**Manchester Health and Wellbeing Board**
**Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 20 March 2013

**Subject:** Joint Health and Wellbeing Strategy

**Report of:** David Regan, Director of Public Health

## Summary

At the November 2012 meeting the Board considered the first draft of the Joint Health and Wellbeing Strategy. Following comments from Board members, the attached revised version of the strategy was issued on the 3 January 2013 as part of a two month engagement exercise with all key stakeholders. This report summarises the comments received and also presents the work undertaken to develop an outcomes framework for the strategy.

Following consideration by the Board the comments will be incorporated into the final Strategy. Furthermore it is acknowledged that the Integrated Care Blueprint, also to be presented to the Board today, and the development of the strategic outline case are fundamental to the delivery of the Joint Health and Well Being Strategy. The Integrated Care Programme, if agreed, will have relevance to all eight priorities of the Health and Wellbeing Board, however, it will form the cornerstone of work on priorities two, three, four six and eight in particular:

- Educating, informing and involving the community in improving their own health and well being
- Moving more health provision into the community
- Providing the best treatment we can to people in the right place at the right Time
- Improving people's mental health and wellbeing
- Enabling older people to keep well and live independently in their community

## Recommendations

The Board is asked to:

1. Consider and note the substantive comments received as part of the engagement process for the Strategy;
2. Task the driver group to complete the work on the strategy and framework in time for the official launch of the strategy, at the first meeting of the Board as a statutory body on 8th May 2013

## Board Priority(s) Addressed:

All

**Contact Officers:**

Name: David Regan
Position: Director of Public Health
Telephone: 0161 234 3981
E-mail: d.regan@manchester.gov.uk

**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.

Manchester Health and Wellbeing Board Minutes, 14 November 2012

## 1.0 Introduction

1.1 Following the November 2012 meeting of the Board, the draft Joint Health and Wellbeing Strategy was updated and circulated to a wide range of partner agencies and Boards that will have a key role to play in the successful implementation of the Strategy including:

- Manchester Health Scrutiny Committee
- City Council Members Seminar
- Central Manchester Clinical Commissioning Group (CCG) Board
- South Manchester CCG Board
- North Manchester CCG Board
- Patient and Public Advisory Groups
- Central Manchester Foundation Trust
- University Hospitals South Manchester Foundation Trust
- Pennine Acute NHS Trust
- Manchester Mental Health and Social Care Trust
- Community and Voluntary Sector Organisations
- Strategic Regeneration Framework (SRF) Delivery Groups

The draft Strategy has also been available for comment on the Manchester Partnership website. This report sets out the comments received.

## 2.0 General Comments

- In the main there was a really positive response to the strategy. The joint ownership of the strategy and the inclusion of wider determinants of health were very much welcomed.
- The language was seen as accessible and the format is easy to follow, however a number of people suggested that it would be good to produce a more public facing summary version of the strategy.
- There was strong evidence of clear alignment between the Clinical Commissioning Groups (CCGs) strategic commissioning plans and the strategy and it had the feel of a shared partnership strategy document.
- The focus of the strategy on ‘high cost’ or troubled families was seen to be a positive thing.
- Concerns were raised about how the Strategy will be financed and some respondents were wary of the strategy determining all local CCG investment decisions.
- Concerns were also raised about the ability to succeed in certain areas of the strategy against a backdrop of reduced resources and the potential impact of a reduction/removal of services, especially in the third sector.
- It was suggested that the strategy’s implementation plan included a clear description of how resources, including the Public Health allocation, were being allocated to support the delivery of the strategy. The strategy should include the required investments and the expected benefits from these investments.
- The links between the strategy to geographically focussed plans (i.e. CCG and SRF) needs to me more explicit

- Capturing this vast agenda that faces us all is not an easy task, but overall this document provides a good summary of what we need to do within the city.

### 2.1 Strategic Priority 1 – Getting the youngest people in our communities off to the best start

- The integration of health visiting and early years was seen as a priority project for all of the organisations involved. The governance framework should therefore be amended to show the accountability through the Children's Board and links to the Central Integrated Care Board (CICB) and the Children's Clinical Commissioning Board for the three CCGs. If midwifery is to be encompassed in this project, then the other trusts providing maternity services, not just Central Manchester Foundation Trust will also need to be involved.
- Support for the recognition that austerity measures/welfare reforms will have a significant impact on children and a request that the impact on housing (needs) be included in this section.

### 2.2 Strategic Priority 2 – Educating, informing and involving the community in improving their own health and wellbeing.

- The issues of obesity and alcohol were seen as the two major factors currently impacting upon this priority and there should be better alignment locally of public health and planning policy to more effectively control consents for fast food and alcohol outlets.

### 2.3 Strategic Priority 3 – Moving more health provision into the community

- Several respondents commented on the considerable overlap between priority 3 and priority 4 and that the work on integrated care may lead to a programme of work that addresses both priorities and provides realistic timescale for the delivery (five years suggested)
- Need to state clearly that the accountability for the work on this priority is through joint commissioning and provider multi agency boards rather than the possible perception that they are CCG Boards
- Proposal that that this priority might be more accurately described as ‘building capacity in the community to deliver more health care’, rather than moving provision into the community, which isn't necessarily what is required in all cases.

### 2.4 Strategic Priority 4 – Providing the best treatment we can to people in the right place and at the right time

- It was felt that the actions and detail underpinning this priority focus on ‘right time, right, place’ rather than ‘providing the best treatment’. This priority should encompass the principle that patients, wherever they are treated, should get the highest quality services, and should therefore include indicators such as patient satisfaction.
- Again in terms of accountability and responsibility, the establishment of integrated services is not just the responsibility of the commissioners, but should be a joint responsibility with the providers that will be delivering the care.

## 2.5 Strategic Priority 5 – Turning round the lives of Troubled Families

- The expectations in respect of Community Budgets and Troubled Families needs to be more spelt out. For instance in action point 5 - 'Promote the benefits of this new approach to our partner organisations in order to attract investment into the Manchester Investment Fund' it is unclear who the partners are and what they are expected to invest.
- The outcome/evaluation of the pilots in Longsight/Gorton and North Manchester should be presented to the respective clinical boards
- From a housing perspective, troubled families need more intensive management and can result in failed tenancies, which is costly. There is a feeling that there is less support available to families than there was and funding cuts may impact on floating support services.

## 2.6 Strategic Priority 6 – Improving people's mental health and wellbeing

- In a significant number of cases Troubled Families prove hard to support due to the lack of mental health care and support. These two priority areas need to be more clearly linked and actions/headline outcomes should include measures to reflect this. For example, the numbers of people with mental health needs who receive regular, repeated interventions from agencies such as the police, landlords should be reduced.

## 2.7 Strategic Priority 7 - Bringing people into employment and leading productive lives

- Whilst the focus on people with mental health difficulties is welcome the needs of people with other health issues and disabilities should also be addressed. Actions to encourage employers to adopt practices which result in higher numbers of people with disabilities being employed should be included. In addition, reference to low literacy levels as a barrier to employment could be included.

## 2.8 Strategic Priority 8 - Enabling older people to keep well and live independently in their community

- This priority reflects the work that is being undertaken around falls. However again providers' responsibilities need to be made more explicit (NHS and independent sector) and particularly the role of the North West Ambulance Service (NWAS).

## 3.0 Outcomes Framework

3.1 It is important that the Health and Wellbeing Board has a means of assessing progress towards the strategic objectives described in the strategy. The draft Joint Health and Wellbeing Strategy Outcomes Framework (JHWSOF) below has been developed with the following principles in mind:

- The content of the JHWSOF is aligned with other existing outcomes frameworks, including the NHS Outcomes Framework (NHSOF), Public Health Outcomes

Framework (PHOF), Adult Social Care Outcomes Framework (ASCOF) and the CCG Outcomes Indicators.
- All indicators should, as far as possible, be properly validated, measureable and routinely available from national systems or tools
- Where local data is not routinely available, the necessary processes for collecting the required data should be in place (or be put in place) so that the Board can be reassured that the data will be available within a given period.
- The process for monitoring the JHWSOF should not duplicate or supersede other performance monitoring processes that individual partners are engaged in, e.g. the Community Strategy Delivery Plan.

3.2 At the City Council members seminar on 4 March 2013 the draft framework was presented for discussion and the suggested amendments to the framework have now been included, namely:

- An indicator of the quality of antenatal care has been added. The measure used is the percentage of women who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices within 13 weeks of pregnancy. The indicator reflects one of the components of high-quality care as defined in the NICE clinical guideline for antenatal care.
- An improved indicator relating to domestic violence as the previous indicator based on the number of cases of domestic violence reported to Greater Manchester Police and formally recorded was inappropriate. This has now been replaced with one based on reducing the number of repeat referrals to Multi Agency Risk Assessment Conferences (MARAC).

3.3 Many of the indicators contained in the JHWSOF (particularly those taken from one of the national outcomes frameworks) are already being monitored by one or more of the partner organisations represented on the Board. It is not proposed to duplicate these activities by introducing another layer of performance reporting to the Board. It is the role of the driver group to track progress on the supporting indicators and assess when to alert the Board in good time if a significant deterioration in performance is likely to impact on the headline indicator and the delivery of the strategic priority.

3.4 Finally in order to provide the Board with a comprehensive update on progress against the activities and outcomes contained within the strategy, it is proposed that an annual audit is produced for the Board. This is equivalent to the 'local account' for adult social care produced by the Directorate for Adults, Health and Wellbeing, which is a self-evaluation highlighting good performance (i.e. celebrating success) as well specifying where more work is needed.

## 4.0 Next steps

4.1 The Driver Group will meet on 28th March 2013 to incorporate the comments agreed by the Board and better reflect the Integrated Care blueprint in the final version of the strategy. The Outcomes Framework will also be included in the final version, which will come to the next meeting of the Board on 8th May 2013.

**Strategic priority:**

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

**1.0 Headline indicator:**

Children's readiness for school (PHOF 1.2)

**Supporting indicators:**

1.1 *Antenatal assessments <13 weeks (tbc)*
1.2 Population vaccination coverage - 2 years old (PHOF 3.03iii)
1.3 Breastfeeding (PHOF 2.2ii)
1.4 Speech and language development
1.5 *Neglect – attendance and engagement activity data (tbc)*
1.6 Excess weight in 4-5 year olds (PHOF 2.6)
1.7 Improved performance in the Early Years Foundation Stage Profile (EFYSP)
1.8 Pupil absence (PHOF 1.3)
1.9 Emotional wellbeing of looked after children (PHOF 2.8)
1.10 Tooth decay in children aged 5 (PHOF 4.2)

**Strategic priority**

Turning round the lives of Troubled Families

**5.0 Headline indicator:**

Number of troubled families receiving interventions as part of the Troubled Families Programme

**Supporting indicators:**

5.1 Number of A&E admittances for members of Troubled Families
5.2 Number of presentations at GP practices for members of Troubled Families
5.3 Improved emotional and mental ill health for members of Troubled Families
5.4 Reduced drug and alcohol misuse for members of Troubled Families
5.5 Reduction in number of adults, children and young people who are subject to domestic violence
5.6 *Number of repeat referrals to Multi Agency Risk assessment Conferences (MARAC) tbc*

**Strategic priority:**

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

**2.0 Headline indicator:**

Mortality from causes considered preventable (PHOF 4.3 NHSOF 1a)

**Supporting indicators:**

2.1 Smoking prevalence - adults (over 18)
2.2 Take up of NHS Health Check programme - by those eligible (PHOF 2.22)
2.3 Utilisation of outdoor space for exercise/health reasons (PHOF 1.16)
2.4 Proportion of people who use services and carers who find it easy to find information about support (ASCOF 3D)

**Strategic priority**

Improving people's mental health and wellbeing

**6.0 Headline indicator:**

Composite indicator (i) Number of frontline staff and service users / residents who have undertaken learning in mental health self care; (ii) Increase in ability to advise and support people with mental health problems about their personal mental wellbeing

**Supporting indicators:**

6.1 Proportion of people using specialist mental health services who agree they are fully involved in care planning based on recovery principles
6.2 Number of frontline staff and volunteers in statutory and voluntary / community organisations who report changes to practice as a result of mental health training.
6.3 Numbers of organisations that engage with vulnerable individuals that are equipped to provide advice on self help guidance for mental health
6.4 Number of community organisation initiatives related to improving mental health measured by regular audit
6.5 Periodic review, using agreed criteria, of public availability of information about mental health and self help guidance
6.6 Number of residents attending courses in mental health self care who report improved mental wellbeing

**Strategic priority:**

Moving more health provision into the community

**3.0 Headline Indicator:**

Health related quality of life for people with long-term conditions (NHSOF 2.0)

**Supporting indicators:**

3.1 Emergency readmissions within 30 days of discharge from hospital (NHSOF 3b)
3.2 Smoking status at time of delivery (PHOF 2.3)
3.3 Prevalence of smoking - adults (over 18) (PHOF 2.14)
3.4 Hip fractures in people aged 65 and over (PHOF 4.14)
3.5 Injuries due to falls in people aged 65 and over (PHOF 2.24).
3.6 Proportion of people using social care who receive self-directed support and those who receive direct payments (ASCOF 1C)
3.7 Proportion of people who use services and carers who find it easy to find information about support (ASCOF 3D)

## Manchester Joint Health and Wellbeing Strategy Outcomes Framework 2013/14 at a glance

**Strategic priority**

Bringing people into employment and leading productive lives

**7.0 Headline indicator:**

Proportion of adults in contact with secondary mental health services in paid employment (ASCOF 1F PHOF 1.8 NHSOF 2.2)

**Supporting indicators:**

7.1 Proportion of adults moving back into, training, volunteering or work as a consequence of accessing the Fit for Work referral service
7.2 Percentage of GP practices referring individuals to the Fit for Work referral service
7.3 Percentage of Fit for Work referrals who remain in or find employment
7.4 Percentage of people accessing the Fit for Work referral service that report improved mental health status

**Strategic priority**

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

**4.0 Headline indicator:**

Number of patients with long-term conditions who are managed in primary care

**Supporting indicators:**

4.1 Proportion of patients satisfied that they are able to access appropriate advice and treatment from their GP practice
4.2 A&E attendances
4.3 Hospital admissions through A&E
4.4 Delayed transfers of care from hospital and those which are attributable to adult social care (ASCOF 2C)
4.5 Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11 NHSOF 3b)
4.6 Percentage of deaths that occur outside hospital (own home/hospice/care home)

**Strategic priority**

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

**8.0 Headline indicator:**

Life expectancy at age 65

**Supporting indicators:**

8.1 Injuries due to falls in people aged 65 and over
8.2 Hip fractures in people aged 65 and over
8.3 Permanent admissions of older people to residential and nursing care homes (ASCOF 2A),
8.4 Older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation service (NHSOF 3.6i, ASCOF 2B)
8.5 Health related quality of life for older people (PHOF 4.13)
8.6 Estimated diagnosis rate for people with dementia (PHOF 4.16 NHSOF 2.6i)
8.7 Effectiveness of post-diagnosis care for people with dementia (NHSOF 2.6ii, ASCOF 2F)
8.8 Patients with dementia whose care has been reviewed in the last 15 months
8.9 People with dementia prescribed anti-psychotic medication

# Manchester Health and Wellbeing Board

# Joint Health and Wellbeing Strategy

# (Second Draft)

## 3 January 2013

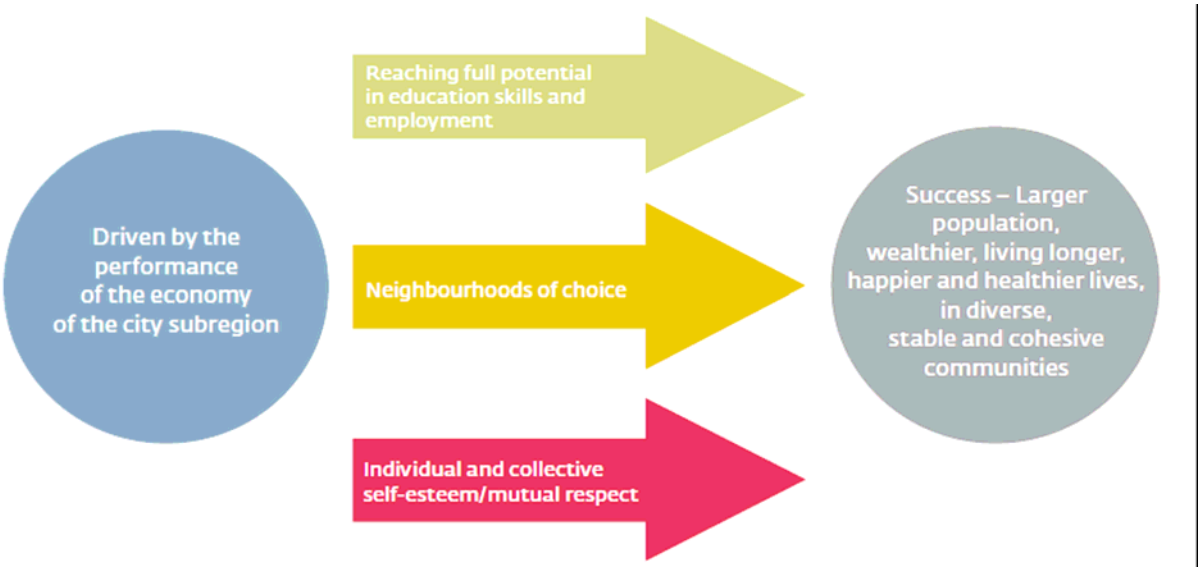
# Introduction

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 (JSNA), 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 The Community Strategy is currently being refreshed and whilst the spines remain an integral part of the strategy a new strategic narrative is emerging. This reflects the desire and ambition of Manchester as an engine of growth within the wider sub-region and as a world class competitive city. The NHS with considerable economic assets, strong links to the Universities and a track record of research and innovation has a vital role to play in the growth agenda. Furthermore all partners on the Health and Wellbeing Board are aware of the need for reform that will help the City to get where it needs. By developing the skills we need and equipping local people to access good jobs we will make a real impact on reducing health inequalities. Also accelerating plans for health and social care integration and a greater focus on early years will lead to better outcomes for people across the life course. Finally vibrant neighbourhoods with access to high quality services and facilities will increase the opportunities for improving well-being.

1.6 The priorities and outcomes we are trying to achieve with this strategy will impact positively on all three of the central “spines” of the Community Strategy, and on the key themes of growth, reform and place.

1.7 Manchester prides itself on its commitment and reputation as a place where diverse communities and people from all backgrounds can work and live together. The concept of equality or the idea of tackling inequalities is therefore nothing new to the city and over the past decade considerable progress has been made. However all of the organisations represented on the Board recognise the need to meet the legal duties set out in the Equality Act 2010 by:

- Eliminating unlawful discrimination in service provision and employment
- Reducing inequalities in health amongst different groups of people living in the city
- Promoting equality of opportunity and inclusion

The Equality Act defines nine ‘protected characteristics’ which afford people protection under anti -discrimination legislation and protects their human rights. This will ensure that everyone has equal access to high quality services and equality of opportunity and health outcomes, regardless of age, caring responsibilities, disability, ethnicity, gender, gender identity religion, sexual orientation or socio economic status.

# 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 agreed 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 over the next two years. 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.

2.5 These actions are summarised at the end of the next section.

# 3. Strategic Priorities

**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.

The Early Year's strategy focuses on 'early learning' as a key component of the integrated new delivery model, ensuring that the core purpose of Sure Start is met, in particular, through the integration of social care with health services and primary schools thereby increasing universal services to all families whilst providing suitably targeted support for families with additional needs, assertively reaching out to those families who do not access services via traditional routes. The early year's new delivery model is based upon a clear care pathway involving midwives, health visitors and early year's staff using agreed evidence based assessment tools and is clearly linked through to education and skills. Three implementation sites will be developed, one in each Clinical Commissioning Group (CCG) area, from April 2013. These sites will use the agreed new integrated care pathway. This will include developing an accountability framework, a suite of interventions, jointly designing the early years outreach role, increasing capacity in health visiting and measuring impact through the

new framework. There is a clear intention to develop a range of local high quality early learning and day care provision in the Private, Voluntary and Independent Sector.

Further work will continue at Greater Manchester (AGMA) level on the new delivery model. Likewise, work continues with Central Government and locally on the development of the new investment models which are building on the Community Budget and Manchester Investment Fund for Troubled Families – the aim being to stem the flow of children and families into 'Troubled Families'.

There is growing concern regarding the impact of current changes and austerity measures on the most vulnerable children and young people in the City. These children and young people may be impacted upon by a number of factors including workless parents, low family 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.

Therefore to address these issues in 2013-15 there will be a focus on the following target groups:

**Target group(s) for 2013 – 2015**

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

**Headline outcomes by 2015**

Children at the age of 5 are ready to engage effectively with their school
Children aged 5-18 are able to access early help and support when issues are identified.

**Preferred headline indicators:**

Outcomes at the Early Years Foundation Stage
Parents to be and new parent being "child ready"
Eradicating the gap in health outcomes for vulnerable infants compared to their peers.

**Actions**

By April 2013 the Children's Board and the Strategic Regeneration Framework (SRF) Children's Partnerships will be:

Implementing the agreed vision and city wide strategy for children and the Early Help strategy

Embedding the Manchester Common assessment Framework as an Early Help delivery tool, including the training and support to schools and lead professionals

By September 2014 the Children's Board will have:

Completed a review of progress against agreed milestones.
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 (CCGs), 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 SRF partnership groups will advise 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 of the city 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 the whole strategy will only be successful if we can completely change the relationship between communities and services and adopt a more assertive approach.

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. Three 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. The third is to ensure a life course approach is adopted, that embeds healthy behaviours in children and young people that continue into adulthood and old age and there are obviously strong links and interdependencies with priority one (children's health) and priority eight (health ageing) . We are committed to action across all three.

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; working with 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.

**Target group(s) for 2013 – 2015**

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

**Headline outcomes by 2015**

1. People and communities will do more themselves to improve their own health and wellbeing.
2. More people will be leading healthier lifestyles across the risk factors of smoking, physical activity, diet, alcohol and fewer children and young people will be taking up risky behaviours
3. People will be using the right services for their needs

**Preferred headline indicators:**
Premature mortality rate from cardiovascular diseases, cancers, cancers considered preventable, liver diseases, liver diseases considered preventable, respiratory diseases, respiratory diseases considered preventable - age-standardised rate of mortality in persons less than 75 years of age per 100,000 population

**Actions**

Over the next two years:

1. Health, care and public health services will work with people, families and communities to improve independence and self reliance
2. We will work with local communities to:
    - create new urban spaces that support people's health and wellbeing

- protect and enhance existing green space
- encourage development and urban design that is accessible and promotes physical activity

From April 2014 we will:

3. Integrate existing Healthy Living Network approaches into new neighbourhood services that support families and communities to take action to improve their own health and wellbeing
4. Have reviewed our approach to implementing the NHS Health Check and increased uptake of this service
5. Ensure specialist services are targeted to those who most need specialist support and we will have identified a new approach to running healthy lifestyles services that will help people across the life course to change their own lifestyles
6. Have identified a new model for services that help individuals and families to reach and maintain a healthy weight
7. Have established and promoted "Choose Well", a web based tool to support people in deciding which service is most appropriate for their needs.

   By April 2015:
8. We will have trained an agreed number of front-line workers from the City Council and local NHS Trusts to motivate clients or patients to change their lifestyles

**Who will be accountable for achieving these results**

- Responsibility for leading and co-ordinating action on 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 the voluntary and community sector, 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 (co-morbidities) 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 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 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 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 accompanied by the integration of IT systems to share patient information where necessary; and
- Using self care services, information and support to encourage people to look after themselves better and improve their wellbeing.

Work on this priority area and on priorities four (best treatment, right place, right time) six (mental health and wellbeing) and eight (older people living independently) will be informed by the model of integrated care set out in the recent Health and Social Care Study, commissioned by the Health and Wellbeing Board.

**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.

**Headline Outcomes by 2015**

Adults in the target groups:

1. Are routinely risk profiled, receive regular screening and health checks at their GP

practice and have appropriate medication prescribed
2. Understand how to manage and/or improve their conditions themselves
3. Those at "moderate" risk are less dependent on avoidable health and social care support
4. Hospital admissions and readmissions related to long term conditions will have been reduced
5. The number of bed days associated with admissions for long term conditions will be reduced

**Preferred headline indicator:**

Overall satisfaction of people who use services with their care and support

**Actions**

1. Implement and evaluate the pilots taking place in North, Central and South Manchester to ensure models of delivery fit with local requirements
2. Implement integrated care team models and services at a neighbourhood level across North, Central and South Manchester
3. 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
4. Develop and implement a city wide community engagement programme to support an improvement in health literacy
5. Develop and facilitate a culture that enables and supports health and social care workforces to work in an integrated way around the needs of individual patients and their carers.

**Who will be accountable for achieving these results**

Each Manchester Clinical Commissioning Group area 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.

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, informed by the study commissioned by the Health and Wellbeing Board and at a Greater Manchester level (the 'Healthier Together 'Programme)

One area that cuts across a number of strategic priorities is End of Life Care. Each of the three Clinical Commissioning Groups (CCGs) has prioritised this issue and recognise the need to improve services related to this pathway. It is proposed to develop a co-ordinated programme of work with measurable outcomes (e.g. reducing the proportion of people who do not want to die in hospital), following a citywide summit to be held in March 2013

**Target group(s) for 2013 - 2015**

- 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

**Headline Outcomes by 2015**

1. Easy access to strong, high quality, responsive primary care that makes out-of hospital care the first point of call for people
2. Integrated primary and community services providing a wide range of round-the-clock support, assessment and treatment;
3. Rapid response to urgent needs so that fewer patients need to access hospital emergency care
4. Simplified planned care pathways so that care can take place out of hospital where possible
5. Appropriate time in hospital when admitted, with early support discharge into well organised community care.

**Preferred headline indicator:**

Numbers of patients with long-term conditions who are managed in primary care.

**Actions**

By the end of 2013 we will have:

1. Published our vision, strategies and service models for the future of high quality effective primary and community care
2. Reviewed and be commencing the re-organisation of hospital-based services
3. Commenced public consultation on acute reconfiguration led by the Healthier Together programme
4. Started to implement the plans for the future of primary and community care services
5. Ensured that commissioners and providers are working closely through the local and regional acute reconfiguration programmes to:
   - review the requirements for safe, high quality acute care in the future
   - plan changes to hospital services
6. Clinical Commissioning Groups will work with NHS community and acute services, GPs, the National Commissioning Board and the City Council to continue the design and roll-out of integrated care across the city.

**Who will be accountable for achieving these outcomes**

- The establishment of integrated primary and community services is the responsibility of the CCGs 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 '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.

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.

**Target group(s) for 2013 - 2015**

Families experiencing:

- Emotional and mental ill health
- Drug and alcohol misuse
- Long term health conditions
- Health problems caused by domestic abuse
- Under 18 conceptions

**Headline Outcomes by 2015**

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.

**Preferred headline indicator:**

A reduction in the number of troubled families as a result of the community budget approach resulting in savings to different areas of the public sector.

**Actions**

1. From April 2013, roll out the new delivery model for troubled families city wide
2. Continue to refine the way we work with troubled families and individuals, including the development of a single assessment process
3. Develop new pathways for families with a range of needs including those who make regular return visits to A&E and better access to mental health, drug and alcohol services.
4. Establish an agreed model for Assertive Outreach that we will roll out across our key partner agencies.
5. Promote the benefits of this new approach to our partner organisations in order to attract investment into the Manchester Investment Fund

**Who will be accountable for achieving these results**

The leadership of work with troubled families will be through both the Integrated Delivery Directorate and the Integrated Commissioning Directorate of the City Council. However, this work will be strongly supported by the governance of the Manchester Investment Fund, involving a wide range of key partners including the voluntary and community sector. Effective implementation at a locality level will be progressed through Strategic Regeneration Framework (SRF) areas. It is essential 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

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 one and older peoples' mental health in priority eight. However this priority will need to take into account the impact of adult mental health on dependent children. Priority area seven will address specific issues related to mental health and employment.

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.

Finally the work on this priority will also be informed by the recent study commissioned by the Health and Wellbeing Board and the implementation of the key recommendations.

### Target group(s) for 2013 – 2015

The particular focus of this priority area are:

- Adults experiencing mental ill health

- The general population for whom maintaining wellbeing is the main focus

**Headline Outcomes by 2015**

1. Suicides in Manchester will be no higher than in 2010
2. People and communities will be doing more for themselves to improve their own mental and physical health and wellbeing
3. There will better access to and improved outcomes from low level social support for people with mental health problems
4. People with both mental health and substance misuse problems will be better supported
5. There will be faster access to urgent care for people with mental health problems with shorter waiting times for hospital admission

**Preferred headline indicators:**

- Number of frontline staff and service users/ residents who have undertaken learning in mental health self care.
- Reported increases in ability to advise and support people with mental health problems (staff) and in personal mental wellbeing (service users and residents).

**Actions**

1. Develop and implement a clear and coherent strategy for mental health and wellbeing that:
   - takes account of the diverse needs of our communities
   - builds on the refreshed Mental Health and Wellbeing Commissioning strategy and ensures that mental health and wellbeing is included as an integral part of other strategies (e.g. the Manchester Alcohol Strategy) and planning for service
2. Integrate the health and social care systems, protocols and procedures involved in delivering the strategy and ensure these facilitate the joint working needed to improve both mental and physical health and wellbeing.
3. Train front line workers in specialist and non-specialist areas to promote recovery and self care as an outcome for people with mental ill health issues.
4. Provide clear and consistent messages for service providers, their service users and local people that promote/support self management and self care.

**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.

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.

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. However approaches to employers around this agenda will need be aligned with approaches around related themes (e.g. sustainability and the environment) to ensure employers are not overwhelmed and can be supported effectively.

**Target group(s) for 2013 – 2015**

We will be focusing on the following priority groups between 2013 and 2015:

- adults with diagnosed and undiagnosed mental health problems who are not in employment
- people employed by the public sector, large private sector organisations and public sector contractors.

**Headline Outcomes by 2015**

1. More GP practices will be systematically supporting people back into work or training
2. More adults with diagnosed mental health problems will have been supported back into employment or training through primary care or self help interventions.
3. More adults with mental health problems will be appropriately referred to mental health services from employment services.
4. An increased number of employers in Manchester and Manchester City Council (MCC) and NHS suppliers will have signed up to the Good Work Good Health charter or equivalent workplace health standards

**Preferred headline indicators:**

- Proportion of adults in contact with secondary mental health services in paid employment
- Proportion of adults moving back into, training, volunteering or work as a consequence of accessing the Fit for Work referral service.

**Actions**

1. Deliver primary care interventions to help people enter, stay, or return to work in targeted areas of the city displaying high levels of worklessness
2. The Fit for Work Programme will be adopted by GP led Primary Care Services in these targeted areas and will be rolled out across the city by 2015
3. Develop and commission self-help programmes with wrap around employment support to help claimants of out of work sickness-related benefits.
4. Create clear referral mechanisms, incorporating a single point of access phone number, for employment support providers to support people with mental health issues and co-case manage individuals who are not in work
5. The board and its strategic partners will work with a wide range of employers, starting with MCC and NHS, to encourage investment in workplace initiatives to promote the health and wellbeing of employees.
6. Encourage 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 and CCGs and the NHS Commissioning Board will have a crucial role to play going forward.

**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.

The three Clinical Commissioning Groups and the City Council have already begun to address the challenges facing older people with one or more long term conditions (i.e. co-morbidities) but it is recognised that much more needs to be done. The findings from the Health and Social Care Study report highlighted that there is

- Considerable variation by GP practices in urgent care admissions for elderly patients across Manchester
- Urgent care admissions for elderly people in Manchester are 40% higher than the national average, with longer than average stays in hospital

The work on strategic priority three (more health provision in the community), four (best treatment, right place, right time) and six (mental health and wellbeing) will impact significantly on the successful achievement of outcomes related to this priority.

**Target group(s) for 2013 – 2015**

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 are elderly and/or have one or more long term conditions
- people who have fallen or who are at risk of falling;
- people who are socially isolated and/or lonely; and
- people with dementia.

**Headline Outcomes by 2015**

1. Hospital admissions and readmissions related to long term conditions will have been reduced.
2. People will spend appropriate time in hospital when admitted, with early and

safe supported discharge into well organised community care.
3. People who have fallen or are at risk of falls say that services have helped them feel safer in their homes
4. People who are at risk of becoming isolated and lonely are taking advantage of a range of activities that reduce their loneliness and/or isolation.
5. People in the early stages of dementia and their families are aware of the symptoms and seek support, guidance and diagnosis.
6. 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

**Preferred headline indicator:**

Life Expectancy at age 65/Healthy Life Expectancy.

**Actions**

1. Implement the relevant recommendations of the Health and Social Care Study Report when these have been finalised and agreed.
2. Improve our data collection and sharing arrangements to make sure that we have a good understanding of who falls and why
3. Establish a citywide co-ordinated person-centred response to those at risk of falls, including a clear care pathway, home checks, medication review including a wider health check for other risk factors
4. Establish a local network of agencies that will work jointly with the National Campaign to End Loneliness and coordinate, research, policy and practice
5. Publish the city's new Dementia strategy in 2013 that will deliver the planned outcomes
6. Continue to consider the needs of carers and ensure that independent, community and voluntary sector organisations can support and in many cases lead service delivery.

**Who will be accountable for achieving these results**

The Health and Wellbeing Board will ensure that the recommendations of the Health and Social Care Study are implemented. The responsibility for falls prevention and commissioning falls services will be part of an integrated approach to commissioning and delivery across the Council, public health and the CCGs as will the coordination of work on loneliness and isolation. Support for people with dementia will be co-ordinated through MCC Directorate for Adults, Health and Wellbeing.

**Summary Action Plan**

| PRIORITY | ACTIONS |
|---|---|
| **1. Getting the youngest people in our communities off to the best start** | By April 2013 the Children's Board and the Strategic Regeneration Framework (SRF) Children's Partnerships will be:<br>1. Implementing the agreed vision and city wide strategy for children and the Early Help strategy<br>2. Embedding the Manchester Common assessment Framework as an Early Help delivery tool, including the training and support to schools and lead professionals<br><br>By September 2014 the Children's Board will have:<br>3. Completed a review of progress against agreed milestones.<br>4. Refreshed its prioritisation in consultation with the SRF Delivery Groups and Children's SRF partnership groups. |
| **2. Educating, informing and involving the community in improving their own health and wellbeing** | Over the next two years:<br><br>1. Health, care and public health services will work with people and communities to improve independence and self reliance<br>2. We will work with local communities to:<br>• create new urban spaces that support people's health and wellbeing<br>• protect and enhance existing green space<br>• encourage development and urban design that is accessible and promotes physical activity<br><br>From April 2014 we will:<br>3. Integrate existing Healthy Living Network approaches into new neighbourhood services that support communities to take action to improve their own health and wellbeing<br>4. Have reviewed our approach to implementing the NHS Health Check and increased uptake of this service<br>5. Ensure specialist services are targeted to those who most need specialist support and we will have identified a new approach to running healthy lifestyles services that will help people to change their own lifestyles<br>6. Have identified a new model for services that help individuals and families to reach and maintain a healthy weight<br>7. Have established and promoted "Choose Well", a web based tool to support people in deciding which service is most appropriate for their needs.<br><br>By April 2015:<br>8. We will have trained an agreed number of front-line workers from the City Council and local NHS Trusts to motivate clients or patients to change their lifestyles |

| PRIORITY | ACTIONS |
|---|---|
| **3. Moving more health provision into the community** | 1. Implement and evaluate the pilots taking place in North, Central and South Manchester to ensure models of delivery fit with local requirements<br>2. Implement integrated care team models and services at a neighbourhood level across North, Central and South Manchester<br>3. 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<br>4. Develop and implement a city wide community engagement programme to support an improvement in health literacy<br>5. Develop and facilitate a culture that enables and supports health and social care workforces to work in an integrated way around the needs of individual patients and their carers. |
| **4. Providing the best treatment we can to people in the right place and at the right time** | By spring 2013 we will have:<br>1. Published our vision, strategies and service models for the future of high quality effective primary and community care<br>2. Reviewed and be commencing the re-organisation of hospital-based services<br>3. Commenced public consultation on acute reconfiguration led by the Healthier Together programme<br>4. By autumn 2013 we will be implementing the plans for the future of primary and community care services<br>5. Commissioners and providers will work closely through the local and regional acute reconfiguration programmes to:<br>• review the requirements for safe, high quality acute care in the future<br>• plan changes to hospital services<br>6. Clinical Commissioning Groups will work with NHS community and acute services, GPs, the National Commissioning Board and the City Council to continue the design and roll-out of integrated care across the city |
| **5. Turning round the lives of Troubled Families** | 1. From April 2013, roll out the new delivery model for troubled families city wide<br>2. Continue to refine the way we work with troubled families and individuals, including the development of a single assessment process<br>3. Develop new pathways for families with a range of needs including those who make regular return visits to A&E and provide better access to mental health, drug and alcohol services.<br>4. Establish an agreed model for Assertive Outreach that we will roll out across our key partner agencies.<br>Promote the benefits of this new approach to our partner organisations in order to attract investment into the Manchester Investment Fund |
| **6.** | 1 Develop and implement a clear and coherent strategy for mental |

| PRIORITY | ACTIONS |
|---|---|
| **Improving people's mental health and wellbeing** | health and wellbeing that:<br>• takes account of the diverse needs of our communities<br>• builds on the refreshed Mental Health and Wellbeing Commissioning strategy and ensures that mental health and wellbeing is included as an integral part of other strategies (e.g. the Manchester Alcohol Strategy) and planning for service<br>2. Integrate the health and social care systems, protocols and procedures involved in delivering the strategy and ensure these facilitate the joint working needed to improve both mental and physical health and wellbeing.<br>3. Train front line workers in specialist and non-specialist areas to promote recovery and self care as an outcome for people with mental ill health issues.<br>4. Provide clear and consistent messages for service providers, their service users and local people that promote/support self management and self care. |
| **7. Bringing people into employment and leading productive lives** | 1. Deliver primary care interventions to help people enter, stay, or return to work in targeted areas of the city displaying high levels of worklessness<br>2. The Fit for Work Programme will be adopted by GP led Primary Care Services in these targeted areas and will be rolled out across the city by 2015<br>3. Develop and commission self-help programmes with wrap around employment support to help claimants of out of work sickness-related benefits.<br>4. Create clear referral mechanisms, incorporating a single point of access phone number, for employment support providers to support people with mental health issues and co-case manage individuals who are not in work<br>5. The board and its strategic partners will work with a wide range of employers, starting with MCC and NHS, to encourage investment in workplace initiatives to promote the health and wellbeing of employees.<br>6. Encourage all supply chain partners to sign up to the Greater Manchester Good Work Good Health Charter or equivalent workplace health standards. |
| **8. Enabling older people to keep well and live independently in their community** | 1. Implement the relevant recommendations of the Health and Social Care Study Report when these have been finalised and agreed.<br>2. Improve our data collection and sharing arrangements to make sure that we have a good understanding of who falls and why<br>3. Establish a citywide co-ordinated person-centred response to those at risk of falls, including a clear care pathway, home checks, medication review including a wider health check for |

| PRIORITY | ACTIONS |
|---|---|
| | other risk factors.<br>4. Establish a local network of agencies that will work jointly with the National Campaign to End Loneliness and coordinate, research, policy and practice.<br>5. Publish the city's new Dementia strategy in 2013 that will deliver the planned outcomes<br>6. Continue to consider the needs of carers and ensure that independent, community and voluntary sector organisations can support and in many cases lead service delivery. |

**Appendix One**

**JSNA fit with Health and Wellbeing Board Priorities**