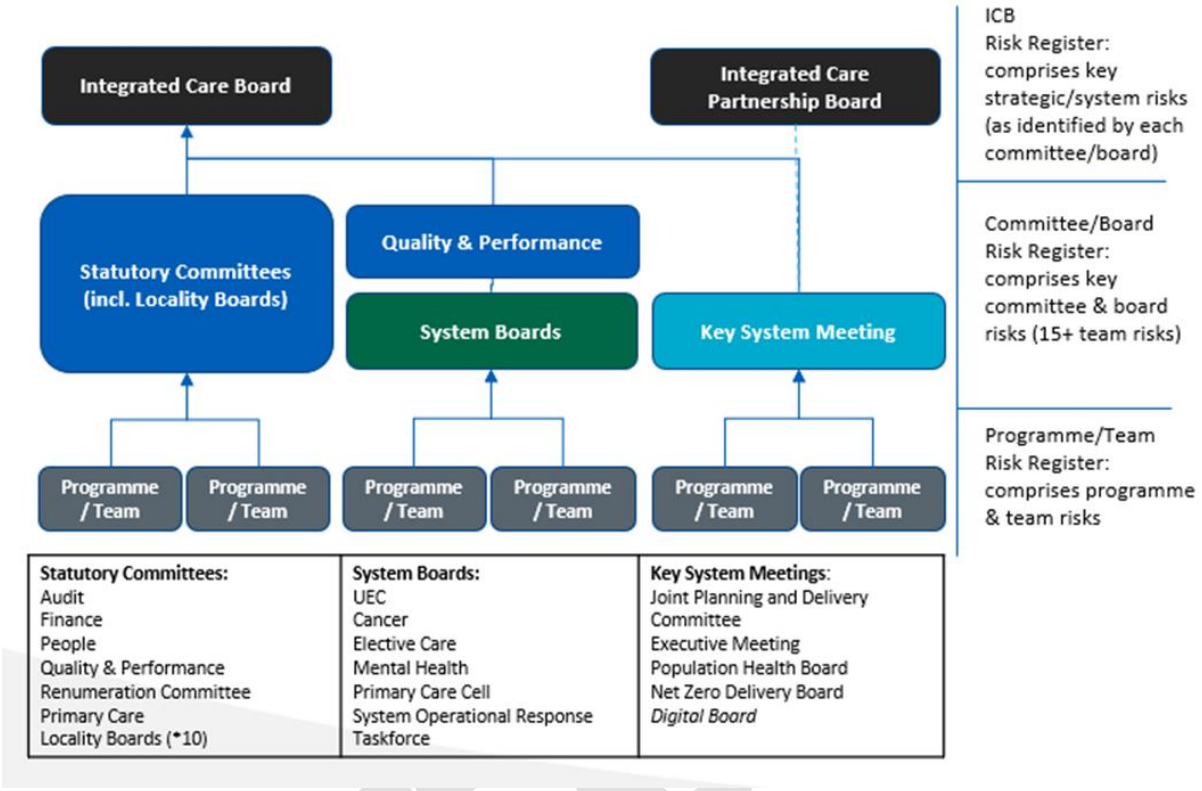
- Quality of care, access and outcomes (34 measures)
- Preventing ill health and reducing inequalities (8 measures)
- Leadership and capability (3 measures)
- Finance and Use of Resources (4 measures)
- People (7 measures)

We will use all these measures to assess progress against this plan but will also add others to enable a balanced view of performance across the whole health system and its wider context. These will be mapped to the sections of the performance framework.

11.2 Assurance and Governance Arrangements

We will manage delivery and risk through our governance and assurance arrangements – these are shown in Figure 12.

Figure 12



The delivery of our operational plans will be overseen by a Finance and Performance Recovery Board, which will be responsible for assuring delivery of the GM operational plan, providing overall system oversight and direction.

Through its membership reporting will flow into the various statutory organisations within the system.

It will be supported by

(a) A Finance and Workforce Group: responsible for

- Having oversight of the overall GM financial plan / position
- Tracking delivery of system/organisation Cost Improvement Plans (CIPs) and Quality, Innovation, Productivity and Prevention (QIPP) plans
- Alignment of workforce planning with financial recovery
- Overseeing implementation of specific projects relating to financial recovery

(b) A Performance and Delivery Group: responsible for

- Resolving planning risks
- Gaining greater assurance of delivery of high risk plans

- Tracking achievement of GM planning assumptions
- Overseeing implementation of specific projects to achieve either performance or financial objectives.

11.3 Commissioning

The 2022 Health and Care Act entailed significant structural change for NHS commissioning with NHS Greater Manchester Integrated Care becoming responsible for the commissioning responsibilities of CCGs, as well as taking on several commissioning functions from NHSE (with a plan for further delegation over time).

We are working with partners across GM to optimise the way we commission services and realise the efficiencies from bringing twelve organisations into one. We will confirm our plans in 2023/24.

11.4 Locality plans

Our ten localities in Greater Manchester - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan - all have local authority plans (or strategies), locality plans for health and care and Health and Wellbeing plans. The Joint Strategic Needs Assessments (JSNAs) in each locality have specifically informed the Health and Wellbeing plans, as well as the other plans.

These plans have informed our ICP Strategy and this Joint Forward Plan. As set out in this document, a significant proportion of this plan will be delivered by our 10 localities.

Links to each of these plans for each of the localities, where information is available at time of writing, are given in the table below, along with a link to the Health and Wellbeing Board in each locality. This information will be updated as plans in localities are updated. A summary of the plans can be found in Appendix 2.

A draft of this plan was sent to each Health and Well Being Board (HWB) in GM for comments. When the plan is updated, it will be shared with HWBs for comment and feedback will be incorporated.

Locality	Local Authority Plans/ Corporate Plans	Health & Care (Locality) Plans	Health & Wellbeing Plans Health and Wellbeing Board
Bolton	Bolton Vision 2030 (currently being updated)	Currently being updated	Same as LA plan **H&WB Board**: Active, Connected and Prosperous Board 2014 Onwards > The Active, Connected and Prosperous Board (bolton.gov.uk)
Bury	Let's Do It! Strategy (bury.gov.uk)	 221222 locality plan refresh v3.1.docx	Same as LA plan **H&WB Board:** Browse meetings - Health and Wellbeing Board - Bury Council
Manchester	Our Manchester Strategy- Forward to 2025 | Manchester City Council	Refreshed 2021 - 5 yr. strategy  Manchester Locality Plan Refresh v2.0 MPI Priorities for adults and children (2023-2026)  MPB priorities - 2 slides.pptx	Making Manchester Fairer https://www.manchester.gov.uk/makingmanchesterfairer **H&WB Board** Browse meetings - Health and Wellbeing Board (manchester.gov.uk)
Oldham	Corporate Plan | Corporate Plan | Oldham Council - 2022-27	currently being updated	Currently being updated **H&WB Board:** Committee details - Health and Well Being Board (oldham.gov.uk)
Rochdale	https://www.rochdale.gov.uk/downloads/download/393/corporate-plan	Rochdale Borough Locality Plan 2020-2024	Same as locality plan **H&WB Board** https://democracy.rochdale.gov.uk/mgCommitteeDetails.aspx?ID=558
Salford	Our priorities, the Great Eight • Salford City Council	Salford Locality Plan 2020-25 (partnersinsalford.org)	Same as locality plan **H&WB Board** Browse meetings - Health and Wellbeing Board • Salford City Council
Stockport	borough-plan.pdf (onestockport.co.uk)	Enc 1 - One Health and Care Plan.pdf (stockport.gov.uk)	Same as locality plan **H&WB Board** https://www.stockport.gov.uk/health-and-wellbeing-board
Tameside	'Our People Our Place Our Plan'	Currently being updated - will be a joint locality and H&WB Plan	Currently being updated **H&WB Board** https://tameside.moderngov.co.uk/mgCommitteeDetails.aspx?ID=221
Trafford	Corporate-Plan-2021-2024.pdf (trafford.gov.uk)	2021 refresh Trafford Together Locality Plan (traffordpartnership.org)	2019-2029 Trafford Health and Wellbeing Strategy 2019.pdf **H&WB Board:** Health and Wellbeing Board (traffordpartlonership.org)
Wigan	The Deal 2030 (wigan.gov.uk)	Currently being updated - Due Sept 23	Currently being updated - Due Sept 23 **H&WB Board:** Committee details - Health and Wellbeing Board (wigan.gov.uk)

11.5 Implementing this Plan – Next Steps

This is the first delivery plan for the Integrated Care System in Greater Manchester. In developing this plan, we are clear that we must maintain our focus on making best use of our resources and achieving the best outcomes for our residents.

This means that we will continue to develop this plan after this first version is finalised at the end of June 2023.

The steps we will take following the publication of this plan will focus on confirming our approach to long-term financial sustainability. The steps we will take are:

- Setting out in detail the phasing of all the programmes set out in this plan – across years 1,2 and 3 of the plan and prioritising those initiatives that will have the greatest impact
- Ensure that all elements of the plan are costed in line with our medium-term financial plans and ensure we are maximising efficiency across the range of our activity
- Continue to strengthen the delivery metrics and accountability arrangements
- Quantify the population health potential of a fundamental shift in demand and a greater emphasis on early intervention and prevention. This will include modelling across all care settings. This needs to extend across all points of delivery
- Drawing on this, confirm the process to undertake the population level segmentation and analysis for the longer-term transformation
- Informed by this, position the key choices the GM system will need to make to deliver on long-term financial sustainability and continue to improve health outcomes

Appendix 1

How this plan addresses the statutory requirements for a JFP

The legislative requirements for the JFP[14] – which relate to the statutory responsibilities of the ICB – are summarised below, along with how they are covered in this plan.

Legislative requirement	GM response
Describing the health services for which the ICB proposes to make arrangements.	Covered particularly in our missions for: • Helping people stay well and detecting illness earlier • Recovering core NHS and care services • Supporting our workforce and carers
Duty to promote integration	As part of a mature partnership model in GM, working across sectors, this plan ensures that the ICB develops activities and works in ways which promote and enable integration. Going beyond the legislative requirements, the integrated approaches adopted in GM ensure that health services, social care and health-related services and designed and delivered in ways which align to support attainment of the whole systems shared outcomes and commitments.
Duty to have regard to wider effect of decisions	The outcomes we have defined through the strategy and that will be delivered through this plan, have been developed in ways which ensure we are clear on the impacts of our decisions, and responsive to the 'triple aims' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.
Financial duties	Described in our mission for: • Achieving financial sustainability

[14] https://www.england.nhs.uk/long-read/guidance-on-developing-the-joint-forward-plan/#appendix-1-legislative-framework-further-detail

Legislative requirement	GM response
Implementing any JLHWS	Our locality (health and care) and Health and Wellbeing Plans are all linked from this plan (section 11.4) and summarised in Appendix 2. They are aligned with this plan.
Duty to improve quality of services	Covered in our missions for: • Helping people stay well and detecting illness earlier • Recovering core NHS and care services. Our quality strategy is a specific action in this mission.
Duty to reduce inequalities	The activities we deliver through this plan seek to reduce unwarranted inequalities in outcomes, service experience and access for all people and parts of Greater Manchester, as described throughout. One of our ways of working (section 4.2) specifically emphasises this duty
Duty to promote involvement of each patient	In addition to this being one of our ways of working (section 4.2), it is also a fundamental element of our Model for Health and Wellbeing. It is also a focus of our missions for: • Strengthening our communities and • Helping people stay well and detecting illness earlier.
Duty to involve the public	The strategy was developed through extensive consultation and engagement with communities, partner agencies, practitioners and staff, across all ten localities (section 2.4). The process of development was iterative, developing and adapting to the feedback received and ensuring the strategy and this plan are reflective of the needs and expectations of our communities.
Duty to patient choice	This is implicit in our mission for recovering core NHS and care services
Duty to obtain appropriate advice	As part of the network of governance which oversees and supports the delivery of this plan the ICB has access to and routinely draws upon appropriate advice and guidance from partners, stakeholders and experts.
Duty to promote innovation	Innovation is a specific action in the mission for Recovering core NHS and care services (section 8.5.2), and draws on our assets in Health Innovation Manchester

Legislative requirement	GM response
Duty in respect of research	Utilising the research expertise in our city region, and building on working relationships we already have, we will ensure our responses to these challenges are data driven, drawing on the best possible evidence to support the design and delivery of our actions, as described in section 8.5.2.
Duty to promote education and training	Covered in our mission for: • Supporting our workforce and our carers
Duty as to climate change, etc.	As partners in Greater Manchester, we share the GMS vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region. The NHS contribution to this (section 5.3.1) is an area of focus in our mission for: • Strengthening our communities
Addressing the particular needs of children and young persons	This is a specific action in our mission for strengthening our communities (section 5.2.4) and is also covered in a number of other sections including sections 6.1.2 and 6.2.5.
Addressing the particular needs of victims of abuse	A specific action in our mission for strengthening our communities (section 5.2.6), and part of a GM approach to violence reduction.

Appendix 2

Our locality plans[15]

Bolton

The health and care (Locality) plan is currently being updated. The Health & Wellbeing Plan is the Local Authority Plan.

Bolton Vision 2030 is a local partnership that brings together senior leaders from the voluntary, community and faith sector, the private sector, the university, college and schools, health, emergency services and the council. Bolton 2030 is the long term vision for the borough. The vision partnership wants to see a Bolton which is ACTIVE, CONNECTED AND PROSPEROUS

Principles

The vision is supported by a set of principles:

- Generating inclusive growth and prosperity which reaches all corners of communities and benefits all citizens
- Protecting the most vulnerable whilst recognising that they are members of their communities and can have much to offer
- Reforming services in partnership in order to maximise the impact of activities and create sustainable change in communities.

Outcomes

Bolton 2030 is built around 6 outcomes for their people and places. These are:

- **Start Well:** Our children get the best possible start in life, so that they have every chance to succeed and be happy
- **Live Well:** The health and wellbeing of our residents is improved, so that they can live healthy, fulfilling lives for longer
- **Age Well:** Older people in Bolton stay healthier for longer, and feel more connected with their communities
- **Prosperous:** Businesses and investment are attracted to the borough, matching our workforce's skills with modern opportunities and employment
- **Clean and Green:** Our environment is protected and improved, so that more people enjoy it, care for it and are active in it
- **Strong and Distinctive:** Stronger, cohesive, more confident communities in which people feel safe, welcome and connected

[15] Correct as of 31 May 2023

Bury

The Health & Wellbeing Plan is the Local Authority Plan

Bury's refreshed Locality Plan (2023) is a refresh of their strategy for health and care and wellbeing in the borough. It sits in the context of the overall strategy for the borough – "Let's Do It". This plan – like its predecessors - has at its core the ambition to fundamentally improve population health and wellbeing, and to reduce health inequalities. This is important to ensure Bury residents can lead the lives they want, but also to create a financially sustainable health and care system that is characterised by prevention of poor health, and early intervention, rather than reactive and costly service provision.

Bury has four overarching outcomes for the Locality Plan:

1. A local population that is **living healthier for longer** and where healthy expectancy matches or exceeds the national average by 2025.
2. A **reduction in inequalities** (including health inequality) in Bury, that is greater than the national rate of reduction.
3. A local health and social care system that provides high quality services which are **financially sustainable and clinically safe.**
4. A greater proportion of local **people playing an active role in managing their own health** and supporting those around them.

The objectives of the refreshed locality plan are:

1) We will seek to **influence the factors that improve population health** and well-being and reduce health inequalities and foster inclusion
2) We will **support residents to be well, independent, and connected** to their communities and to be in control of the circumstances of their lives
3) We will support **residents to be in control of their health and well being**
4) We will **support children to 'start well'** and to arrive at school ready to learn and achieve
5) We will **support people to take charge of their health and care and the way it is organised around them, and to live well at home**, as independently as possible
6) We will ensure all residents **have access to integrated out of hospital services** that promote independence, prevention of poor health, and early intervention and where front-line staff are working together in 5 neighbourhood teams
7) We will work to ensure **high quality responsive services** where people describe a good experience of their treatment
8) We will work to **control the overall costs of the health and care system** by earlier intervention, prevention, and working with the strengths within people, families, communities

A range of Transformation Programmes are described including Urgent and Emergency Care; Learning Disabilities; Elective care; Cancer Services; End of Life Care Pathway; Primary Care; Mental Health; Community Services; Adult Social Care; Children's Health and Care and Public Health.

Manchester

The 2021 refresh of Manchester's Locality Plan, Our Healthier Manchester, seeks to reaffirm their ambition to create a population health approach that puts health at the heart of every policy, improving health and care outcomes for the people of Manchester, whilst recognising that plans for the future will need to continue to evolve and respond to those changing needs, within a new governance structure.

Manchester's Locality Plan has five strategic aims and key intended outcomes:

- Improve the health and wellbeing of people in Manchester
    - Narrow the life expectancy gap between the city's residents
    - Improved health & wellbeing, quality of life
    - Reduction in preventable deaths (all causes).
- Strengthen the social determinants of health and promote healthy lifestyles
    - Reduction in smoking prevalence to 15% or lower by 2021
    - Increase in the number of children who are school ready
    - Reduction in residents who are out of work due to an underlying health condition/disability.
- Ensure services are safe, equitable and of a high standard with less variation
    - All providers have a CQC rating of good or above
    - All national and local quality standards are met.
- Enable people and communities to be active partners in their health and wellbeing
    - Increase the level of knowledge and confidence that people have in managing their own health.
- Achieve a sustainable system
    - Achievement of financial balance across the system
    - Achievement of constitutional and statutory targets
    - Developing a sustainable workforce.

Manchester's Health and Wellbeing Plan is the 'Making Manchester Fairer' Plan 2022-2027 which has 8 themes focused on tackling health inequalities:

1) Focus on giving children the best start in life
2) Addressing poverty. This affects everything, especially set against the cost-of-living crisis
3) Good work is good for your health
4) Focus on preventing ill health and preventable deaths, so this will also include the four big killer diseases/conditions in Manchester
5) Homes and housing
6) Places, environment and climate change
7) Tackling systemic and structural racism and discrimination
8) Focus on communities and power, so that we concentrate on what really matters to our local communities and residents, and so that they are heard and influence what we do. This includes acting on the voices of those who are often less heard.

Oldham

Locality Plan currently being updated – due July 2023

The Oldham Health & Wellbeing Strategy (2022-30) does not represent the extent of their commitment to health and wellbeing or all the work on health and wellbeing taking place in the borough but focuses on some of the issues which make the greatest contribution, and where they can have the biggest impact in the shortest amount of time, working together. The overall aim for the Health and Wellbeing Strategy is to close the gap in life expectancy between Oldham and England as a whole.

Vision
Oldham residents are happier and healthier; they feel safe, supported and they thrive in this vibrant and diverse borough.

Ambition
People lead longer, healthier, and happier lives, and the gap in health outcomes between different groups and communities in Oldham, and between Oldham and England, is reduced. A demonstrable difference will be made to the average life expectancy and average healthy life expectancy of residents, and inequalities will be reduced.

Principles

Oldham are resident-focussed, this means they are:

- Having a two-way conversation with residents about their health and wellbeing, making sure residents feel heard and that needs are responded to in ways that can be understood by all
- Building trust and strengthening relationships with residents through kindness and compassion
- Engaging with communities to co-produce solutions and co-design services
- Providing support and care which is as close to, and as connected with, home and community as possible

We have a well-managed health and care system:

- Which provides good quality, safe services, and we use resident feedback to continually improve
- With services which are easy to access, and transition between different services is seamless; digital solutions are embraced where appropriate
- Which uses data, intelligence, and insight to plan services and improve the coordination of care
- Ensuring best value for the Oldham pound and maximising the wider social, economic, and environmental benefits of public spending

We are champions of equality; we are:

- Striving to reduce inequalities, offering more to those who face the greatest disadvantage or experience the worse outcomes
- Recognising diversity and delivering culturally competent services

- Developing a workforce which represents the community
- Focussing equally on mental health and emotional wellbeing, and physical health

We prioritise prevention by:

- Promoting wellbeing and prevention of ill-health for residents in all life-stages
- Providing residents with easy access to the information and support that need to stay well, healthy and be independent
- Taking a whole-system view for each of our residents, taking account of wider determinants and past experiences to provide the most appropriate and effective care
- Recognising the importance of voluntary, community and faith organisations in improving health and wellbeing, and making the most of existing community assets and insight

Oldham's Priorities

- Supporting our residents to gain the knowledge and skills to confidently make choices and participate in decisions about their own health
- Giving children the best start in life
- Improving mental wellbeing and mental health
- Reducing smoking
- Increasing physical activity

Rochdale

The Health & Wellbeing Plan is the Local Authority Plan

The Rochdale Locality Plan 2020-24 – 'Co-operating for better health and wellbeing' - sets out how they will do all they can so that residents in the borough live long and happy lives that are as healthy as possible, for as long as possible. If achieved, it will mean that they will have '**improved the health, care and wellbeing outcomes for the borough of Rochdale'.** They will work together in partnership so that '**everyone in the borough will make things better for themselves and others'.**

To do this, Rochdale have established six core principles, or ways of working across their partnership of stakeholders (including residents). These six principles run through every aspect of the plan and are core to how they operate. These principles are set out below.

- Co-operation
    - Public services, partners, citizens, businesses and the voluntary sector will share decision making and jointly design and deliver services.
- Prevention and intervention
    - Prevention will be part of everything they do, and they will support their residents and workforce to take care of themselves and others.

- Integrated and local
    - Public services, partners and the voluntary and community sector will share skills, expertise and resources to deliver person and community centred services at the right time and in the right places for residents.
- Strengthening community assets
    - Individuals and families will be supported to use their skills, experience and collective kindness to improve communities.
- Collective change
    - They will work together to change things so that Rochdale will have sustainable services and have reduced inequalities.
- Addressing the climate emergency
    - Rochdale will increase efforts to ensure that they consider and reduce the negative impacts that services and activities have on the environment

Strategic workstreams

- Further developing **Integrated Strategic Commissioning**
- Further establishing the **Local Care Organisation**
- Delivery of a programme of **transformation** in order to reduce demand, improve outcomes and reduce inequalities
- Strengthening a range of **enablers** to support this work; Workforce, Health and social care intelligence, Estates, Digital and Finance.

Salford

Locality plan is also the Health and Wellbeing Plan

The 2020-2025 refreshed Salford Locality Plan is the link between understanding of needs and opportunities in health and wellbeing, and the coordinated response to them. Right across Salford, all partners are committed to improving health and wellbeing and to reducing health inequalities and maximising the social value return to Salford. Pooling of the great majority of the health and social care budget, and greater transparency on the rest, is helping Salford to invest in prevention, to prioritise spend on areas most needed, and to mitigate the impact of reducing resources on the most vulnerable and on health inequalities.

Vision: Salford is a place where everyone can enjoy the best opportunities that Salford has to offer. People in Salford will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health well into their older age and die in a dignified manner in a setting of their choosing. People across Salford will experience health on a parallel with the current 'best' in Greater Manchester (GM), and the gaps between communities will be narrower than they have ever been before.

Core outcomes

1) People will live longer, and those years will be lived in good health
2) The gap in life expectancy between the most and least deprived communities in the city will be reduced

Starting well outcomes

- I am a child who is physically and emotionally healthy, feel safe and able to live life in a positive way
- I am a young person who will achieve their potential in life, with great learning, and employment opportunities
- I am as good a parent as I can be.

Living well outcomes

- I lead a happy, fulfilling and purposeful life, and I am able to manage the challenges that life gives me.
- I am able to take care of my own health and wellbeing and I am supported to care for others when needed.
- My lifestyle helps me to stop any long term condition or disability getting worse and keeps the impact of this condition or disability from affecting my life.

Ageing well outcomes

- I am an older person who is looking after my health and delaying the need for care.
- If I need it, I will be able to access high quality care and support.
- I know that when I die, this will happen in the best possible circumstances.

Strong and resilient communities

- I feel safe and connected, and able to influence the decisions that affect me.
- I feel supported to make healthy choices in the places where I live, work, volunteer or visit.
- I have opportunities to contribute, and benefit from, a strong economy with quality local jobs.

There are a number of cross-cutting enablers that will facilitate delivery of the plan through workforce, estate, supportive technology, and a focus on quality and social value.

Stockport

Locality plan is also the Health and Wellbeing Plan

ONE Stockport - the Borough Plan - is based on the priorities which have come from extensive engagement with the people who live and work in Stockport. Health and Wellbeing are at the forefront of Stockport's vision for 2030 and a key priority for local people. Stockport believe that the best way to deliver their vision is through collaboration across the wide range of partners who support health and wellbeing for local people.

The locality plan – ONE Stockport Health & Care Plan - sets how they will work together as a system to deliver ONE Stockport's vision for **a Healthy and Happy Stockport.** Stockport's vision for 2030 sees everyone working together to develop a borough which is inclusive, caring, enterprising and full of ambition. They want people to live the best lives they can and feel happy, healthy, included, and independent.

Their principles are:

- Person-centred
- Place-based
- Outcomes-focused
- Strengths and asset-based
- Fair
- Sustainable

Stockport intend to deliver each of the health and care commitments in the borough plan through eight delivery programmes:

- Quality & Leadership
- Early Help & Prevention
- Independence & Reablement
- Mental Health & Wellbeing
- Tackling Inequalities
- Stockport's Neighbourhoods
- Age-Friendly Borough
- Valued Workforce

The impact of these changes will be seen in the following outcomes:

- Stockport residents will be healthier and happier
- Health inequalities will be significantly reduced
- Safe, high quality services will work together for you
- Stockport residents will be independent and empowered to live their best lives

Tameside

Currently being updated (Joint Locality and Health and Wellbeing Plan) – Timescales TBC

Trafford

The Trafford Together Locality Plan 2019-24 was first agreed in November 2019, and the plan has been refreshed in 2021 in light of the changing context and the formation of the Integrated Care System. The refresh, like the 2019 Plan, is based on 4 main priorities; Our Population, The People We Serve, The Place Where We Live and Work, and The Partnerships We Create. There are three main aspirations for this plan: better lives for Trafford's most vulnerable people, better wellbeing for their population and better connections across their communities.

The principles in the 2019-24 Plan remain a key focus; Together as Partners – co-ordinating across the health and social care system, thinking bigger and doing better using combined resources to improve outcomes for residents.

- In a Place – being positive about places and spaces, bringing people who live and work in an area together to build stronger communities.
- With People – putting residents at the heart of what they do, listening and working with people.
- Focusing on Prevention – commitment to taking action early and making every contact count.
- Continually improving – making the most of technology and using data and information to make shared decisions. Continuing to learn and develop workforce and make the best use of combined assets

Trafford has 4 Strategic Design Groups:

- Living Well in My Community
- Living Well at Home
- Short Stay in Hospital
- Our Ambition for Children in Trafford

The Health and Wellbeing Board is focussed on its residents' journeys through life, taking a life course approach that reflects the public health needs of that age group. Through the Health & Wellbeing Strategy they aim to improve outcomes at each stage while ensuring that seven overarching priorities (below) are considered, and ensuring interventions are evidence based, measurable and add value.

1. To reduce the impact of poor mental health
2. To reduce physical inactivity
3. To reduce the number of people who smoke or use tobacco
4. To reduce harms from alcohol
5. To reduce poverty
6. Reduce the impact of climate change
7. Healthy Weight

Wigan

Locality and Health and Wellbeing Plan currently being updated – expected Sept 23