Manchester City Council
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 14 November 2012

Subject: Joint Health and Wellbeing Strategy

Report of: David Regan, Director of Public Health

Summary

At its last meeting, the Board approved proposals for the structure of the Joint Health and Wellbeing Strategy, production of which will be a requirement on the Board from April 2013. This paper is a draft of that strategy which has been prepared by the Driver Group and other colleagues over the last two months. Some points of detail remain to be resolved, particularly around measurement of the outcomes, but the key strategic direction and areas for action are now clear and the Driver Group is now seeking the Board's approval for these prior to wider stakeholder engagement.

Following review at the Board the Driver Group will produce a further iteration of the strategy and a process for engagement with other stakeholder bodies (such as the Children's Board and the Work and Skills Board) and with the wider community. It is proposed that:

- the Chair be delegated authority to sign off the draft for engagement
- an interim report on the progress with wider engagement be brought back to the Board in January
- a revised strategy following this period of engagement be brought back to the Board in March for approval.

Recommendations

The Board is asked to:

1. comment on the attached draft, in particular on the vision section (section 2) and on the outcomes within each of the strategic priorities;
2. note the proposed process for further development and wider engagement described above.

Board Priority(s) Addressed : All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Document Title	Joint Health and Wellbeing Strategy
Author	HWB Driver Group
Owner	Health and Wellbeing Board
Date	2 November 2012
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Status	Draft

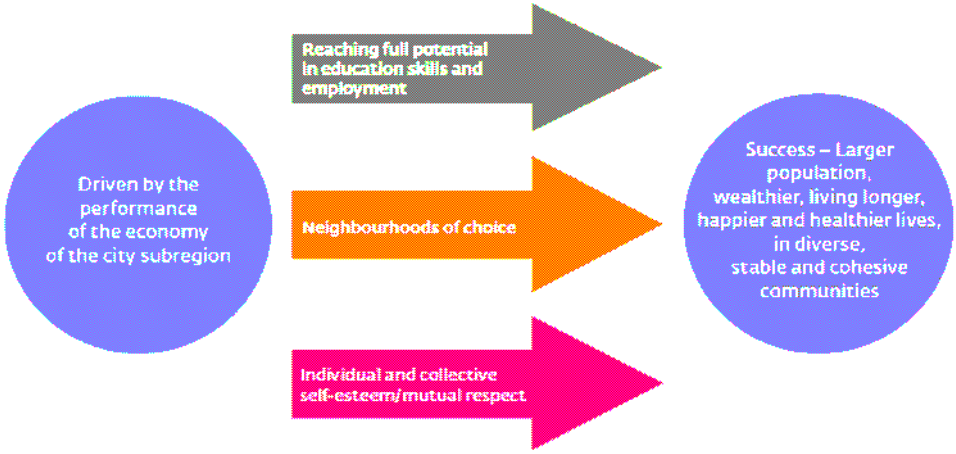
1. Introduction

1.1 The Manchester Health and Wellbeing Board is made up of the most senior leaders from all the main organisations involved in improving health and care in the city. Membership covers the City Council's services for children and adults, including public health; the city's three Clinical Commissioning Groups, which are made up of primary care providers and which commission secondary care services for the people of Manchester; the four main NHS Trusts in the city, which provide hospital, community health, mental health and public health services; and representation from the community and voluntary sector. This board has been formed to make sure that we are all working together to improve health and wellbeing in the city.

1.2 Across the whole country, health and social care services are changing. Partly this is in order to meet changing expectations and patterns of demand for services; partly it is in response to rising costs and reducing budgets. This strategy sets out how Manchester is responding to these two challenges. It begins by setting out our shared vision for what health and care in Manchester will look like in future and then goes on to describe our priorities for action in more detail, including what we want to achieve, how we plan to achieve it, and how we will measure whether we've succeeded.

1.3 The strategy has been informed by and should be read alongside the city's Joint Strategic Needs Assessment, which identified key priorities for the city and makes recommendations for commissioners about what needs to be done to address these priorities.

1.4 This strategy is an important part of the city's overall Community Strategy, which describes the long term aims for the city, as set out in the diagram below.



1.5 This strategy has an impact on all three of the central "spines" of the Community Strategy, and ultimately on many of the outcomes that the Community Strategy identifies as most important for the city.

2. Vision

2.1 Our vision for health, wellbeing and life chances in Manchester is a radical one. We want to see a major shift in the focus of services towards prevention of problems and intervening early to prevent existing problems getting worse. And we want to see a shift towards services provided closer to home.

2.2 So what will be different in 10 years?

The people of Manchester will be living longer, healthier and more fulfilled lives because:

- the city is a place where they choose to live and stay as it:
  - is safe
  - provides the opportunity to work
  - gives access to affordable housing and leisure
  - offers a wealth of opportunities to enjoy a good quality of life;
- the life they have, the employment they are in and the skills they have developed give them a real sense of purpose and the confidence and aspiration to achieve and believe in themselves;
- regardless of age or ability, they feel that they have:
  - a valuable role to play and are making a positive contribution to their family and community
  - a sense of belonging and take a pride in the communities where they live;
- they are using information and advice and taking the opportunities that help them make the best choices about how they live their lives and stay fit for work and recreation;
- they see the benefit of being independent and are less reliant on public services but know that, when needed, the most vulnerable will be supported;

- they understand what to expect from public services and are using these in a responsible way;
- they have trust and confidence in the services that are provided, knowing that they are accessible and right for them and their families;
- their symptoms and problems are diagnosed early and they receive the best interventions from the right people, in the right place, at the right time;
- everything is being done to help them to have an independent and active life and to regain this following illness;
- children in the very earliest stage of their lives are getting off to a good start because their parents have the right skills, knowledge and local support;
- adults in the family and community are strong positive role models for children and young people;
- children and young people are making the most of the opportunities and choices that education, training and leisure offer them; and
- older people are treated with dignity and respect, are able to live safely and independently and continue to add value to their community with the skills and experience they have.

2.3 In order to achieve our vision for the future, the Health and Wellbeing Board has set out the following broad priorities:

1. Getting the youngest people in our communities off to the best start
2. Educating, informing and involving the community in improving their own health and wellbeing
3. Moving more health provision into the community
4. Providing the best treatment we can to people in the right place and at the right time
5. Turning round the lives of troubled families
6. Improving people's mental health and wellbeing
7. Bringing people into employment and leading productive lives
8. Enabling older people to keep well and live independently in their community

2.4 The remainder of this strategy describes in more detail what is required to achieve these priorities and sets out the key actions that will be taken during 2013/14. In setting out action it draws heavily on the recommendations made in the JSNA as well as reflecting known priorities not covered by the JSNA. It does not attempt to cover every action required, but focuses on those that need to be progressed jointly.

STRATEGIC PRIORITY 1

Getting the youngest people in our communities off to the best start

Background

The vision for the Manchester Children's Board is that children and young people in the City will be healthy, safe, enjoy and achieve in learning and will have the skills, abilities, self-esteem and outlook to access sustainable employment, make a positive contribution to society and be successful in adult life.

Our mission is to ensure that every preschool child gets off to a good start; every child of school age will be ready for, and succeeding in, school; and every young person of school leaving age will be ready for, and succeeding in, further education, employment or training.

Target group(s) for 2013 – 2015

There is growing concern about the impact of current changes and austerity measures on the most vulnerable children and young people in the City. These children and young people could be impacted upon by a number of factors including workless parents, low income, or some form of additional needs, including health needs such as long-term conditions, disabilities, obesity, teenage conception, immunisation and developmental concerns. We need to ensure that any austerity measures do not further disadvantage such children and young people.

The Joint Strategic Needs Assessment identified a number of priorities around children's health and well being including; improving oral health, reducing our level of obesity, and improving emotional, mental health and well-being.

To address these issues in 2013- 2015 we will focus on the following target groups:

- **children under 5 identified as needing support to be ready to start school**
- **children and young people who have early help needs in order to engage effectively with school**

The outcomes we want to achieve by 2015 and how we will measure them

Children at the age of 5 are ready to engage effectively with the school as assessed by a set of agreed outcomes including:

1. Improved uptake of universal services such as immunisation or antenatal care
   Measured by: routine data including on immunisation rate

2. Increased rates of breast feeding and improved oral health
   Measured by: routine data on breast feeding initiation and maintenance and on decayed, missing and filled teeth

3. Reduced numbers of obese and overweight children in reception year
   Measured by: the National Child Measurement Programme

4. Number of parents of the target group being offered, accepting and acting on appropriate early help
   Measured by: ***[DN – measure needed]***

5. Parent and teacher perception of children's readiness for school
   Measured by: feedback from parents and head teachers.

6. Improved performance in the foundation stage profile
   Measured by: ***[DN – measure needed]***

Children aged 5-18 being able to access early help and support as issues are identified. This should include access to prevention and early help relating to needs, for example, mental or emotional health, communication skills, weight management; outcome measures could include

7. Reduction in obese and overweight children in Year 6
   Measured by: the National Child Measurement Programme

8. Reduction in decayed, missing or filled teeth
   Measured by: routine dental care indicators

9. Improvements in indicators of emotional health and well being
   Measured by: ***[DN – measure needed]***

10. Reduction in teenage conceptions *(link with priority 5 troubled families)*
    Measured by: national conception reporting

11. Improved school attendance
    Measured by: ***[DN – measure needed]***

12. Improved school attainment
    Measured by: ***[DN – measure needed]***

We would also hope to see a reduction in the number of young people not in education, employment or training, and in the numbers known to the youth offending services.

We will also look for indicators of earlier identification of and intervention in indicators of developmental delay in young children.

How we will do this

By December 2012 we will have:

- **Developed an Early Help policy paper**: This will articulate the national policy context and enable Children's Board to develop a shared understanding of what it is we want to achieve in Children's Services and across the Partnership.
- **Agreed a vision and city-wide strategy:** This will include full consultation with partners at both a city-wide and SRF level through 'Visioning events'. These will be delivered by the SRF Children's Partnerships and led by the Chairs and members of the Children's Board.
- Agreement of the Early Help strategy by the Children's Board and SRF Delivery Groups
- **Mapped available services offering early help**

By March 2013:

- **Agreed medium and long-term milestones:** These will be developed through the development of the Early Help Strategy.
- **Embed MCAF as an Early Help delivery tool:** This includes delivery of training, specifically to schools, as well as the provision of support if required to those undertaking the lead professional role.
- **Work with the SRF Children's Partnership groups** over the key priorities for their SRF and key activities to improve priorities.
- Work with the SRF Children's on the implementation of key milestones and priorities.

- Agree dataset and baseline for reviewing progress.

By September 2014

- Children's Board completed a review of progress against agreed milestones.
- Children's Board refreshed its prioritisation in consultation with the SRF Delivery Groups and Children's SRF partnership groups.

Who will be accountable for achieving these results

- The Children's Board will have oversight for the overall strategy for this priority. Its representation includes Schools, the Clinical Commissioning Groups, the main service provider Central Manchester Foundation Trust, the chairs of the 5 children's partnerships and the Chair of the Manchester Children's Safeguarding Board as well as representatives from a number of City Council departments and the voluntary sector.
- This strategy will be located at an SRF level and so will seek support and clarification of priorities through the SRF delivery groups.
- The Children's Single Regeneration Framework (SRF) partnership groups will advice on the priorities and implementation of the Early Help Strategy.

STRATEGIC PRIORITY 2

Educating, informing and involving the community in improving their own health and wellbeing

Background

Manchester has some of the poorest health in England, and even within Manchester people die younger and experience higher levels of illness in some parts than others. This alone is a reason to act to improve health; the fact that poor health also prevents people from reaching their full potential and holds back the development of the city provides further reasons for acting to improve health. In addition, changes to the population and to expectations of good health lead to ever-increasing demands on health, social care and health services. This pattern is clearly not sustainable in the long term.

These problems will not be solved by the development of ever increasing services. Instead we need to prevent people from getting to the stage where they need expensive treatments or services, whether in the NHS or in social care; and where people do need support, we need to reduce their dependency on services. This can only be done in partnership with people themselves and with the communities they live in. This whole strategy will only be successful if we can completely change the relationship between communities and services.

Together we need to build strong communities that are able to take action themselves in support of their own health and wellbeing. Such communities are built on a high quality physical environment, and supported by appropriate universal services. Two main strategies are needed. The first is to work with individuals, challenging them to change their behaviour and take more responsibility for their own health and wellbeing – including making appropriate use of services. The second is to improve the environment people live in: not just their housing, but their neighbourhood, social circumstances and experiences, tackling anti-health forces that make it more difficult for people to take responsibility for their own wellbeing. We are committed to action across both.

Target group(s) for 2013 - 2015

Our target groups are:

- **People living in a number of priority neighbourhoods (to be defined, prioritised by deprivation and level of ill health)**
- **People aged 40-74 who are eligible for an NHS Health Check**
- **People identified as needing support to make appropriate use of local services.**

The outcomes we want to achieve by 2015 and how we will measure them

1. **Empowerment:** People and communities will be more empowered to take action to improve their own health and wellbeing.
   Measured by: ***[DN – measure needed]***

2. **Healthy lifestyles:** People will be leading healthier lifestyles across four key risk factors – fewer people smoking, more people being more physically active, more people eating a better diet, and fewer people drinking harmful levels of alcohol.
   Measured by: ***[DN – measures needed for more physically active, better diet, and fewer harmful levels of alcohol]***
   - The rate of childhood obesity in year 6 via the National Child Measurement Programme (height

and weight monitoring in schools)
- The rate of smoking in the city via the National Household Survey
- The take up of NHS Health Checks
- The number of staff who have been trained to provide health advice and support

3. **Appropriate service use:** People will be making more appropriate use of services – accessing the right services for their needs.
Measured by: ***[DN – measure needed]***

How we will do this

Over the next two years we will transform the way in which health, care and public health services engage with people and communities. The new model will be based on co-production – recognising people as assets and powerful agents of change themselves; empowering communities and individuals; and seeing our services as facilitating the change that people want to make for themselves rather than simply delivering the things we have always delivered. This will need service providers to think very differently about their roles and the way services are currently delivered.

At the level of the **neighbourhood environment**, we will:
- work with local communities to create urban spaces that support people's health and wellbeing
- protect and enhance green space, encourage development that promotes physical activity, and encourage urban design that is accessible and useable by all.

At **community** level, we will:
- build the existing local Healthy Living Network approaches, together with learning from the most successful community health development programmes throughout the world, into the way in which Neighbourhood Services support communities to take action to improve their own health and wellbeing. This will include much greater emphasis on the development of peer support and other volunteering networks.

Our **universal services** will also support people to become more directly engaged in their own health and wellbeing. We will:
- train a wide range of front-line workers to ensure that they are able to help motivate their own clients or patients to take action to change their lifestyles – making public health everyone's business so that every contact people have with public services is taken as an opportunity to promote health and wellbeing
- promote the uptake of the NHS Health Check, and where such checks identify a need for people to make lifestyle changes to improve their own health, we will ensure that support is available either within the community, through other universal services, or in some cases through specialist lifestyle services
- work to address the preventable causes of cancer, improve awareness of potential cancer symptoms and improve outcomes by promoting early diagnosis and treatment
- establish and promote "Choose Well", a web based tool to support people in deciding which service is most appropriate for their needs

Our **specialist services** will be targeted to those who most need specialist support. We will:
- set up a new integrated Healthy Lifestyles Service that will motivate people to change their own lifestyles, help them to identify ways of doing this, and support them to take action
- develop services that support and empower individuals and families to reach and maintain a healthy weight.

Who will be accountable for achieving these results

- Responsibility for leading and co-ordinating action on the empowerment and healthy lifestyles outcomes sits with Public Health Manchester within Manchester City Council.

- Responsibility for encouraging appropriate service use sits with the Clinical Commissioning Groups.

However achieving results across all three will require action by a wide range of partners, including GPs and other primary care staff, social care, and neighbourhood delivery teams.

STRATEGIC PRIORITY 3

Moving more health provision into the community

Background

While the number of people with any long term condition should be relatively stable over the next 10 years, there will be a 60% increase in the number of people with three or more long term conditions over the same year period (2006 – 2016). In a quarter of people with multiple long term conditions one of the conditions will be depression. For the purpose of this priority, when we refer to 'long term conditions' we mean conditions like asthma, heart disease, respiratory / lung diseases, angina, dementia, atrial fibrillation, and epilepsy.

Patients universally say that they wish to be treated as a whole person and for health services to act as one team. Despite this, those people who have more than one long term condition, particularly older people, currently face an increasingly fragmented response, often being treated for each long term condition separately rather than holistically. This can often lead to patients not managing themselves well, a reluctance to use services available when they start to feel unwell and a reliance on services for when one of their long term conditions worsens to such an extent that they need to be admitted to hospital.

Long term condition 'needs' transcend the organisational boundaries of social care, general practice health care support and provision, community services such as district nursing and hospital care. The current system fragments care for individual patients and this lack of continuity often leads to poorer outcomes and hospital admissions that should have been avoided. We therefore need a paradigm shift in the provision of care to meet the needs of a population in which most of the disease burden is attributable to chronic diseases. The shift calls for a radical reappraisal of current patterns of investment in health care if changing population needs are to be met effectively.

It is crucial that health and social care services plan these changes together, as changes to one part of the system are likely to have significant effects on the rest of it. We therefore need to be able to invest resources appropriately as a whole health and social care system to ensure that services are being provided in an integrated way, including:

- Using a local tool to systematically risk profile patients who are at risk of future crisis and attendance at Accident and Emergency or admission to hospital in order proactively to support people and provide them with the skills to look after themselves outside periods where health and social care support is required;
- Establishing integrated health and social care teams (around GP practice populations and including a core team of the GPs, case managers, district nurses and social care workers) to work together around the needs of individual people identified as part of the target population; and
- Using self care services, information and support to encourage people to look after themselves better and improve their wellbeing.

Target group(s) for 2013 - 2015

Initially we will have a focus on adults (aged 18 years and over), registered with a Manchester General Practitioner, who:

- **have two or more long term conditions; and / or**
- **are identified as being at least moderately at risk by risk stratification tools.**

The outcomes we want to achieve by 2015 and how we will measure them

1. Each person in the target group will be following an agreed care and treatment management plan so that they:
   - are routinely risk profiled
   - receive routine screening and checks at their doctors practice and have appropriate medication prescribed
   - understand how to manage and/or improve their conditions themselves
   - know where and how to access health and care services in their community
   - make contact with their local health and care services as soon as they start to feel ill
   - understand who to contact if their condition gets worse as soon as they get worse
   - have increased understanding and awareness about their long term conditions and can make the best use of self management tools, information and support
   - taking up opportunities to increase their use of active lifestyle services

   Measured by: Patient surveys and feedback on the patient experience, knowledge and self care behaviour will identify whether the treatment plan outcome is being met and will inform further service development, improvement or redesign within each of the models being delivered in Central, North and South Manchester.

2. Patients identified as being at 'moderate' risk are less dependent on avoidable health and social care support (i.e. their risk rating remains static or 'reduces', they require less / no hospitalisation, they are not reliant upon social care services)
   Measured by: ***[DN – measure needed]***

3. The number of admissions and readmissions related to long term condition areas by Clinical Commissioning Group area in Manchester will have been reduced:
   - hospital admissions - by 20-40% (by 2016/17) from baseline levels for long term conditions
   - hospital readmissions – by 10% (by 2016/17) from baseline levels for long term conditions

   Measured by: Routine hospital data for admissions and readmissions

4. The number of bed days associated with admissions for long term conditions by CCG will be reduced as a consequence of 3 above.
   Measured by: Routine data on bed days

How we will do this

- Establish and learn from the pilots taking place in North, Central and South Manchester in 2013 to ensure models of delivery fit with each of the local requirements
- Implement integrated care team models and services (covering multi-disciplinary working across general practice, community health services and social care team with specialist input as and when required) working together around the needs of individual patients) at a neighbourhood level (working around GP practice populations) across North, Central and South Manchester. These teams will carry out risk profiling to identify target population and health and social care assessments and checks for the target population, and will agree with each person their care and treatment plans that bring together self-care, services provided for them and services they can access when any of / their conditions worsen.
- Enhance our knowledge and understanding about the level of population need for services within each GP locality or patch through greater use and analysis of the risk profiling tool
- We will develop and implement a city wide community engagement programme (*linked to Strategic Priority 2)* to support an improvement in health literacy with a view to:
  - patients and the public in Manchester having a greater understanding of their health condition
  - patients and the public being more self reliant in the management of their long term conditions and knowing what appropriate steps to take if their condition deteriorates.
- Develop a culture where health and social care workforces are working in an integrated way

around the needs of individual patients and supported by local training and development programmes and learning from pilots
Who will be accountable for achieving these results Each Manchester CCG has a Clinical Board that includes representation from health and social care commissioners and providers at an executive level. It will be each of these Boards that has responsibility for ensuring this priority is delivered in Central, North and South Manchester.

STRATEGIC PRIORITY 4

Providing the best treatment we can to people in the right place and at the right time

Background

90% of peoples' contact with the NHS is through primary care – seeing their GP or practice nurse, dentist or optician, or visiting their local pharmacy. The health care system in Manchester includes 101 GP practices and a range of out of hospital community services. It also includes three 'acute' hospitals - hospitals which provide adult patients with a full range of emergency and bookable physical healthcare services. They are North Manchester General Hospital, Manchester Royal Infirmary, and Wythenshawe Hospital. These hospitals are run by the following Trusts: Pennine Acute Hospitals NHS Trust, Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of South Manchester NHS Foundation Trust, respectively. The three hospitals comprise one quarter of the twelve acute hospitals in Greater Manchester.

Manchester's hospitals have their roots in the nineteenth century, or earlier, but the environment in which they now operate is very different from even a generation ago. In response, hospitals, like the health service in general, is in the process of major change. Some of the main factors which are driving this change are listed below:

- The changing pattern of disease, with increasing numbers of patients with long-term conditions such as diabetes and heart disease and many of those patients with more than one illness
- Increasing expectations that care will be provided outside of hospital settings, in the community and in people's homes
- Increasing public expectation of what the NHS will provide, and increasing intolerance of any poor standards
- Changes in the overall population, with more older and very old, people
- Increasing competition for health services, offering patients choice
- Public sector financial austerity, following the global banking crisis and economic downturn
- Advances in medical and surgical techniques and technologies, and continued advances in information technology
- The increase in integrated care, where care, provided by a range of organisations and professionals, is organised around a patient rather than around the organisations themselves

These factors are national ones, but they strongly influence both the city of Manchester and Greater Manchester. One of the main implications of these factors is that, in the future, many more patients will be best seen, assessed and treated, in primary and community settings rather than in acute hospitals, although there will always be a group of patients whose needs are such that they can only be treated in hospital.

Primary and community services will increasingly be 'integrated' services, meaning that they bring a wide range of health and social care services together around an individual patient to meet the patient's needs as effectively and efficiently as possible.

Planning for both these patient groups and their future services is now going on both in Manchester, and at Greater Manchester level.

Target group(s) for 2013 - 2015
The two target groups are

- **Patients who currently use hospital-based services but who in the future will be able to use, and will be best served by, integrated primary and community services to meet their needs instead.**
- **Patients who will continue to need to use, and will be best served by, hospital-based services**

The outcomes we want to achieve by 2015 and how we will measure them

By 2015, Manchester's health and social care services aim to have in place:

1. Easy access to high quality, responsive primary care that makes out-of hospital care the first point of call for people
   Measure by: ***[DN – measure needed]***
2. Strong, high quality, care outside hospital through integrated primary and community services, providing Manchester residents with a wide range of round-the-clock support, assessment and treatment; specifically focussed on people with long term conditions, older people, and those at end of life *(Link to Strategic priority 3).*
   Measure by: ***[DN – measure needed]***

3. Rapid response to urgent needs so that fewer patients need to access hospital emergency care
   Measure by: ***[DN – measure needed]***

4. Simplified planned care pathways so that care can take place out of hospital where possible
   Measure by: ***[DN – measure needed]***

5. Appropriate time in hospital when admitted, with early support discharge into well organised community care
   Measure by: ***[DN – measure needed]***

We will measure delivery of the new vision for primary care through achievement against outcomes as set out in the NHS Commissioning Outcomes framework which incorporates measures to

- Improve life expectancy
- Improve quality of life for people with long term conditions
- Enable effective recovery from ill health and injury
- Deliver an excellent patient experience
- Create safe and effective services, eliminating avoidable harm

- **How we will do this**

- We will develop our vision, strategies and service models for the future of high quality effective primary and community care. Plans for the future of primary and community care services will be published by the spring of 2013 and implemented from the autumn

- We will review and commence re-organising hospital-based services to reflect both the extended range of integrated care provision, and the continued need for high quality hospital care. Public consultation on acute reconfiguration, led by the Healthier Together programme, is planned to commence in spring 2013.

- Commissioners and providers will work closely through the local and regional acute reconfiguration programmes to review the requirements for safe, high quality acute care in the future and to plan changes to hospital services accordingly.

- Clinical commissioning groups (CCGs) will work with NHS community and acute services, GPs, the National Commissioning Board and the City Council in continuing the design and roll-out of integrated care across the city. This design will include the enhanced provision of round-the-clock services for residents and patients who would otherwise be seen in hospital

- The CCGs will work with their member practices and groups of practices as well as with the NCB to ensure a consistent offer of primary care for Manchester's patients; to drive up quality, improve health outcomes and develop and deliver the new vision for primary care

Who will be accountable for achieving these outcomes

- The establishment of integrated primary and community services is the responsibility of the clinical commissioning groups and the City Council as a commissioner of social care services

- Specifying the future requirements for hospital services is the responsibility of NHS commissioners, working closely with the acute hospitals themselves. Accountability for the reconfiguration of hospital services is shared between provider trusts, the Local Area Team of the National Commissioning Board, and local commissioners. The Greater Manchester change programme entitled 'Healthier Together' will play a major role in determining the shape of acute hospitals in Greater Manchester as a whole

- Commissioning Primary care in the form of GP Practices is the responsibility of the National Commissioning Board (NCB) Local Area Team (LAT); although the CCGs have a key role to work with the NCB to secure improvement in primary care quality.

STRATEGIC PRIORITY 5

Turning round the lives of Troubled Families

Background

The public sector in Manchester provides or commissions a wide range of services, some of which are universal (such as libraries and primary care) and some of which are targeted to those with more specialist needs. What has become clear over recent years is that a relatively small number of families in the city account for a considerable number of the more targeted interventions from across the public sector. It is estimated that there are approximately 4,000 such families in the city, characterised by multiple and frequent contacts with a number of different public bodies, including social care, health services and the criminal justice sector, and poor outcomes despite all this contact with services.

The need to improve outcomes for these families and the challenging economic climate has focused the public sector on the need for all public services to work together in order to reduce the number of troubled families in the city. The focus will be on investment into services which address underlying health and wellbeing problems within Manchester's Troubled Families.

We are therefore working through the city's Community Budget processes to focus on the need to turn around the lives of troubled families. This involves reforming the way residents receive services and in doing so promotes independence, resilience and better outcomes including health and wellbeing. In turn this will ensure that all of Manchester's residents have an opportunity to share in the benefits of economic growth in the city.

The work to date has focused on both Troubled Families and those families at risk of becoming complex in two pilot areas (Longsight/Gorton and Wythenshawe); this is currently being rolled out to reach 1000 families in North Manchester. This approach will be scaled up city wide in April 2013.

Target group(s) for 2013 – 2015

Nationally, the Communities & Local Government Department has defined Troubled Families as being households who:

- Are involved in crime and anti-social behaviour
- Have children not in school
- Have an adult on out of work benefits
- Cause high costs to the public purse

However, Manchester has extended its definition to include all adult households and those families at risk of being complex. The experience of family services such as the Family Intervention Project is that many troubled families have underlying health problems. Often these are not fully recognised until intensive work with the family is underway. Particular priority health problems therefore need to be considered in a whole family context including families experiencing:

1. **Emotional and mental ill health**
2. **Drug and alcohol misuse**
3. **Long term health conditions**
4. **Health problems caused by domestic abuse**
5. **Under 18 conceptions**

The outcomes we want to achieve by 2015 and how we will measure them

Overall
To achieve an integrated approach to working with Troubled Families that will reduce demand for public services, improve outcomes for troubled families and residents and make our investment agreement real.
Measured by: ***[DN – measure needed]***

Specifically:

1. A reduction in the number of troubled families as a result of the Community Budgets approach
   Measured by: ***[DN – measure needed]***

2. A reduction in the involvement in crime and anti-social behaviour
   Measured by: ***[DN – measure needed]***

3. A reduction in the number of children not in school
   Measured by: ***[DN – measure needed]***

4. An Increase in the number of adults in work through increased skills and improved access to employment opportunities *(Linking to Strategic Priority 7).*
   Measured by: ***[DN – measure needed]***

5. An improvement in emotional and mental ill health through faster and more effective access to mental health services through the development of clear pathways *(Linking to Strategic Priority 6).*
   Measured by: (a) the waiting times in weeks per referral for access to mental health services for adults and also for children and young people (aged under 18) over the period of 1/4/13 -31/3/15.

   (b) The existence of a specific pathway for adults and also for children and young people (aged under 18) by 31/3/14.

6. A reduction in drug and alcohol misuse through faster and more effective access to drug and alcohol services through the development of clear pathways *(Linking to Strategic Priority 6).*
   Measured by: (a) the waiting times in weeks per referral for access to drug and alcohol services for adults and also for children and young people (aged under 18) over the period of 1/4/13 - 31/3/15.

   (b) The existence of a pathway for adults and also for children and young people (aged under 18) by 31/3/14.

7. Prevention and reduction of long term conditions through healthy lifestyles reducing obesity, smoking and alcohol consumption *(Linking to Strategic Priority 2)*.
   Measured by: the prevalence of adults who are obese, who smoke and with alcohol consumption above the recommended weekly units.

8. A reduction in instances of domestic violence within the City through early intervention.
   Measured by: the prevalence of adults and also children and young people (aged under 18) who are subject to domestic violence that has been reported to Greater Manchester Police and formally recorded.

9. A reduction in the number of conceptions for under 18s within the City through education and early interventions *(Linked to Strategic Priority 2)*.
   Measured by: the prevalence of conceptions for under 18s.

10. A reduction in public sector costs related to the support provided to troubled families.
    Measured by: ***[DN – measure needed]***

How we will do this

We will roll out the new delivery model for troubled families city wide from April 2013, and scale up the approach to include a wider range of interventions based on evidence of what works.

Recognising that this is a new approach, we will continue to refine the way we work with complex families/individuals. This will include the development of a single assessment process, identification of the Whole Family Lead and an improvement in communication between agencies and partners.

We will work together to develop pathways for families with a range of needs including those who make regular return visits to A&E Departments at the Manchester hospitals as well as better access to mental health, drug and alcohol services.

We will establish an agreed model for Assertive Outreach (AO) that we will roll out across our key partner agencies.

Finally, given that the longer term requirement is to attract investment into the Manchester Investment Fund we will continue to promote the benefits that the new approach can have for our partner organisations in terms of savings. Therefore, the evaluation will monitor reductions in demand for partners to inform future decommissioning and investment.

Who will be accountable for achieving these results

The leadership of work with troubled families is through the Manchester Investment Board and Strategic Regeneration Framework Delivery Groups as it is important that the work is locally focused so that families are linked into, and benefit from, community based services, such as libraries and leisure centres, and community activities and opportunities where they live

STRATEGIC PRIORITY 6

Improving people's mental health and wellbeing

Background

For too long, mental health and wellbeing has not received the attention that physical health has been given. However, with the JSNA demonstrating the very high levels of mental ill health and low levels of wellbeing in the city, and the impact this has on our health, social and economic aspirations, it is time for this to take centre stage in our local strategies.

Two distinct strands of work need to be identified within this priority:

- establishing the conditions that support people's general mental wellbeing; and
- providing good quality, recovery orientated services that support those with mental ill health to recover.

While the second of these is individually focused and mainly the responsibility of health and social care services, the first is partly individual, partly environmental, and partly socioeconomic, and consequently responsibility is widely spread across the system. This has led in the past to a lack of a coherent strategy for wellbeing, which the Health and Wellbeing Board aims to develop in future.
This priority will reflect the objectives of the national, cross government outcomes strategy for mental health 'No health Without Mental Health' 2012

Target group(s) for 2013 – 2015

People with mental ill health problems are represented in each of the priority areas within the strategy and mental health is therefore a recurrent theme. It is clear that action needs to be taken across the life-course, ensuring that children and young peoples' mental health needs are supported from the outset and that this is continued so that it is also a consideration of ageing well.
In order to limit the scope of this section children and young peoples' mental health will be addressed in priority 1 and older peoples' mental health in priority 8. Priority 7 will address specific issues related to mental health and employment.

The particular focus of this priority area therefore are:

- **Adults experiencing mental ill health**
- **The general population for whom maintaining wellbeing is the main focus**

It is also important to note that times of economic downturn can have a negative impact on mental health generally including anxiety and depression, and especially in relation to alcohol misuse and increased levels of suicide, which is why actions in relation to these areas are included. Partnership working in this priority area provides a good opportunity to mitigate some of the effects of economic downturn on mental wellbeing.

The outcomes we want to achieve by 2015 and how we will measure them

1. By 2015 suicides in Manchester will be no higher than 2010
   Measured by: mortality data from the Office for National Statistics

2. That people and communities are more empowered to take action to their own mental (and

physical) health and wellbeing through self care and that stigma about mental ill health is reduced.
Measured by:

3. There will be a improvement in access and outcomes of low level social support for people with mental health problems through improving the skills of frontline statutory, voluntary sector and community staff and increasing self help
   Measured by:
   - The number of staff trained in supporting people with mental health problems
   - The number of local residents/community groups trained in maintaining wellbeing e.g. 'Boost programme'
   - The establishment of a Manchester Healthy Living Service and uptake of services including health trainers
   - A remodelling of the priorities of community and voluntary sector services
   - Asking a sample group of local people about their awareness of mental health issues and experience of accessing help

4. Those with mental illness have improved physical health
   Measured by: assessed by primary or secondary care measured via data from primary care (GP and mental health services)

5. Those with 'dual diagnosis', that is mental health and substance misuse problems, are better supported and that the links between substance misuse and mental ill health are better understood.
   Measured by: People with dual diagnosis will be asked about the quality of their care**.**
   Measurement of uptake of training in dual diagnosis by key staff.

6. People with mental health problems receiving urgent care will do so more quickly with shorter waiting times for hospital admission, where required.
   Measured by: urgent care/hospital data

We acknowledge that some of the baseline information about mental ill health and wellbeing needs to be established so that we can measure improvements. This is especially true for the whole population.

How we will do this

1. Develop and implement a clear and coherent strategy for mental health and wellbeing that takes account of the assessed needs of our communities (including Black and Minority Ethnic communities, those who are homeless, those who otherwise are socially excluded e.g. gay men and lesbians and people with substance misuse problems) and includes the spectrum from population based wellbeing through to those with severe and enduring mental illness. This will build on and include the existing Mental health and Wellbeing Commissioning strategy, which will be updated in 2013, and will incorporate suicide prevention and a recognition of the socioeconomic and environmental impacts on mental health.
2. Health and social care systems, protocols and procedures will be integrated to deliver seamless care and improved health and wellbeing outcomes to the target groups.
3. Recovery and self care will be promoted as an outcome for people with mental ill health, and frontline workers in non-specialist services will be trained to respond to people with mental health problems
4. Mental wellbeing will be a cross cutting consideration in planning for services, the environment and the economy and mental health impact assessment will be included as part of all strategic board decision making
5. We will develop clear and consistent messages for service providers so that their service users are given the appropriate information to help them improve their own health and wellbeing through supported self management and self care. This will include the provision of training accessible to

specialist and non specialist staff
6. Provision of information on self care and training for local people on maintaining good mental health
7. Improve the physical aspects of health care for people with severe and enduring mental health problems through joint work between mental health staff and GPs
8. Develop better joint working between mental health and substance misuse services and improve the care pathway for people with a dual diagnosis. Provide training in dual diagnosis for key frontline staff.
9. We will ensure that other relevant strategies support mental health and wellbeing e.g. we will align the Alcohol Strategy with these objectives and ensure that other initiatives that impact on mental health are supported e.g. Alcohol minimum unit price

Who will be accountable for achieving these results

The achievement of these objectives will require the full engagement of all partners in the city, to develop community understanding and resilience, identify 'target groups', and provide health messages, information and strategies. The provision of the appropriate service responses will be for all sectors, statutory and non-statutory, in the city.

The leadership and co-ordination of the actions will be from the Clinical Commissioning Groups and City Council, supported by good health intelligence and public health initiatives, to ensure priorities are identified and commissioned from the range of providers on the basis of sound evidence.

STRATEGIC PRIORITY 7

Bringing people into employment and leading productive lives

Background

The interrelationship between health and work or indeed a lack of work is vital to the economic and social wellbeing of a local economy, particularly in major cities such as Manchester. Being out of work, or in some instances never having been in work, puts individuals at increased risk of ill health and premature death, with all of the associated costs to society that this involves.

Supporting individuals back into work and assisting them to sustain work where they have long term health issues not only boosts the local economy but improves the life chances and health outcomes for individuals and their families. Alongside this is the need to ensure that work supports good health.

'Good work' ensures that the health benefits of employment are realised and sustained. A healthy workplace is characterised by a safe and healthy working environment, clarity of expectation on staff, feedback on performance, and employees having some control and influence over their work. The business case for promoting and supporting employee health and well-being has been well documented. Employers can gain clear benefits in reducing employee turnover and increasing the productivity and engagement of employees**.**

Related to this is the need to ensure that wages enable individuals to achieve an adequate level of warmth and shelter, a healthy diet, social interaction and avoidance of chronic stress on earners and their dependents. The promotion of the need for a 'living wage' within the wider economy requires further consideration.

These are policy areas that are not directly led on by the Health and Wellbeing Board, but there is no doubt that the health and social care system *can* do its part to support people to get into and sustain good employment, and that it *should* do so in order to improve the health, wellbeing and independence.

Target group(s) for 2013 – 2015

A large number of Manchester residents claim Incapacity Benefit, Employment Support Allowance and other sickness related out of work benefits primarily because of a mental health condition. There is also a flow of new claims for Employment Support Allowance from residents who have fallen out of work due to a mental health condition that it is critical to stop. Just under 34,000 of the 64,000 workless residents in Manchester are claiming Incapacity Benefit or Employment Support Allowance because they have previously been assessed as medically unfit for work and half of these are primarily claiming benefits because of a mental health condition. For this reason we will be focusing on the following priority group between 2013 and 2015:

- **adults with diagnosed and undiagnosed mental health problems who are not in employment**

In addition, there is currently an opportunity to support wider health and wellbeing through a focus on the role of employers in promoting health at work. Consequently we will also be focusing in the following target group:

- **people employed by the public sector, large private sector organisations and public sector**

contractors.

The outcomes we want to achieve by 2015 and how we will measure them

Supporting people into work

1. More primary care practices will be working in a way that systematically supports people back into work or training.
   Measured by: establishing a baseline set of GPs using Fit for Work intervention and will measure and evaluate all referrals made through this service.

2. More adults with diagnosed mental health problems will have been supported into employment or training through primary care interventions or self help interventions.
   Measured by: a) number of people with diagnosed mental health problems who are in training or employment through primary care or self help services.
   b) Increased numbers of people from the target population using self care services.

3. More adults with mental health problems will be appropriately referred to mental health services from employment services.
   Measured by: increased number of referrals from employment services into mental health services

Healthy Workplaces

4. An increased number of employers in Manchester will have signed up to the Good Work Good Health charter or equivalent workplace health standards
   Measured by: identifying the baseline of the number of Manchester employers signed up to a workplace health charter and report the increase in this number.

5. An increased number of MCC and NHS suppliers will have signed up to the Good Work Good Health charter or equivalent workplace health standards
   Measured by: identifying the baseline of MCC and NHS suppliers signed up to a workplace health charter and report the increase in this number.

How we will do this

Supporting people into work

1. We will deliver **primary care** interventions to help people enter, stay, or return to work in targeted areas of the city displaying high levels of worklessness including North and East Manchester. The Fit for Work Programme will be adopted by GP led Primary Care Services in these areas of the City, targeting those in danger of falling out of work. Fit for Work to be in place across the city by 2015 as part of a planned roll out starting in North and East Manchester.

2. We will develop and commission **self-help** programmes with wrap around employment support to help claimants of out of work sickness-related benefits to manage their health conditions better and increase their chances of getting back into the labour market. We will support the integration of employment and skills support as part of any future commissioning of Improving Access to Psychological Therapies or similar services.

3. We will create clear referral mechanisms, incorporating a single point of access phone number, for employment support providers (including Work Programme providers) to support people with **mental health** issues and co-case manage individuals who are not in work and who have a mental health condition. This will lead to non mental health specialists knowing how to refer clients into the most

appropriate mental health services. In order to do this we will establish an agreed process to obtain informed consent around sharing client information.

Healthy Workplaces

4. The board and its strategic partners will work with a wide range of employers to encourage investment in **workplace** initiatives to promote the health and wellbeing of employees. The first stage of this process will be to work through MCC and NHS employers to ensure that their organisations adopt strategies to promote the health and wellbeing of employees through schemes such as the Greater Manchester Good Work Good Health Charter.

5. We will influence public sector commissioning to ensure that good, healthy work is promoted through **procurement and contracting** processes, encouraging all supply chain partners to sign up to the Greater Manchester Good Work Good Health Charter or equivalent workplace health standards.

Who will be accountable for achieving these results

The Health and Wellbeing Board and the Work and Skills Board will provide the strategic drive for this work; however much of the action to support people into work sits with primary care.

STRATEGIC PRIORITY 8

Enabling older people to keep well and live independently in their community

Background

Manchester's older population is unusual: we have lower than average number of older people; many older people live in neighbourhoods that experience high levels of population 'churn'; typically there are higher numbers of minority ethnic elders; and older Mancunians face high levels of disadvantage and social exclusion. This later term refers to the multi-faceted concept which includes: material resources, social relations, civic activities, basic services and neighbourhood exclusion.

Therefore the development of programmes which address the wider determinants of health and social wellbeing, have a key role to play. The Manchester Ageing Strategy (2010-2020) sets out eight domains of activity of which "healthy ageing" and "care and support services" are the two most closely aligned to the HWB strategy The first of these refers to the range of public health programmes, particularly those aimed at improving lifestyle behaviour, whilst the later is focused services and initiatives grouped around the health and social care system

Target group(s) for 2013 – 2015

Through the JSNA consultation, which included meetings with the Valuing Older People Board – a representative group of older people – we have identified three main groups of people that we need to focus on in order to make a significant improvement in this area:

- people who have fallen or who are at risk of falling;
- people who are socially isolated and/or lonely; and
- people with dementia.

The outcomes we want to achieve by 2015 and how we will measure them ***[DN – these measures need further clarification]***

People who have fallen or are at risk of falls

1. People at risk of falls say services have helped them feel safer in their homes
   Measure by: target group and/or family survey
2. Rate of emergency admissions as a result of falls reduced by ten per cent (closer to national average)
   Measure by: hospital data
3. Rate of repeat admissions for falls reduced by ten per cent
   Measure by: hospital data

People who are at risk of becoming isolated and lonely

4. We have identified key risk groups and developed and implemented new initiatives that have had a positive impact on their life
   Measure by: target group survey
5. People know about and are taking advantage of the support, activities and other opportunities that reduce their loneliness and/or isolation
   Measure by: target group survey; data re increase in participation/membership of organised activities/support

6. People say that they are accessing support and activities easily and that it makes them feel less lonely and/or isolated
   Measure by: target group survey; data re increase in participation/membership of organised activities/support

   People with dementia
7. People in the early stages of dementia and their families are aware of the symptoms and seek support, guidance and diagnosis
   Measure by: population survey; data from GPs (and voluntary sector enquiries?)
8. We know who the people with dementia are and are confident that they are being provided with effective medical treatment that is continually kept under review
   Measure by: GP data
9. People with dementia and their families/carers say that the support that is provided is enabling them to continue to participate in family and community life
   Measure by: target group and family/carer survey; data re increase in participation in organised activities/support
10. People with dementia and their families/carers say that the community is understanding, supportive and inclusive
    Measure by: target group and family/carer survey

How we will do this

- We will improve our data collection and sharing arrangements to make sure that we have a good understanding of who falls and why, so we can put in place a comprehensive approach that includes better prevention services
- We will establish a citywide co-ordinated person-centred response to those at risk of falls, including a clear care pathway, home checks, medication review, a wider health check for other risk factors such as cardiac problems, lifestyle support, and more appropriately targeted information about availability of services.
- We will establish a local network of agencies working to reduce loneliness, working jointly with the national Campaign to End Loneliness.
- We will promote this work through the Age-Friendly Manchester programme
- ***[DN – action on dementia needed]***

Who will be accountable for achieving these results

The responsibility for leading on falls prevention and commissioning falls services will sit in future with public health, which will also be responsible for co-ordinating work on loneliness and isolation. Support for people with dementia will be co-ordinated through MCC Directorate for Adults, Health and Wellbeing.