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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 3 March 2020
Time: 2.00 pm
Venue: Council Antechamber, Level 2, Town Hall Extension

This is a **Supplementary Agenda** containing additional information about the business of the meeting that was not available when the agenda was published

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Membership of the Health Scrutiny Committee

Councillors - Farrell (Chair), Nasrin Ali, Clay, Curley, Holt, Mary Monaghan, Newman, O'Neil, Riasat and Wills

Supplementary Agenda

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

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This supplementary agenda was issued on **Friday 28 February 2020** the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension , Manchester M60 2LA

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 3 March 2020

Subject: Update on the mobilisation of Manchester Community Response

Report of: The Director of Adult Social Care, Manchester City Council and the Chief Operating Officer, Manchester Local Care Organisation

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Summary

This paper updates the Health Scrutiny Committee on the work of health and social care staff in the Manchester Community Response (MCR) services.

It describes the work is taking place and sets out the integrated model of service provision delivered by our health and social care staff.

The report also includes a case study and overview of current performance within the team.

In presenting this paper the positive impact on the lives of Manchester residents will be highlighted.

Recommendations

The Committee is asked to note the contents of the report, progress made to date and the work of teams with MCR to deliver person centred services to residents in Manchester.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city

Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	

A highly skilled city: world class and home grown talent sustaining the city's economic success	MLCO are actively engaging communities in their workforce, and through the reablement are working to support Manchester residents including those that have been economically inactive into employment. contributing the economic growth of the city.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The underpinning principle of MCR planning is that services are aligned to the needs of residents and delivered within community based settings.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

1. Introduction

1.1 This paper updates the Health Scrutiny Committee on the work of health and social care staff in the Manchester Community Response (MCR) service.

1.2 The Committee are reminded that MCR is one of MLCO's new models of care.

2. Background to MCR

2.1 Manchester Community Response (MCR) provides crisis, intermediate care, reablement and rehabilitation services to patients, often older people, after leaving hospital or when they are at risk of being sent to hospital. These services offer an interface between hospitals and where people live, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

2.2 The three overarching aims of MCR are to:

- Help people avoid going into hospital unnecessarily.
- Help people be as independent as possible on discharge from hospital.
- Prevent people from having to move into a residential home until they really need to.

2.3 MCR is comprised of a number of different teams:

Crisis response

The crisis response team works collaboratively to provide a more rapid response to a patient in urgent need of health and social care at home. It provides a short term assessment and intervention for patients in their own homes allowing them to remain safely at home and avoid an unnecessary A&E admission.

Discharge to Assess (D2A)

D2A is about helping people home from hospital, quickly and safely. The essence of the approach is that the person, once medically optimised, goes home and is assessed for their ongoing needs in their home or other place of residence rather than remaining in hospital for these assessments. The aim is to reduce unnecessary delays in discharge when they could be back at home or in a more appropriate place to receive ongoing assessment, short term interventions and support.

Intermediate care beds

Short term bed based rehabilitation offers the patient a chance to work with a multi-disciplinary team to gain as much independence as possible and help them return home. Many patients, particularly the elderly, suffer with loss of function after a major physical illness or following a hospital admission and this can make it difficult for them to cope in their usual environment.

Intermediate care home pathway

The home pathway team supports people in receiving or completing their rehabilitation in their own homes. Short term care and therapy are provided by the community and reablement teams to support the person's recovery to independence.

Reablement

Reablement service is another evidence based approach to support maximising people's ability to return to their optimum level of independence with the lowest appropriate level of ongoing support. The service focuses on restoring independent functioning and helping people to do things for themselves rather than the traditional approach of doing things for people.

Community IV

The delivery of IV therapy* in the community setting can reduce the requirements for hospitalisation and improve quality of life. The extension to the existing IV model in the city is agreed and will go live in the autumn 2019. This will include enabling care to be delivered within the community and people's homes with a focus on independence, choice and self-care.

**any treatment administered by intravenous injection, infusion or subcutaneous infusion.*

The multi-disciplinary team

The MCR integrated team encompasses a range of community health and social care staff at various grades including community nurses, advanced practitioners in various disciplines, physiotherapists, occupational therapists, assistant practitioners, pharmacists, social workers, primary assessment officers, reablement managers and reablement staff.

2.4 Although there are discreet specialist teams and pathways within MCR, staff will flex and work across the teams and pathways when required.

3. What will Manchester Community Response deliver

3.1 The aims of MCR are to drive and deliver person centered assessment, care planning and rehabilitation to the people receiving its services. It will deliver services at the right time, by the right person and in the right setting. It will provide high quality, evidence based, safe services delivered in a personalised and compassionate way that promotes independence, self-management and proactive use of personal and community resources. It will also offer support to the carers supporting our cohort.

3.2 MCR services are delivered across the three localities in Manchester (North, Central & South) and are supported by a Service Lead or manager and a senior Clinical Lead in each locality.

3.3 MCR will provide a quality service to enable the people to live independently, receiving the support they require within their own homes and communities. MCR will:

- Provide care as close to home as safely and as cost effectively as possible.
- Support people to achieve their optimum health and wellbeing and enable a return to as much independence as possible to improve quality of life.
- Encourage and support carers to take an active role in the recovery/ rehabilitation/ reablement of the person they care for.
- Ensure effective care co-ordination and care navigation across the services.
- Provide safe care and treatment that meets a person's individual needs and aspirations.
- Provide evidence based care delivered in line with quality standards (e.g. CQC, NICE).
- Protect and safeguard vulnerable adults in line with statutory responsibilities.
- Avoid unnecessary hospital admission for people whose needs can be managed at home and in the community. This includes:

- *The NWAS Pathfinder programme and Amber Pathway which enables people to remain at home rather than be taken to A&E by the ambulance service following their assessment because their needs can be met quickly and safely by the Crisis response team*
- *deflecting people who present/admitted to A&E back home where they can be supported by service such as Crisis Response.*

- Reduce the number of avoidable admissions to residential care by providing viable interventions and support to remain as independent as possible for as long as possible.

3.4 The D2A model, which sits within MCR, supports hospital systems and flow with better outcomes for individuals by:

- Transferring people out of hospital as soon as they are medically fit, preventing 'deconditioning' and hospital acquired infections.
- Assessing people in a more suitable environment (home) which leads to a more accurate picture of their needs.
- Supporting people with short term care and rehabilitation or support, to help them gain or re-gain independence and preventing or reducing the potential need for longer term care.

3.5 There are a range of anticipated benefits and outcomes for MCR, and for the people that are in receipt of its service. These include:

- Improved quality of service for people accessing intermediate care.
- People being assessed in a more appropriate setting to understand their longer term needs.

- Providing care closer to home.
- Support for wider system flow and resilience across Manchester.
- Helping people receive additional health and care support to enable them to remain safely at home.
- Helping to avoid unnecessary or untimely transfer to long term care.
- Increased number of customers/patients in their own homes 91 days after discharge.
- Supporting a reduction in non-elective admissions and readmissions.
- Reduction in long term admissions to residential and nursing care.
- Reduced length of stay in hospital.
- Supporting carers feel involved in the assessment and planning of care for the person they support.
- Reduced care packages (number and size of package).
- Improved patient and carer experience of services.

4. Manchester Community Response and MLCO operating model

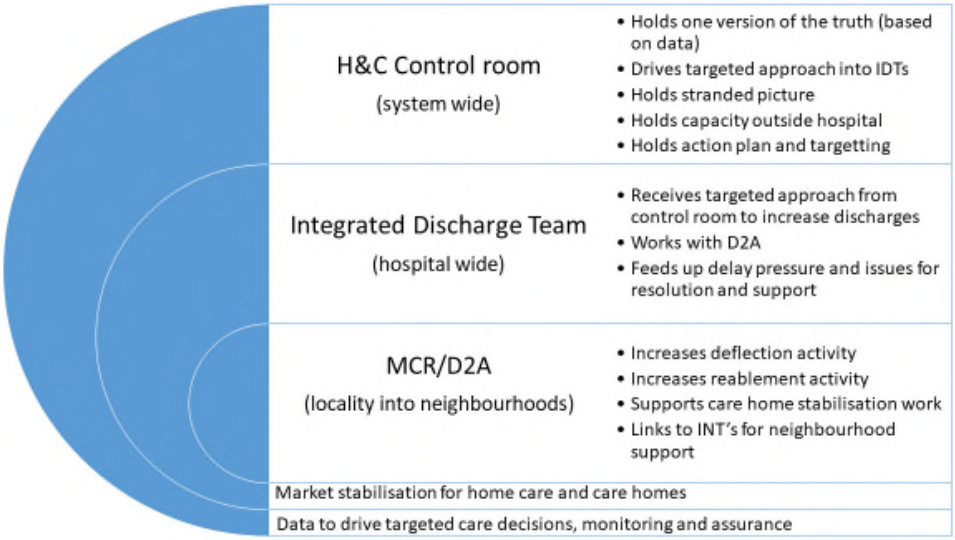
4.1 In addition to being one of MLCOs new models of care, MCR plays a key role in delivering against MLCO's four key delivery priorities, in particular 'Supporting people in and out of hospital':

4.2 As the Committee have been previously advised in November 2019 brought forward a short term plan to respond to continued and escalating pressures within the health and care system in Manchester.

4.3 As part of this process five priority areas were identified, which included expediting the mobilisation of one of the elements of MCR:

- Establishment of a control room;
- Mobilising an integrated discharge team;
- Roll out of discharge to assess;

- Market stabilisation; and,
- Data driven decision making.



4.4 A key part of work described at 4.3 is to increase deflection activity and to target health and care support into care homes. It includes increasing primary care referrals in MCR, and the expansion of the model to include medical input and a service for primary care to review patients being considered for admission.

4.5 The work builds upon the MCR model to increase deflection activity and to target health and care support into care homes. It will include increasing primary care referrals in MCR, and the expansion of the model to include medical input and a service for primary care to review patients being considered for admission.

4.6 The reablement function described at 2.3 works in conjunction with health practitioners to support discharges from hospital settings across the City. The services provide a rapid response delivering personalised support which meets the outcomes of each individual and their carers(s) to maintain they live independently in the community.

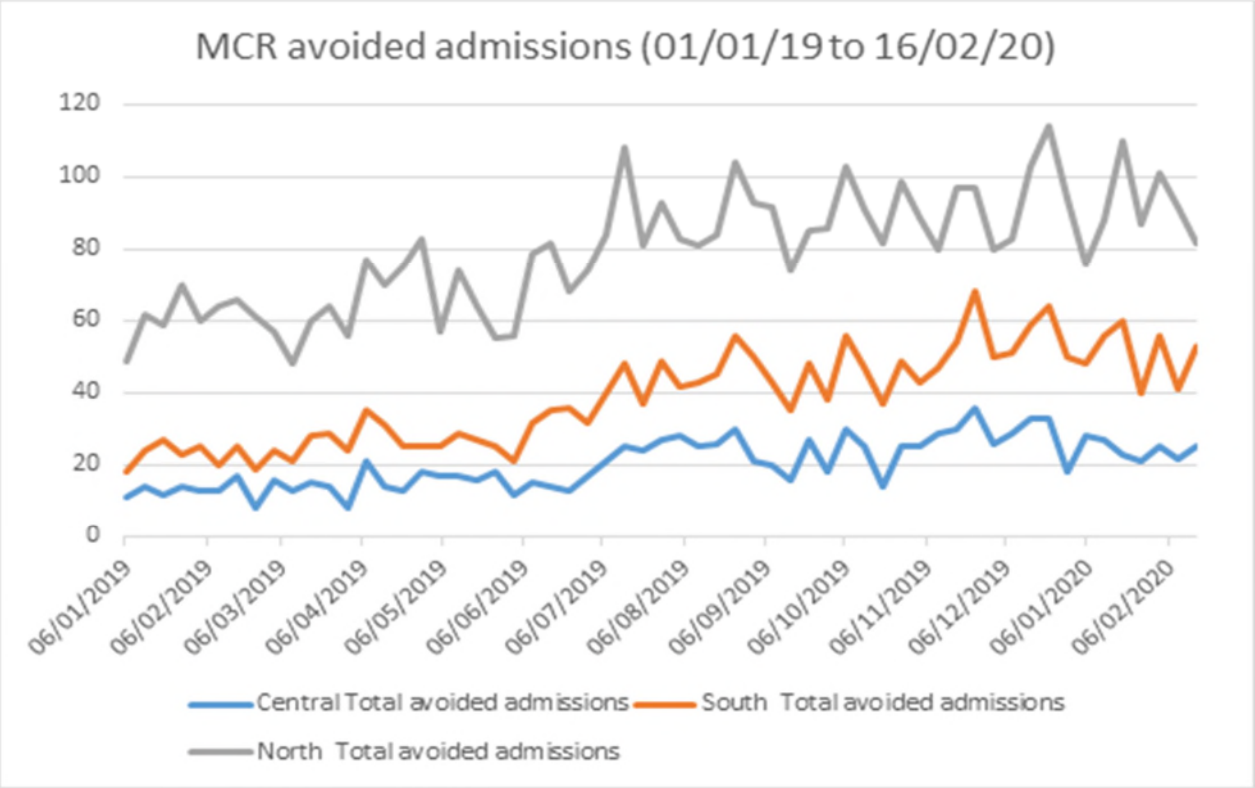
4.7 Reablement plays a critical role in supporting health and social care to manage increasing demand. Activity for December 2019 was significantly higher than December 2018 with a 61% increase in the number of referrals requesting reablement to facilitate a smooth transition from hospital to home. The total number of people in service continues to increase which has been driven by an increase in staffing levels, and continued improvements in the responsiveness of securing packages of care from homecare providers.

4.8 In addition to the work that is being delivered through Manchester Community Response, Manchester Case Management (formerly known as High Impact Primary Care) continues to work with some of the most complex residents in the city.

5. Manchester Community Response in numbers

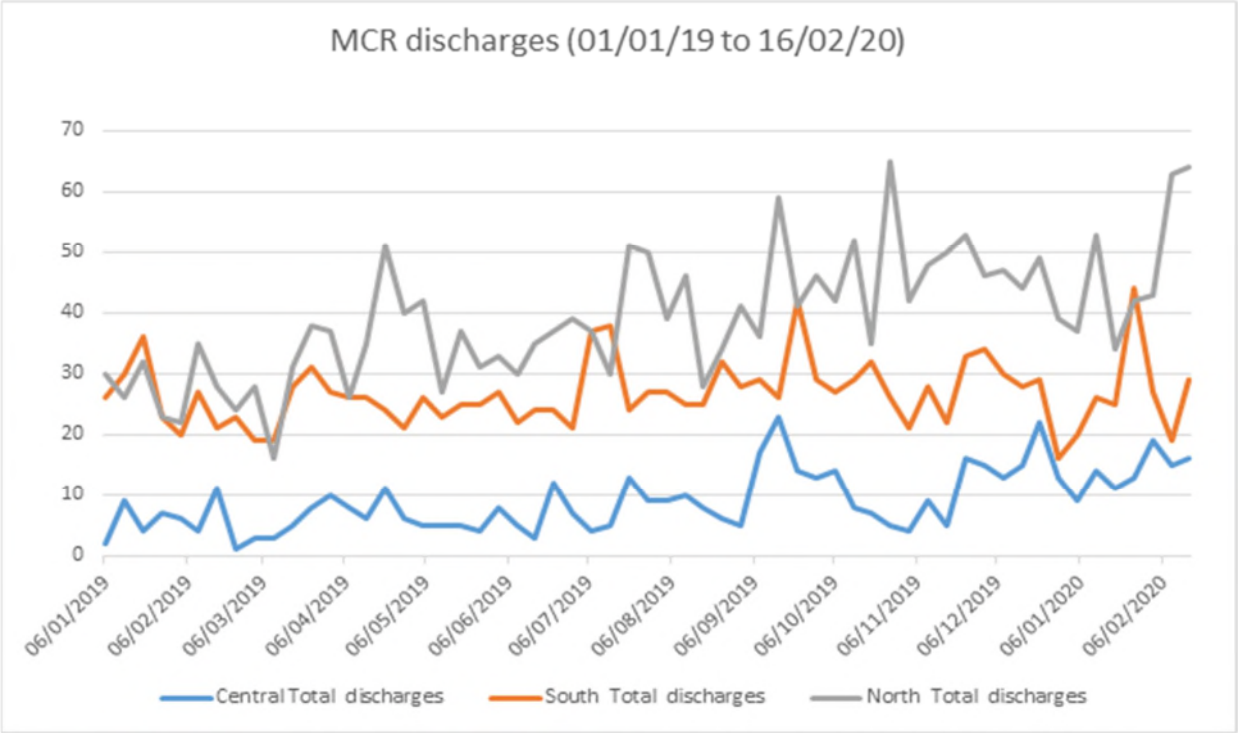
5.1 Since January 2019, MCR has avoided 4,686 admissions to hospital. This means that a significant number of people who would otherwise have ended up in hospital have been supported by MLCO into urgent care settings.

5.2 As can be seen from the graph below there is significant variation across the three localities in Manchester. The MCR service in North Manchester is the most mature in the city, and the analysis below highlights the potential and what could be achieved across both Central and South Manchester when they reach similar levels of maturity.



5.3 In addition to the numbers of avoided admissions, the MCR services support a significant number of discharges out of hospital settings. Between January 1st 2019 and February 16th 2020 MLCO supported a significant number of people into alternative care settings (including their own homes) via MCR, with the three MCR services facilitating 4,434 discharges.

5.4 The table below shows the level of discharges through the discharge to assess pathways, by week, through the period set out at 5.3.



6. Recommendations

6.1 The Committee is asked to note the contents of the report, progress made to date and the work of teams with MCR to deliver person centred services to residents in Manchester.

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Appendix One – MCR and what it means for residents

Crisis Response

Mr B was seen at home by one of our physiotherapists as part of the community element of the new South Manchester **community crisis response service** which provides a crisis service to hospital, primary care and social care referrals. Mr B's wife was very complimentary of the service they received, which prevented a hospital admission, and stated 'the crisis response service has done more for Mr B in 72 hours than any other service has done in 3 years'.

Discharge to Assess

Mrs W was discharged home and was assessed by the team on day of discharge with the family present on assessment. During assessment Mrs W was identified as a high falls risk. She had a pendant alarm but has not pressed the alarm when she has fallen previously and has had six hospital admissions in the last year. The team arranged for a falls sensor which was delivered the same day. Following the family leaving, Mrs W fell and the falls sensor alerted the alarm company and the family so the right care could be provided immediately. The family thanked the team for their support and also for arranging the sensor so promptly.

High Impact Primary Care/Manchester Case Management

Mrs H is a service user with multiple issues including alcohol dependency, epilepsy, hearing and sight impairment, anxiety and depression and multiple long-term health conditions. She had started detox several times but not completed the courses and had cancelled multiple social care packages – putting herself at risk of harm and self-neglect. She attended A&E almost every day. Her alcoholism had created a strained relationship with her children and she had no contact with her grandchildren.

The HIPC team provided weekly support and developed a plan with Mrs H. They accompanied her to hearing and eye tests, arranged counselling and alcohol service support and organised attendance at social interaction groups to pursue her interest in drawing.

With the support of the team, Mrs H's drinking has significantly reduced and she has agreed to go to residential detox. She now has a hearing aid that has greatly improved her communication and has had support from pharmacy to improve how she uses her inhaler to control breathlessness; and the HIPC GP to prescribe a nebuliser to reduce anxiety. She is now much more willing to work with agencies and her attendance at A&E has reduced from once every day to around once every three weeks. Family relationships have improved greatly and her children and grandchildren now come to visit.

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 3 March 2020

Subject: The Marmot Review – 10 Years On

Report of: Director of Population Health

Summary

The Marmot Review – 10 Years On was published on Tuesday 25 February 2020.

The review report provides a stark assessment of the fact that the last decade in England has been marked by deteriorating health and widening health inequalities.

A summary of the key messages from the review is provided along with an initial assessment of how plans, programmes and activities in Manchester relate to the key recommendations contained in the review report.

Recommendation

The Committee is asked to note the report.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
Zero carbon and climate change is a key component of the review report

Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	The Marmot Review addresses all of the outcomes of the Manchester Strategy
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	

A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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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.

The link to the full Marmot Review Report and Executive Summary is provided below:

https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

1. Introduction

1.1. In February 2010 Sir Michael Marmot published his first report: Fair Society Healthy Lives. In this report there were six priority objectives, namely:

i. Give every child the best start in life.
ii. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
iii. Create fair employment and good work for all.
iv. Ensure a healthy standard of living for all.
v. Create and develop healthy and sustainable places and communities.
vi. Strengthen the role and impact of ill health prevention.

1.2 The Manchester Population Health Plan, approved by the Health and Wellbeing Board in March 2018, is based on these priority objectives and the Committee has received a number of reports on relevant population health programmes over the last two years.

1.3 The Marmot Review Report published on 25th February 2020 presents a detailed analysis of what has happened at a national level in relation to the first five priority objectives listed under 1.1 (https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on). The headlines from this analysis and a summary of the key messages from the review are provided in section 2.

1.4 The Marmot Review Team was based with the Institute of Health Equity (University College London) and supported by the Health Foundation.

1.5 The Chief Executive of Manchester City Council, Joanne Roney, was a member of the National Advisory Group for the review and has played a leading role in bringing the Marmot Review Team to work with partners in Greater Manchester (GM). Indeed, there are two GM case studies in the full report and these are also included in section 2.

2. Key messages from the Review

2.1 The findings from the review were presented to a national conference on 25th February that included keynote speeches from Sir Michael Marmot, Andy Burnham (the Mayor of Greater Manchester) and Jon Ashworth (the Shadow Secretary of State for Health).

1. Since 2010 life expectancy in England has stalled; this has not happened since at least 1900. If health has stopped improving it is a sign that society has stopped improving. When a society is flourishing health tends to flourish.
2. The health of the population is not just a matter of how well the health service is funded and functions, important as that is. Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.

3. The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality.
4. Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18.
5. There are marked regional differences in life expectancy, particularly among people living in more deprived areas. Difference both within and between regions have tended to increase. For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in the North East and the largest increases in the least deprived 10 percent of neighbourhoods in London.
6. There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.
7. The gradient in healthy life expectancy is steeper than that of life expectancy. It means that people in more deprived areas spend more of their shorter lives in ill-health than those in less deprived areas.
8. The amount of time people spend in poor health has increased across England since 2010. As the Marmot Review Team reported in 2010, inequalities in poor health harm individuals, families, communities and are expensive to the public purse. They are also unnecessary and can be reduced with the right policies.
9. Large funding cuts have affected the social determinants across the whole of England, but deprived areas and areas outside London and the South East experienced larger cuts; their capacity to improve social determinants of health has been undermined.
10. As in 2010 reducing health inequalities requires action on six policy objectives. In this Report the Marmot Team review significant changes since 2010 in five of them.
    i. Give every child the best start in life.
    ii. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
    iii. Create fair employment and good work for all.
    iv. Ensure a healthy standard of living for all.
    v. Create and develop healthy and sustainable places and communities.

    For each objective they outline areas of progress and decline since 2010 and make clear the links with health and health inequalities.
11. Despite the cuts and deteriorating outcomes in many social determinants some local authorities and communities have established effective approaches to tackling health inequalities. The practical evidence about how to reduce inequalities has built significantly since 2010.

12. The national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010. The Marmot Review Team see this as an essential first step in leading the necessary national endeavour to reduce health inequalities.
13. The Marmot Review Team set out a clear agenda for national government to tackle health inequalities, building on evidence of experience in other countries and local areas since 2010. They establish how the Government must take action in England as a matter of urgency.
14. The goal should be to bring the level of health of deprived areas in the North up to the level of good health enjoyed by people living in affluent areas in London and the South.

2.2 The Population Health Team (PHT) are currently considering some of the national data sets and whether the trends described in the report are the same for Manchester. The initial assessment concludes that many of them do and a specific example of this relates to concerns about falling life expectancy amongst women, highlighted in the two figures below.

Figure 1
Gap in life expectancy at birth between women living in the most and least deprived parts of the city is increasing – the inequality gap in men is reducing

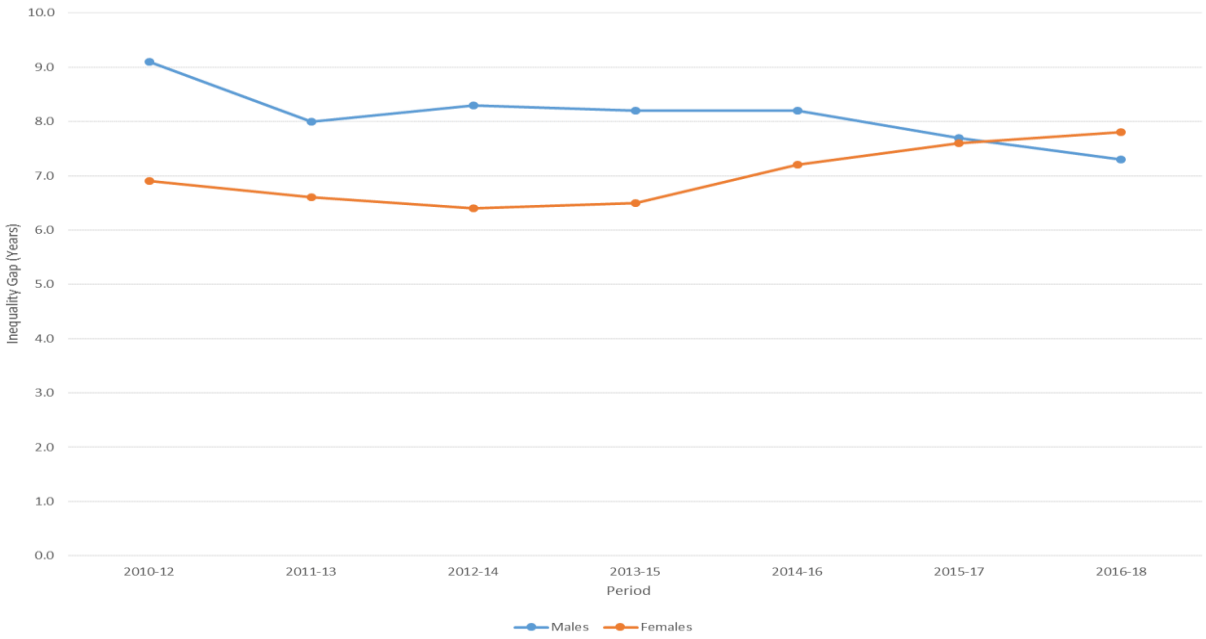
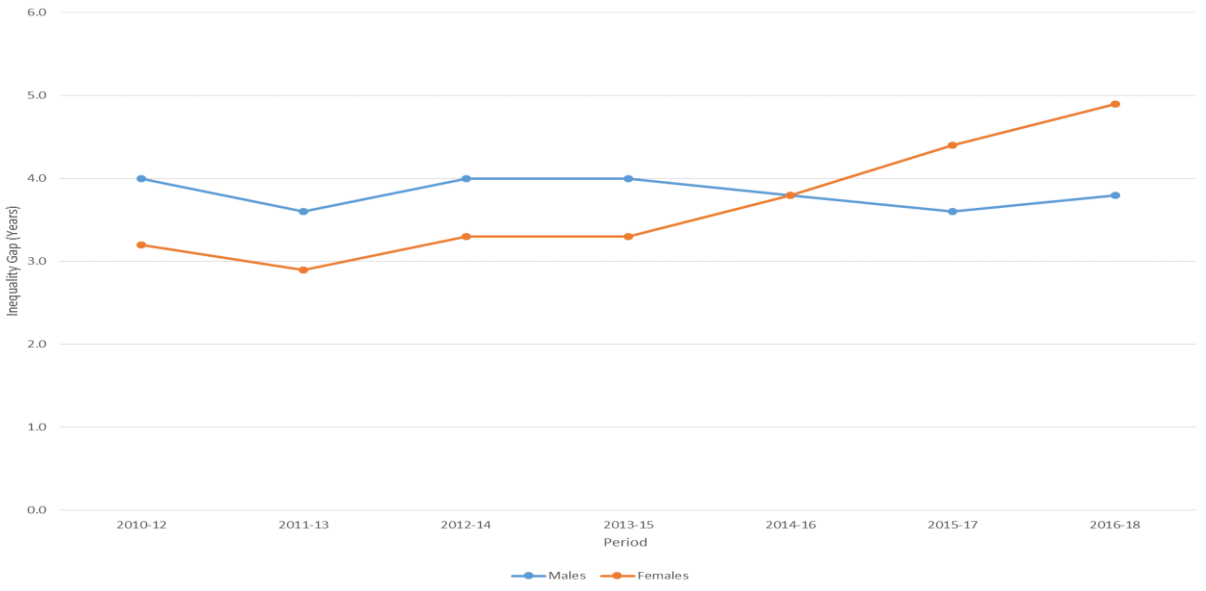


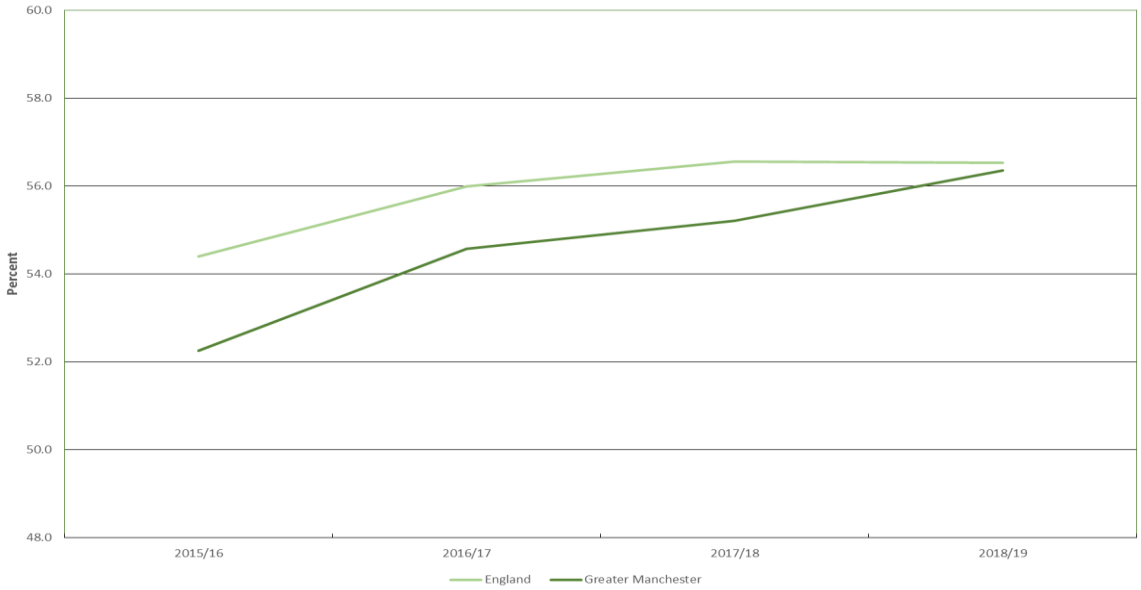
Figure 2
A similar trend of increasing inequality in life expectancy among women living in the most and least deprived parts of the city is seen at age 65



CASE STUDY: GREATER MANCHESTER – CLOSING INEQUALITIES IN THE EARLY YEARS

School readiness for all pupils has improved in Greater Manchester. In the school year 2018/19, 68.2 percent of children achieved a good level of development, compared with 71.8 percent nationally, in 2013 this figure was 47.3 percent. In Greater Manchester, levels of good development at the end of Reception for children eligible for free school meals have improved by four percentage points since 2015/16, a rate of improvement faster than for England as a whole. Greater Manchester has closed the gap in school readiness when compared to the England average.

Pupils achieving a good level of development eligible for Free School Meals 2015/16-2018/19



These marked improvements are the result of a significant endeavour by schools and children's services to improve school readiness, which has been a priority outcome for Greater Manchester. Tough targets have been set, including all early years settings to be rated 'good' or 'outstanding' in 2020, and to close the gap in school readiness between Greater Manchester and the national average (54).

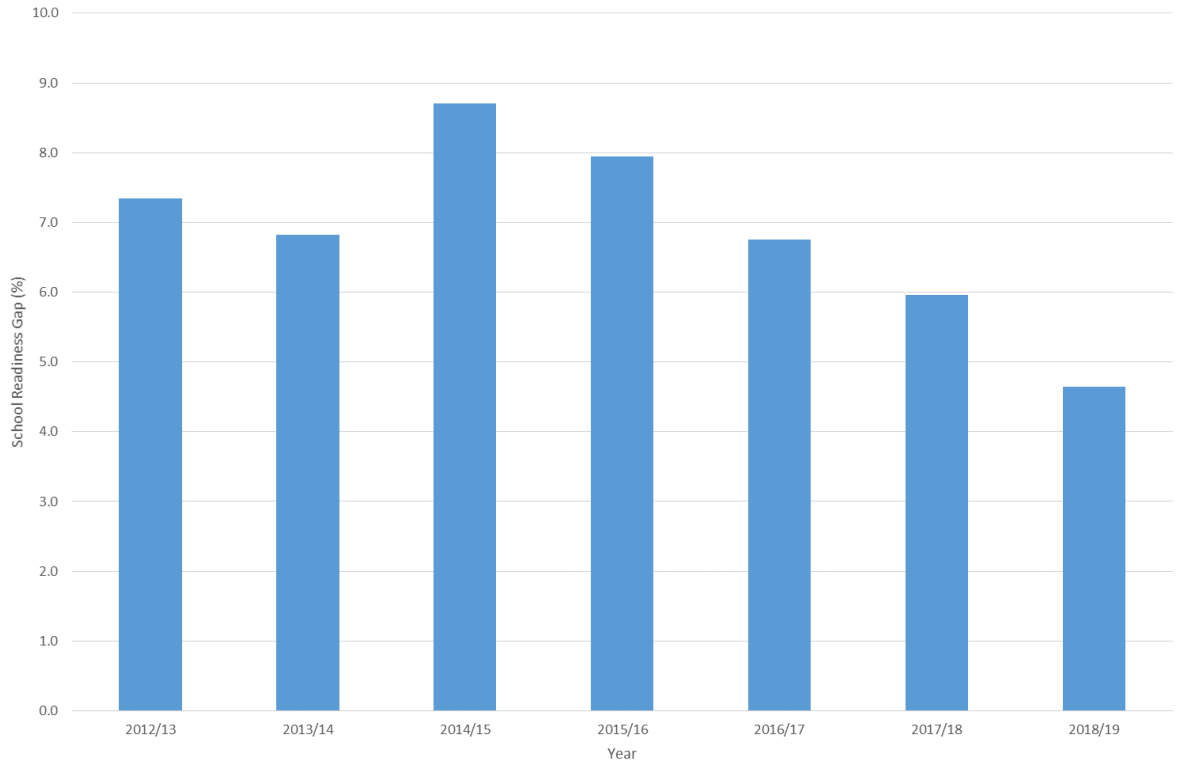
Particular programmes include:

- At scale implementation of early years pathways across GM to support; speech, language and communication; parent and infant mental health; physical development; and social, emotional and behavioural needs
- A focus on delivering both universal and targeted parenting and child development programmes which are evidence-based, like Solihull approach and Incredible Years
- Developing an Early Years Workforce Academy to support workforce development amongst all early years practitioners (in public and private settings) and encourage more integrated working
- I-THRIVE programme to promote children's and young people's wellbeing

2.3 However, it is encouraging to note that in the full report the Greater

Manchester case study on early years shows how we have “bucked the national trend” and the gap between Greater Manchester and England has narrowed. Furthermore, when we look at the specific Manchester dataset, we can see Manchester’s significant contribution to this success, see figure 3 below.

Figure 3
Absolute gap in school readiness between children with a Free School Meal Status in Manchester and the rest of the population has narrowed



2.4 The second Greater Manchester case study in the report focuses on the approach to integrating services. In Manchester this relates to the establishment of Manchester Health and Care Commissioning in April 2017 and the Manchester Local Care Organisation in April 2018. It is acknowledged that Manchester is one of the areas "further along the transformation pathway" than other parts of GM.

CASE STUDY: INTEGRATED SERVICE IN GREATER MANCHESTER

Greater Manchester is a city-region of 2.8 million people with an economy bigger than that of Wales or Northern Ireland. Greater Manchester has ten district councils that come together with each other and the Mayor of Greater Manchester to form the Greater Manchester Combined Authority (GMCA). GMCA works with other local services, the devolved health and care system in GM, businesses, communities and other partners to improve the city-region. The ten GM councils (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan) have worked together voluntarily for many years on issues that affect everyone in the region, such as transport, regeneration, and attracting investment. In 2011, this led to the creation of the GMCA and then to the devolution deals which were announced from 2014 onwards

Devolution has empowered Greater Manchester to further develop new ways of working which has included a new model for Unified Public Services. The ambition is that the integration of health and social care services is brought together with a range of other public services including education, policing, fire, housing, employment and benefits services. This will provide local teams of public servants that will be aligned to common population footprints of 30,000-50,000 residents. The freedoms permitted by devolution, such as integration of health and social care services and new opportunities for joint commissioning, have enabled the development of a truly place-based population health system across Greater Manchester appropriate for taking action on health inequalities. It means that local public services can together focus on upstream determinants of health while mitigating crises downstream with effective multidisciplinary care for those most in need.

Greater Manchester, highlights the opportunities of coterminous Clinical Commissioning Groups and Local Authorities aggregating to a single Integrated Care System and Combined Authority which significantly expands the opportunities for placed based action, population health focus and intervention across all social determinants .Challenges still remain as some boroughs are further along the transformation pathway than others. However the new model for unified public services is helping to spread best practice and create a shared set of principles which underpin service delivery across Greater Manchester (489).

2.5 Furthermore, population health data released in December 2019 shows that our approach to integration in Manchester may be starting to deliver benefits and there has been good progress against a number of key indicators:

- There has been a small increase in Life Expectancy and Healthy Life Expectancy data for the period 2016 to 2018;
- The gap in life expectancy at birth between Manchester and England has narrowed slightly, from 3.8 to 3.5 years for men and from 3.6 to 3.4 years for women;
- There has been a relatively large increase in healthy life expectancy at birth for both men and women over the period 2015-17 to 2016-18;
- The proportion of eligible children deemed to be school ready in Manchester is continuing to improve;
- The latest data for 2017 represents a reduction in number of low birth weight;
- There has been a reduction in the rate of preventable deaths due to Cardiovascular Disease from 94.4 per 100,000 in 2015-17, to 90.1 per 100,000 in 2016-18; and
- There has been a sharp reduction in the rate of people dying from cancers considered preventable from 127.9 per 100,000 between 2015-17, to 121.0 per 100,000 between 2016-18.

2.6 The PHT will do a further analysis of the Marmot dataset that focuses on the wider determinants (e.g. housing, employment, poverty) and assess the Manchester position against these other indicators.

3 Responding to the recommendations in the review report

3.1 The PHT have listed each of the recommendations under the priority areas in the left hand side of the table below and provided an initial response on some of the Manchester strategies and plans that relate to these recommendations.

3.2 It is also important to note that there will be a specific Greater Manchester event in late spring/summer that will share best practice in recognition of Greater Manchester being a designated Marmot City Region.

Recommendation	**Manchester's response**
Best start in life	
Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.	National response required Manchester Population Health Plan 2018-2027. Priority 1 of the Plan relates to 'The first 1,000 days of a child's life'. The required local actions were set out in the Annual Report of the Director of Public Health presented to the Committee in September 2019
Reduce levels of child poverty to 10 percent – level with the lowest rates in	Family Poverty Strategy 2017-2022 Reducing Infant Mortality Strategy 2019-

Europe.	2024
Improve availability and quality of early years services, including Children's Centres, in all regions of England.	Healthy Child Programme; Early Help Programme; Children's Transformation Programme Our Manchester, Our Children - Manchester Children and Young People Plan 2016-2020 Manchester Early Help Strategy 2018-2021
Increase pay and qualification requirements for the childcare workforce.	To be considered as part of the Living Wage Accreditation work
Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives	
Put equity at the heart of national decisions about education policy and funding.	National response required
Increase attainment to match the best in Europe by reducing inequalities in attainment	Children and Young People's Plan 2016-2020 Recent excellent local progress on narrowing the attainment gap between Manchester and England Children and Young People's SEND Plan
Invest in preventative services to reduce exclusions and support schools to stop off-rolling pupils.	Children and Young People's Plan 2016-2020
Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).	National response required
Creating Fair Employment and Good Work for All	

Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.	The in-work poverty pilot led by the Work and Skills Team at MCC is helping people back into paid and secure work
Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.	Manchester City Council (MCC) and Manchester Clinical Commissioning Group (MCCG) accreditation as a Living Wage Employer (Living Wage Foundation)
Increase the number of post-school apprenticeships and support in-work training throughout the life course.	Locality Workforce Transformation Plan
Reduce the high levels of poor quality work and precarious employment.	Locality Workforce Transformation Plan; Workplace Health and Wellbeing Collaborative; 50+ work and health; Locality approach to Living Wage accreditation
Recommendations for Ensuring a Healthy Standard of Living for All	
Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit	MCC and MCCG accreditation as a Living Wage Employer (Living Wage Foundation)
Remove sanctions and reduce conditionalities in welfare payments	This is being taken forward by the Welfare Reform Board
Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy	Our Manchester Industrial Strategy ('Developing a More Inclusive Economy')
Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.	Our Manchester Industrial Strategy ('Developing a More Inclusive Economy'); Manchester Health and Care Commissioning (MHCC) Inclusion and Social Value Strategy
Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive	National response required

Recommendations to Create Healthy and Sustainable Places and Communities	
Invest in the development of economic, social and cultural resources in the most deprived communities	GM Culture Strategy
100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector	Manchester Climate Change Framework and MCC Climate Change Action Plan 2020-25 (draft)
Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result	Manchester Climate Change Framework and MCC Climate Change Action Plan 2020-25 (draft)
Recommendations for taking action: **All of the following require national action**	
Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health	Manchester Population Health Plan 2018-2027; Social Prescribing/Wellbeing 2021 Model presented to the Committee in February 2020 Draft Manchester Healthy Weight Strategy 2020-2025 presented to the Committee in February 2020 Manchester Homelessness Strategy 2018-2021
Ensure proportionate universal allocation of resources and implementation of policies.	To be considered by the Health and Wellbeing Board partner organisations
Early intervention to prevent health inequalities.	Manchester Early Help Strategy 2018-2021 GM Drug & Alcohol Strategy 2019-21 Manchester Tobacco Control Plan, 2018-2021
Develop the social determinants of health workforce	Social Prescribing/Wellbeing 2020/21 Model presented to the Committee in February 2020
Engage the public	Council community engagement

	activities Manchester Local Care Organisation (MLCO) Neighbourhood Development and Support MHCC Patient & Public Advisory Committee (PPAC)
Develop whole systems monitoring and strengthen accountability for health inequalities	Manchester Health and Wellbeing Board responsibility

4 Recommendation

4.1 The Committee is asked to note the report.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee - 3 March 2020

Subject: Manchester Foundation Trust Clinical Service Strategy Programme Update

Report of: Prof. Jane Eddleston, Group Medical Director
Sophie Hargreaves, Director of Strategy

Summary
Manchester University Foundation Trust was created in 2017 following the merger of Central Manchester Foundation Trust and University Hospital South Manchester Foundation Trust. Clinical teams and services across the hospital sites have now been integrated. This item is to provide an update on this work and to outline some of the proposals the merged clinical teams have identified to improve services further.

Recommendations
The committee is asked to note the contents of the report.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
N/A

Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	The delivery of a single hospital service is a key component of Manchester's strategy to improve the health and wellbeing of the city. This report outlines the work being undertaken to deliver the benefits of a single hospital service.
A highly skilled city: world class and home grown talent sustaining the city's economic success	The proposals contained within the clinical service strategies include the creation of new roles - including apprenticeships.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The single hospital service aims to reduce variation between our hospitals and ensure equitable access to the highest standards of care for all communities. The clinical service strategies include proposals to increase screening such that diagnoses are made earlier and thus improving outcomes for patients.

A liveable and low carbon city: a destination of choice to live, visit, work	The clinical service strategies describe how the very best services can be delivered, how we can access new research and innovations. High quality health care contributes to making Manchester an attractive place to live and work.
A connected city: world class infrastructure and connectivity to drive growth	Limited impact.

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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.

1. Purpose of this report

This report provides an update on the work MFT have been undertaking to develop our clinical service strategies.

Following the formation of MFT our immediate priority was to ensure stabilisation of services and to integrate our clinical teams. This was the main focus of year 1 post-merger. Once this was achieved our clinical teams have been coming together to consider ideas for how we can improve our services as a larger organisation and deliver the benefits of having a single hospital service for Manchester.

As the next stage of this work, we would now like to engage patients and the public to help shape our ideas into firm proposals. Whilst we believe there are great opportunities to deliver improvements to care, we are keen to understand and mitigate any negative impacts of changing services or barriers to improvements for certain groups.

We are working with our commissioners to plan a programme of patient and public communications and engagement to better understand patient and public concerns and to help shape our ideas and plans. We also plan to undertake equality impact assessments with patient and public groups to best understand how proposals might best reflect the needs of our diverse communities.

We have begun working with our commissioners to plan this approach and in anticipation of this are updating the Overview & Scrutiny Committee with background information in advance of sharing our engagement plans later in the year.

This paper also provides the background on the formation of MFT following the merger of Central Manchester Foundation Trust (CMFT) and University Hospital South Manchester (UHSM).

2. Background

2.1 MFT – who we are

Manchester University NHS Foundation Trust (MFT) was launched on 1st October 2017. The new organisation brought together a group of nine hospitals plus community services, providing a once in a lifetime opportunity to deliver even better services for the people of Manchester, Trafford and beyond.

MFT Hospital sites:

Manchester Royal Infirmary *Secondary and tertiary services*	**Saint Mary's Hospital** *Specialist women's hospital and genomics*	**Royal Manchester Children's Hospital** *Specialist Children's hospital*	**University Dental Hospital of Manchester** *Specialist Dental hospital*	**Manchester Royal Eye Hospital** *Specialist eye hospital*
Wythen-shawe Hospital *Secondary and tertiary services*	**Trafford General Hospital** *Secondary care services*	**Withington Community Hospital** *Diagnostics, day-case and community*	**Altrincham Hospital** *Diagnostics and outpatient services*	**North Manchester General Hospital** *Secondary care services* **Planned to join MFT in 2020**

2.2 Single Hospital Service Review

The principle of significantly changing the way that hospital and community services are provided in Manchester was first established late in 2015, in the Manchester Locality Plan. This work was led by MHCC in collaboration with the Manchester Health and Wellbeing Board. It commenced in response to the challenges faced by health and social care providers, and set out an ambitious programme of work made up of three 'pillars' and called the Manchester Locality Plan:

- A Single Hospital Service for Manchester;
- A local care organisation that delivers integrated, accessible, out-of-hospital health and care services across Manchester; and
- A single commissioning system for health and social care services across the citywide footprint.

The Manchester Locality Plan was endorsed by all local stakeholders across the city and supported by Trafford Council.

To commence the Single Hospital Service element of this work the 'Single Hospital Service Review' was commissioned in 2016. Independently led by Sir Jonathan Michael, this work sought to consider the benefits that might be accrued by hospital services in Manchester working more closely together and to identify the optimal organisational form required to deliver these improvements. At the time of the Review there were three hospital service providers in Manchester: CMFT, UHSM, and North Manchester General Hospital (NMGH) – part of Pennine Acute NHS Hospitals Trust (PAHT). All three were included in the review process.

The first stage of the review acknowledged the significant challenges that were facing health and social care providers in Manchester. The review found that hospital care was fragmented and that there was an unacceptable variation across the City in the provision and quality of care provided. The review also identified that although duplication, and even triplication, existed across the city in some clinical services, in other specialties patients were struggling to access healthcare appropriate to their needs. Workforce challenges facing hospital providers, exacerbated by the imperative to move to more even service provision across the seven days of the week, were also highlighted as a key issue. In line with NHS services nationally, increasing financial and operational difficulties were also acknowledged. The development of a Single Hospital Service was identified as a key mechanism to address these issues.

The review also identified a range of benefits that a single hospital service could deliver including:

Quality of Care

- Reduce variation in the effectiveness of care
- Reduce variation in the safety of care
- Develop appropriately specialised clinicians and reduce variation in the access to specialist care, equipment and technologies

Patient Experience

- Provide more co-ordinated care across the city (and reduce fragmentation)
- Enhance the work of the Local Care Organisation to transfer care closer to home
- Improve patient access and choice
- Improve access to services and reduce duplication (and thus unnecessary trips to hospital)

Workforce

- Improve the recruitment and retention of a high quality and appropriately skilled workforce
- Support the requirement to provide a seven-day service
- Reduce the reliance on bank and locum/agency staff

- Support teams to meet the needs of current and future demand for services

Financial and Operational Efficiency

- Reduce costs in supplies and services (including drug costs)
- Reduce staff costs through improvement in productivity and changes in skill mix
- Limit future capital outlay and ongoing fixed costs assets
- Improve operational performance

Research and Innovation

- Increase research activity and income
- Create a single point of entry to all clinical trials thereby improving access
- Ensure new research and best practice guidelines are implemented consistently to improve services

Education and Training

- Optimise curriculum delivery, clinical exposure and reduce the variability in the student and trainee experience
- Widen student and trainee exposure to different clinical environments
- Enhance the reputation of Manchester as a place to come to be trained and to work

Work started in the Autumn of 2016 to merge CMFT and UHSM. A programme team was established and appropriate governance mechanisms were arranged to ensure elements of process, including Competition and Markets Authority (CMA) submissions, the development of a Business Case, Due Diligence and legal mechanisms were completed.

2.3 What has been delivered since the merger?

The key tasks in the first year following the merger were as follows:

- Establishing leadership and organizational structure
- Establishing robust governance and assurance arrangements
- Commencing MFT's service strategy development (see more below)
- Planning for major clinical transformation – integration of clinical teams across our hospital sites

Examples of improvements made post-merger include:

Lithotripsy service - Patients needing kidney stone removal wait no longer than 4 weeks. Before the merger, some patients waited 6 weeks or more.

Urgent Gynaecology Surgery - Women who need surgery after a miscarriage are getting faster treatment in less than 2.5 days instead of 4 before the merger.

Fractured Neck of Femur Service – A specialist rehab service at Trafford means that patients with broken hips have shorter lengths of stay after the merger.

A significant programme of engagement was undertaken pre and post-merger with patients, the public and stakeholders. A full Equality Impact Assessment was undertaken, and an action plan developed to mitigate any identified negative impacts on protected characteristic groups.

3. Clinical service strategy programme

3.1 Overview and approach

The creation of MFT gave us a unique opportunity to think about how we could develop our services to achieve the Trust's vision and long term aims. A key part of this was considering how to address the requirements of the NHS Long Term Plan and other external drivers such as GM reconfiguration plans. Following the merger, we started a programme of work to develop an overarching Group service strategy and a series of clinical service strategies, to engage staff across the organisation and external stakeholders to think about the future of the trust.

The strategies were sequenced into three waves, based on priority of service (e.g. because of significant service duplication across sites) or conversely services which were subject to other decision-making processes and therefore required more time for these processes to run their course (e.g. GM Improving Specialist Care).

Wave 1	Wave 2	Wave 3
Head and Neck	Renal	Infection
Lung	Genomics	Trauma and Orthopaedics
Cardiac	Clinical Haematology	Burns and Plastics
Frailty	Outpatient medical specialties *(including Dermatology, Rheumatology, Clinical Immunology, Endocrinology, Allergy, Diabetes, Neurology)*	Breast
Emergency and Acute Medicine		
GI Medicine and Surgery		

Each service strategy was led by a Clinical Lead from the service and the strategy encompassed all MFT sites that the service is provided from. Overall programme and clinical oversight was provided by the then Deputy Medical Director (now Joint Medical Director).

The service strategies were developed through a series of multi-professional workshops that were designed to answer three questions:

1. Where is the service now in terms of its strategic positioning?
2. What should the service look like in the future?
3. How will we get there?

The strategies did not start with a blank piece of paper; relevant service plans, case studies, performance information, benchmarking data, and 'fixed points' such as the GM or national direction of travel were reviewed prior to the workshops.

The clinical service strategies were developed as individual standalone documents with over 500 individual proposals for change ranging from minor operational improvements to larger proposals for reorganisation of services. However, there were common themes:

1. Standardisation of pathways and protocols
2. Formation of single clinical teams (across all of our hospitals e.g. one team of A&E staff)
3. New buildings and equipment
4. New roles, training and development
5. Diagnostics and screening
6. Increasing research opportunities
7. Improved communications with patients
8. Improved pathways of care
9. Virtual clinics and care (e.g. Skype outpatient clinics, virtual wards)

10. ‘One stop shop’ models (where all diagnostic tests are done in a single trip to hospital)
11. Delivering care closer to home
12. Creation of centres of excellence

3.2 Engagement during strategy development

During the development of the strategies we had a structured communications plan which was developed by our in-house corporate communications team. Existing internal meetings were used to regularly update key stakeholders across the organisation, for example Group Service Strategy Committee, Operations and Transformation Oversight Group, CEO Forum, and Integration Steering Group. Regular updates were also provided to local Hospital and Managed Clinical Service committees so that information could be cascaded to divisional management teams. The Clinical Leads for each strategy made themselves available for drop-in sessions during which all staff were able to come along and ask any questions they might have about the strategies.

We also worked with strategic partners to develop the clinical service strategies; workshop invitations were extended to colleagues in local and regional commissioning, the Manchester and Trafford Local Care Organisations. There were regular update meetings with key commissioners (MHCC, Trafford, NHS England, Manchester and Trafford local authorities) to discuss their views on emerging strategies and address any related issues such as attendance at workshops.

Although patient engagement was not the main focus of this phase of the strategy development work, we worked with our patient services team to identify the issues patients commonly highlight with our services so that these could be explored in the workshops. A service user engagement event was held during the development of the Infection service strategy in collaboration with the George House Trust and LGBT Foundation (two local charities). During this workshop we tested out initial ideas about the Infection strategy, and further refined what the direction of travel should be for our services.

Attachment A is an engagement log that describes all of the meetings and other communications and engagement work undertaken during the development of the overarching Group Service Strategy and the wave 1 Clinical Service Strategies.

Once the strategies had been developed they were shared with the stakeholders described above. They were also summarised in different formats for example each Clinical Lead talked about their strategy in a short vlog (video blog). The vlogs were emailed to all staff in MFT’s weekly iNews newsletter, and have been posted on the intranet. The Chief Executive of MFT regularly relayed the high level messages from each strategy during his Trust-wide CEO briefings for all staff.

3.3 Patient engagement and equality impact assessment

We would now like to engage patients and the public to help shape our ideas into firm proposals. Whilst we believe there are great opportunities to deliver improvements to care, we are keen to understand and mitigate any negative impacts of changing services or barriers to improvements for certain groups.

We are working with our commissioners to plan a programme of patient and public communications and engagement to better understand patient and public views and to help shape our ideas and plans. We also plan to undertake equality impact assessments with patient and public groups to ensure the plans support our diverse community.

We have begun working with our commissioners to plan this approach and in anticipation of this are updating the Overview & Scrutiny Committee with background information in advance of sharing our engagement plans later in the year.

In liaison with our commissioners we are proposing a two-stage approach to undertake this communications and engagement:

Stage 1 – overarching themes
As outlined above, the ideas in the strategies can be grouped into common themes. Therefore, it is planned that stage 1 will be communications, patient engagement and EQIA about these themes. The outputs of this stage will be:

- An overarching EQIA to understand the impacts of these thematic proposals. Representatives from community and voluntary groups representing the protected characteristics have been invited to two workshops on the 19th February and 10th March to do this.
- In conjunction with MHCC - Patient and population engagement to communicate the themes of the strategies. A detailed communication plan is being developed along with suitable communications material (an animation, easy read summaries of the themes, vlogs, written materials).
- Development of implementation guides for hospitals / services – these will collate the feedback from the engagement events and document the design requirements to ensure that when services are planned and implemented, they are accessible and inclusive e.g. all virtual clinics should include a process to include a translator.

This phase will be delivered over the spring / summer.

Stage 2 – strategy / service specific
The service strategies will be suitable for implementation over different timescales. In addition, the proposals in some strategies may result in more substantial change than others and as such will require greater levels of patient and public engagement. Therefore, a bespoke approach will be required for each strategy / service. We are beginning to work with our commissioners to agree the appropriate approach for each strategy and we plan to begin programmes of communication and engagement in relation to specific strategies in the summer.

3.4 Next steps
The next steps are to:

- Finalise the communications plan for Stage 1
- Identify priority strategies for development to detailed proposal stage and determine an appropriate communications and engagement plan for these.
- Agree assurance and governance processes with our commissioners
- Provide further updates to OSCs once communication and engagement plans are developed.

4. Recommendations
The committee is asked to note the contents of this report and to expect further updates on patient engagement later in the year.

Attachment A

Service Strategy Programme Communications Log

Meeting / event	Date	Group Service Strategy	Clinical Service Strategies
Internal meetings			
Operations and Transformation Oversight Group	4/5/18 1/6/18 6/7/18 3/8/18 7/9/18 5/10/18	X X X X X X	X X X X X X
Integration Steering Group	16/5/18 13/6/18 18/7/18 15/8/18 12/9/18 24/10/18	X X X X X X	X X X X X X
Hospital CEO session	30/7/18	X	X
Wythenshawe Hospital Management Board	20/6/18 25/7/18 29/8/18 26/9/18	X X X X	
RMCH Strategy Board	6/9/18 4/10/18	X X	
MREH Strategy Committee	22/10/18	X	
Single Hospital Service Operational Group	30/10/18	X	X
Saint Mary's Hospital divisional Business and Innovation meetings	17/7/18 30/7/18 8/8/18 4/10/18 15/10/18 23/10/18	X X X X X X	
Commercial development (Claire Robinson and Keith Chantler)	1/5/18	X	
Strategy/Transformation alignment	8/5/18 31/5/18 29/6/18 30/7/18 6/9/18 4/10/18 17/10/18		X X X X X X X
Strategy/Transformation/Informatics alignment	2/10/18	X	
Comms and OD planning	15/5/18 21/6/18 18/7/18 22/8/18 10/9/18 18/10/18	X X X X X X	X X X X X X

Meeting / event	Date	Group Service Strategy	Clinical Service Strategies
WTWA leadership team (Mandy Bailey and Richard Montague)	15/5/18	X	X
Saint Mary's Hospital leadership team (Karen Connolly, David Kay, Kathy Murphy, Ian Daniels) Saint Mary's Hospital leadership team (Di Donnai, Sarah Vause)	15/5/18 22/5/18	X	X
UDHM leadership team (Mike Pemberton, John Ashcroft, Sue Langley)	17/5/18	X	X
MREH leadership team (John Ashcroft, Sue Langley)	23/5/18	X	X
Clinical leads' group meeting	12/9/18 17/10/18	X X	X X
Bob Pearson and Toli Onon (Group Medical Directors)	26/4/18	X	
Sarah Tedford (MRI Chief Executive)	3/4/18 17/5/18	X X	X X
John Ashcroft (MREH and UDHM Chief Executive)	24/4/18	X	X
Helen Farrington (Deputy Group Director of Workforce and OD)	24/4/18	X	X
Julia Bridgewater (Group Chief Operating Officer)	27/4/18	X	X
Richard Montague (WTWA Medical Director)	30/4/18	X	X
Adrian Roberts (Group Director of Finance)	1/5/18	X	
Margot Johnson (Group Director of Workforce and OD)	1/5/18	X	
Cheryl Lenney (Chief Nurse)	2/5/18	X	
Lesley Watson (Medicine CSG Lead)	3/5/18	X	X
Alison Dailly (Group Chief Information Officer)	9/5/18	X	
Neil Hanley (Director of Research & Innovation)	11/5/18 5/7/18 2/8/18 10/9/18 21/9/18	X X X X X	
Amanda Wood (WTWA Director of Nursing)	15/5/18	X	
Ian Lurcock (CSS Chief Executive)	15/5/18	X	X
David Furnival (Group Director of Estates & Facilities)		X	
Peter Blythin (SHS Programme Director)	17/5/18	X	
Farzin Fath-Ordoubadi (Heart and Lung CSG Lead)	17/5/18	X	
Kathy Cowell (Chairman)	22/5/18 26/6/18 19/9/18	X X X	
Kate Ryan (Consultant and NHS England CRG lead for Haemoglobinopathies)	22/5/18	X	
Ajith Siriwardena (MRI Cancer Lead)	23/5/18	X	
Sean Loughran (Surgery CSG Lead)	25/5/18	X	
Matt Evison (Consultant and GM Cancer Pathway Board Lead for Respiratory)	25/5/18	X	

Meeting / event	Date	Group Service Strategy	Clinical Service Strategies
Mags Bradbury (Associate Director of Employee Wellbeing, Inclusion & Community)	25/5/18	X	
Craig Barclay (Consultant in Restorative Dentistry)	30/5/18	X	X
Gill Heaton (Group Deputy Chief Executive)	30/5/18 18/10/18	X X	 X
Margaret Kingston (Associate Medical Director – Medical Education)	16/4/18 2/7/18 19/9/18	X X	
Lee Rowlands (Director of Contracts)	3/7/18	X	
Christine Doyle (Finance Programme Director)	7/8/18	X	
Next generation innovators (Varinder Athwal, Alex Horsley, Richard Body, Iestyn Shapey, Emma Crosbie)	8/8/18 16/8/18 10/9/18	X X X	X X X
Rishi Sethi (Consultant Radiologist)	17/8/18	X	X
Iain Bruce (Paediatric Otolaryngologist and Honorary Professor of Paediatric Otolaryngology at University of Manchester)	17/8/18	X	
Radiology workshop	20/8/18	X	
Martin Evans (Informatics)	21/8/18	X	
Mark Forrest (Medical Education)	4/9/18	X	
Sue Bailey (NED)	21/9/18	X	
Luke Georghiou (NED / Deputy Vice-Chancellor, University of Manchester)	26/9/18	X	
NED workshop	8/10/18		X
External meetings			
MHCC – catch-up meetings MHCC – meeting with communications team	27/4/18 25/7/18 17/8/18 20/9/18	X X X X	 X X
MHCC – workshop with Governing Body	26/9/18	X	X
Ian Williamson (Accountable Officer, Manchester Health and Care Commissioning)	8/5/18	X	
Trafford CCG – catch-up meetings	22/5/18 25/7/18 2/10/18	X X X	X X X
Trafford CCG – workshop with senior clinicians	16/10/18	X	X
NHS England specialised commissioning	6/6/18	X	X
Manchester LCO (Katy Calvin-Thomas, Helen Ibbotts, Elliot Shuttleworth)	17/5/18	X	X
Sohail Munshi (LCO Medical Director)	25/5/18	X	X
Ben Bridgewater (Chief Executive, Health Innovation Manchester)	1/8/18	X	
University of Manchester (Luke Georghiou - NED / Deputy Vice-Chancellor, University of Manchester)	26/9/18	X	
Manchester Metropolitan University	30/10/18	X	X
Creative Places	24/5/18	X	
<u>NMGH:</u> Head and Neck	29/8/18	X	X

Meeting / event	Date	Group Service Strategy	Clinical Service Strategies
Stroke and Frailty	30/8/18	X	X
Cardiovascular	7/9/18	X	X
Emergency and Acute Medicine	12/9/18	X	X
GI Medicine and Surgery	21/9/18	X	X
Lung	24/10/18	X	X