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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 4 December 2018
Time: 10.00 am
Venue: Council Antechamber, Level 2, Town Hall Extension

Everyone is welcome to attend this committee meeting.

There will be a private meeting for Members only at 9.30am in Committee Room 6 (Room 2006), 2nd Floor of Town Hall Extension

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Membership of the Health Scrutiny Committee

Councillors - Farrell (Chair), Battle, Clay, Curley, Holt, S Lynch, Mary Monaghan, O'Neil, C Paul, Reeves, Riasat, Smitheman, C Wills and J Wilson

Agenda

1. Urgent Business
To consider any items which the Chair has agreed to have submitted as urgent.

2. Appeals
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.

3. Interests
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.

4. Minutes 5 - 16
To approve as a correct record the minutes of the meeting held on 6 November 2018.

To note the minutes of the Public Health Task and Finish Group meeting held on 26 October 2018.

5. Budget 2019/20 Refresh Process: Update for Scrutiny Committees - To follow

6. Adult Respiratory 17 - 74
Report of the Clinical Director, Manchester Health and Care Commissioning

This report provides information on how Manchester Health and Care Commissioning (MHCC) is working collaboratively with partners on a respiratory work programme. The aims are to improve health outcomes and quality of life for patients, support self-management, personalisation and early intervention in the community; and strengthen the quality of end of life care.

7. Transition from young people's health services to adults services - To follow

8. Final Report and Recommendations of the Public Health Task and Finish Group 75 - 88
Report of the Public Health Task and Finish Group

This report presents the findings of the detailed investigation undertaken by the Public Health Task and Finish Group.

9. Overview Report 89 - 102
Report of the Governance and Scrutiny Support Unit

The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission (CQC) within Manchester since the Health Scrutiny Committee last met.

Information about the Committee

Scrutiny Committees represent the interests of local people about important issues that affect them. They look at how the decisions, policies and services of the Council and other key public agencies impact on the city and its residents. Scrutiny Committees do not take decisions but can make recommendations to decision-makers about how they are delivering the Manchester Strategy, an agreed vision for a better Manchester that is shared by public agencies across the city.

The Health Scrutiny Committee has responsibility for reviewing how the Council and its partners in the NHS deliver health and social care services to improve the health and wellbeing of Manchester residents.

The Council wants to consult people as fully as possible before making decisions that affect them. Members of the public do not have a right to speak at meetings but may do so if invited by the Chair. If you have a special interest in an item on the agenda and want to speak, tell the Committee Officer, who will pass on your request to the Chair. Groups of people will usually be asked to nominate a spokesperson. The Council wants its meetings to be as open as possible but occasionally there will be some confidential business. Brief reasons for confidentiality will be shown on the agenda sheet.

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Further Information

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This agenda was issued on **Monday, 26 November 2018** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Mount Street Elevation), Manchester M60 2LA

Health Scrutiny Committee

Minutes of the meeting held on 6 November 2018

Present:
Councillor Farrell – in the Chair
Councillors Clay, Curley, Lynch, Mary Monaghan, O'Neil, Wills and Wilson

Councillor Craig, Executive Member for Adults, Health and Wellbeing
Councillor Midgley, Assistant Executive Member for Adults, Health and Wellbeing
Nick Gomm, Director of Corporate Affairs, Manchester Health and Care Commissioning
Dr Matt Evison, Consultant in Respiratory Medicine Manchester University NHS Foundation Trust
Neil Thwaite, Chief Executive, Greater Manchester Mental Health NHS Trust
Deborah Partington, Director of Operations, Greater Manchester Mental Health NHS Trust
Jane Thorpe, Acting Deputy Director of Commissioning for Mental Health and Children Manchester Health and Care Commissioning

Apologies: Councillors Holt, Paul and Reeves

HSC/18/44 Minutes

Decision

1. To approve the minutes of the meeting held on 9 October 2018 as a correct record.

2. To note the minutes of the Public Health Task and Finish Group meeting held on 18 September 2018.

HSC/18/45 Discussion item with Dr Matt Evison, Manchester University NHS Foundation Trust

The Committee welcomed Dr Matt Evison, Consultant at Manchester University NHS Foundation Trust who had been invited to the meeting to discuss his involvement with the CURE programme, a service to prescribe medication to tackle patients' addiction to tobacco and offer intensive support to help them stay smoke-free during their stay at hospital and once they go home and the lung cancer screening programme.

A Member introduced Dr Evison, informing the Committee that she had personal experience of the care and treatment provided by Dr Evison and his colleagues at the site following a referral by her own doctor to the RAPID (Rapid Access to Complex and Pulmonary Investigation Days) service.

Dr Evison described that the impact of smoking and tobacco addiction, with its associated health conditions, such as lung cancer were the biggest contributor to premature death, illness and economic inequality across the region.

Dr Evison described lung cancer as a particularly aggressive form of cancer that often presented without any symptoms to the patient, therefore detection and treatment at an early stage was very important to improve the chances of a full recovery. He then went onto describe the three initiatives that had been developed at the Wythenshawe Hospital site.

He described that the CURE programme represented a significant shift in the attitude amongst health professionals to the treatment of smoking. He said that for far too long smoking had been regarded as an individual's behaviour and lifestyle choice. He said that now smoking and tobacco dependency was regarded as physical disease and as such needed to be treated as a chronic physical illness with the use of prescription medication. He said that when a patient was admitted to the hospital, regardless of their condition staff were trained to discuss with the patient their smoking habits and their addiction was graded based upon their consumption. He said that this was then electronically recorded and the treatment would commence immediately with the issuing of nicotine patches. He said that following a patient's admission, staff from the CURE team would visit the patient within 48 hours to discuss the medical treatments available to them to assist with their addiction. He said that following discharge from hospital a patient would receive follow up contact and support from the CURE team and the patient's doctor would continue to administer any medication required.

He said that there was overwhelming robust medical evidence to support this approach to treating patients who were addicted to tobacco. He said that in addition to the health benefits to the individual there were significant financial savings to be made to the wider health economy due to a reduction in the number of hospital admissions each year and the pressures on primary care as a result of smoking related illness. He said hospitals needed to invest in medication and staff to realise these long term savings. He commented that the devolution of the health budget and the transformation fund had contributed to these initiatives and these were being closely monitored nationally.

With regard to the lung health checks pilot he said that these had been delivered in areas of the city where the levels of smoking amongst the population were very high. He said that for those citizens assessed as being at high risk of lung cancer they were offered an immediate CT scan. He said that this had resulted in 1 in 23 scans identifying lung cancer, with 80 of these being at stage 1 which meant they were treatable.

Dr Evison described how the RAPID service had been designed from a patient perspective that had brought specialist teams together in a reorganisation of care, rather than working in silos to facilitate the timely screening, diagnosis and treatment of patients. He said that with teams working collaboratively this removed system delays and improved patient diagnosis and care pathways. He said that the lessons of the RAPID programme would be learnt and reviewed with the ambition to scale up this service so that it could be delivered across the city.

In response to a comment from a Member regarding recent reports of a national shortage of radiologists he acknowledged that this was an issue and commented that the success of future schemes was reliant on qualified radiologists being able to undertake and correctly analyse scans and surgical teams able to accommodate the increased number of procedures required. He said that to successfully roll out the scheme more widely across the city this would also require partnership working between commissioners and primary care so that suitable care pathways were established.

Decisions

1. The Committee note the presentation by Dr Evison; and

2. Recommend that the Executive Member for Adults, Health and Wellbeing and the Director of Population Health and Wellbeing support this programme and the wider roll out of this service across the city.

HSC/18/46 Manchester Mental Health Transformation Programme

The Committee considered the report of the Greater Manchester Mental Health NHS Foundation Trust and Manchester Health and Care Commissioning (MHCC) that provided the Members with a progress report on Manchester Mental Health Services, following the acquisition on the 1 January 2017 by Greater Manchester Mental Health NHS Foundation Trust (GMMH). The report provided an update on progress made since January 2018, or 22 months since the acquisition, of the transformation programme, organisational change and development.

The Chief Executive, Greater Manchester Mental Health NHS Trust referred to the main points of the report which were: -

- A description of the different Transformation Working Groups that had been established to deliver the transformation programme;
- The activities to increase Improving Access to Psychological Therapies (IAPT) and an analysis of the impact and outcomes;
- The activities to improve Acute Care Pathways (ACP) designed to improve access and moving health provision into the community, supporting care closer to home and providing the best treatment in the right place at the right time, accompanied with a summary of progress to date;
- Urgent Care and the development of a Section 136 Suite at the North Manchester General Hospital site;
- Activities to reduce the number of Out of Area Placements;
- An update on a range of community engagement activities;
- How performance was managed and reported;
- A description of the challenges in relation to the workforce and the recruitment of skilled mental health professionals; and
- A description of next steps.

The Executive Member for Adults, Health and Wellbeing commented upon the high quality of the report that had been submitted to the Committee, noting the reported progress and improvements. She commented that the report was an honest report that also discussed the challenges. She said that she welcomed the commitment to delivering a seven day a week service and the reduction in the use of out of area placements, commenting that these were very important to both patients and their families. This view was also expressed by the Committee.

The Assistant Executive Member for Adults, Health and Wellbeing echoed the comments of the Executive Member and stated that she had received positive feedback from her constituents regarding the care and service provided by the Trust. She stated that there needed to be a parity of esteem between mental health and physical health and further commented on the national shortage of mental health workers and sought further clarification on the waiting times for IAPT therapy.

In response to a question from a Member regarding staff and the work force strategy the Chief Executive, Greater Manchester Mental Health NHS Trust said that it was very important to recruit and retain the correct staff. He acknowledged the challenges staff had experienced over the previous ten years and described that the work force strategy focused on promoting Manchester as a great place to work. He commented that the Trust appeared in the list of the top 100 NHS organisations to work at. He said staff were engaged with and their views sought so they were involved in the improvement process and involved in designing solutions. He further commented that a lot of work had been done to address the previous negative perceptions of Manchester as a place to work and a national recruitment campaign would be launched.

The Director of Operations, Greater Manchester Mental Health NHS Trust responded to a question asked by a Member about Care Coordinators by explaining that these were not new roles and were currently in place and that where any vacancies existed these would be recruited to. She further commented that the issue of Out of Area Placements was being looked at a Greater Manchester level. She also stated that the number of bed spaces in the city had increased and across GM by 10%.

The Director of Operations, Greater Manchester Mental Health NHS Trust responded to a question regarding the accreditation status as assessed by the Royal College of Psychiatrists. She stated that the application for accreditation was not done for each site at the same time and stated that the other two sites were working towards this.

A Member commented that he welcomed the establishment of the Section 136 Suite at the North Manchester General Hospital site, stating that this was an improvement in how people with mental health issues were treated and asked how common was it for a city like Manchester not to have had such a facility previously. The Director of Operations, Greater Manchester Mental Health NHS Trust stated that it was uncommon not to have one and stated that it was a very positive development for the care of patients.

The Acting Deputy Director of Commissioning for Mental Health and Children Manchester Health and Care Commissioning commented that the access to IAPTS therapy continued to increase and there were a number of sites across the city where

these were now delivered. She said there were both national and internal targets for receiving therapy. She commented that work was also underway at a GM level to review the levels of access and to also look at the issue of delayed transfer of care that had been raised by Members.

Members discussed the issue of safe guarding in relation to community engagement and sought an assurance that the safeguarding of patients would always be considered. The Director of Operations, Greater Manchester Mental Health NHS Trust said that the 'Be Well' service, a social prescribing service in north Manchester worked closely with local community groups and the voluntary sector and gave the assurance that safeguarding was always considered.

Decision

The Committee note the report.

HSC/18/47 Prepaid Financial Cards - Adult social care (MLCO)

The Committee considered the report of the Executive Strategic Commissioning and Director of Adult Social Services that provided Members with some background information regarding Prepaid cards, an update on the Procurement process and an outline of the Implementation process of Prepaid Financial Cards within adult social care, now delivered through the Manchester Local Care Organisation.

The Strategic Lead referred to the main points of the report which were: -

- A description of the rationale for the introduction of Prepaid Financial Cards in the context of The Care Act;
- A description of how the cards would work and what they could be used for;
- A list of benefits to both the Council and to the citizen;
- An update on the procurement process and the implementation process;
- Information on citizen engagement and communication ;
- How pre-paid financial cards were important enablers for moving to a broader strength-based model of social care, noting that the Personalisation of Adult Social Care Services was vital to ensure that Manchester citizens could exercise choice and control over how their care and support needs could be met.

A Member commented that an individual on occasion may wish to purchase a costly one off item, and gave an example of a season ticket for a favourite football team and enquired if the payment cards would be flexible enough to accommodate this type of purchase. The Strategic Lead acknowledged the comment from the Member and said that this type of purchase was acknowledged and it was important that the citizen had improved choices. She said that this would also help address social isolation and that the scheme was flexible to accommodate that type of request.

In response to a question from a Member who asked if the money that was paid weekly onto the card was not spent would that be clawed back, the Strategic Lead said this would not be done immediately, however if there was a pattern of money not

spent over a period of time this would prompt a conversation with the citizen to review what their level of award was.

The Strategic Lead informed the Members that the prepayment card would be offered to ‘new’ users of the service and it was envisaged that this would be approximately 500 citizens in the first year, with a view to rolling this offer out once it was embedded. She said that consideration also needed to be given to ensuring that the market place was aware of this system and work was underway to address this. She said that the company who had been procured to deliver the card service had a lot of experience with other Local Authorities and commented that the delays with introducing the scheme had been as a result of GDPR requirements. She further commented that Manchester had worked closely with other Authorities who had successfully introduced prepayment cards to share their knowledge and understand the lessons they had learnt.

A Member commented upon the important issue of safeguarding and sought an assurance that this was being addressed. The Strategic Lead informed the Members that work had been done with safeguarding colleagues to ensure that this was embedded in the approach and the Cards offered a new feature around tackling suspected financial abuse. She said that spending was audited to identify any anomalies and that she would provide the Committee with information on the Risk Register that had been developed that highlighted any associated risk around implementation.

Decisions

1. The Committee note the report; and

2. Request that information on the Risk Register be circulated to the Committee.

HSC/18/48 Overview Report

A report of the Governance and Scrutiny Support Unit which contained key decisions within the Committee’s remit and responses to previous recommendations was submitted for comment. Members were also invited to agree the Committee’s future work programme.

Decision

To note the report and approve the work programme.

Health Scrutiny Committee – Public Health Task and Finish Group

Minutes of the meeting held on 26 October 2018

Present:
Councillor Wilson (In the Chair)
Councillors Curley, Holt, Lynch and Wills

Councillor Craig, Executive Member for Adult Health and Wellbeing

Apologies: Councillor Mary Monaghan

Also present:
Dr Rebecca Wagstaff, Deputy Director, Health and Wellbeing Public Health England North West
Jane Pilkington, Deputy Director for Population Health
Roisin Reynolds, Senior Advisor, Greater Manchester Health and Social Care Partnership
Dr Caroline Rumble, Consultant in Health Protection (Greater Manchester) Public Health England North West
Prof Christopher Phillipson, Professor of Sociology and Social Gerontology
Leasa Benson, Clinical Lead Health Protection

HSC/PH/18/06 Minutes

Decision

To approve as a correct record the minutes of the meeting held on 18 September 2018.

HSC/PH/18/07 Alcohol, Age Friendly and Health Protection

The group considered the report of the Director of Population Health and Wellbeing that was presented in three sections relating to alcohol related harm, the Age Friendly Manchester Programme and Health Protection. The Group agreed to consider the report in three distinct sections.

Alcohol related harm

The Director of Population Health and Wellbeing referred to the main points and themes within the report relating to alcohol related harm, which included:-

- Information on the co-design of a single Greater Manchester Drug and Alcohol Strategy with the widest possible range of partners, stakeholders, voluntary and community sector organisations and people with lived experience;
- Key indicators relating to alcohol harm in Manchester;
- The ambitions of the Draft Greater Manchester Strategy 2018-2022 with its 6 identified priority areas; and
- Information on areas identified for development including prevention and early intervention activities: reducing drug and alcohol related harm and building

recovery in communities; reducing drug and alcohol related crime and disorder; managing availability and accessibility and establishing diverse, vibrant and safe night time economies.

Members also viewed a video that described the work of the Communities in charge of Alcohol project, launched in 2017 to combat the growing number of people who were drinking excessive amounts of alcohol across the city region, noting that the Manchester Project in Newton Heath and Miles Platting had commenced in June 2018.

Some of the key points that arose from the Members' discussions were:-

- What lessons had been learnt from successful Tobacco campaigns that could be used to address public attitudes towards alcohol;
- Recognising that there was often a link between alcohol and tobacco use a combined approach to these issues would be better and which would also be better use of resources;
- The importance of connecting alcohol services with other health services such as mental health and sexual health programmes;
- Recognising that patterns of drinking behaviour had changed, noting the increase in drinking at home;
- Consideration needed to be given to including Public Health as an objective of licensing conditions; and
- Noting the pilot schemes in North Manchester how were the outcomes of these to be measured.

The Deputy Director for Population Health informed Members that a campaign would be launched on the 15 November 2018 across the city region entitled 'Big Alcohol Conversation'. The purpose of this consultation exercise was to engage with people and test public attitudes towards the issue of alcohol. This conversation would be delivered via a range of mediums and allow for self-assessment so people could consider how they used alcohol. She said that it was recognised that there were a range of issues that contributed to alcohol misuse, including access to cheap alcohol. She described that attitudes towards alcohol needed to be addressed in the same manner as behaviour change was influenced towards the use of tobacco. She said to achieve this a public mandate was required and the consultation exercise was designed to help achieve this across the city region.

The Senior Advisor, Greater Manchester Health and Social Care Partnership said that these discussions were important as it was important to engage with people who don't consider themselves as having an issue with alcohol, especially people who drink at home and campaigns would be delivered around this issue. She further described that a lot of research had been undertaken at Sheffield University around the issue of minimum unit alcohol pricing.

The Director of Population Health and Wellbeing informed Members that waiting times for alcohol services had improved and that the increased use of social prescribing would deliver a holistic approach, across a range of services to address an individual's health needs. The Strategic Commissioning Manager, Public Health,

Manchester Health and Care Commissioning commented that the drug and alcohol service, CGL did work closely with the local Mental Health Trust.

The Deputy Director for Population Health commented that an integrated, place based approach is very important to address the issue of alcohol harm. The Deputy Director, Health and Wellbeing Public Health England said that health professionals needed to be confident to have discussions and ask questions of patients regarding their use of alcohol and that this discussion informed regular heath checks.

The Deputy Director, Health and Wellbeing Public Health England North West said that other authorities had introduced Public Health as a licensing objective and she would forward information on this to the Group. The Director of Population Health and Wellbeing said that consideration was being given to including Public Health as a licensing objective in Manchester and the Strategic Commissioning Manager, Public Health, Manchester Health and Care Commissioning informed the Group that Public Health were represented at licensing policy discussions.

In reply to the question regarding measuring outcomes and evaluation of the schemes in north Manchester the Director of Population Health and Wellbeing said that evaluation had been built into the schemes and the University of Salford would undertake the evaluation and report on this.

The Executive Member for Adult Health and Wellbeing said that the lessons learnt from the success of previous campaigns in influencing behaviour change and attitudes was important. She said that, in addition to this utilising local knowledge would help target initiatives and engage with localities using appropriate campaigns. She said that the work of local teams would link in with the Greater Manchester level strategies.

Age Friendly Manchester Programme

The Director of Population Health and Wellbeing referred to the main points and themes within the report relating to the Age Friendly Manchester Programme (AFM), which included:-

- Describing that AFM aimed to improve the quality of life for older people in the city and to make the city a better place to grow older noting that AFM had been identified as a leading example of the Our Manchester approach;
- Information on the publication in October 2017 of *Manchester: a Great Place to Grow Older 2017-2021* to coincide with International Older People's Day in recognition that older people in Manchester experience some of the worst health and social exclusion in the country;
- Priority four of the Manchester Population Health Plan was to create an age-friendly city that promoted good health and wellbeing for people in mid and later life;
- A description and examples on the three key strategic aims of the ageing strategy that were: Creating more age friendly neighbourhoods; creating age friendly services and promoting age equality.

Some of the key points that arose from the Members' discussions were:-

- Recognising the many good examples of local projects and enquired if there was an established network so groups could share and learn of good practice;
- Noting that there were positive examples nationally of schemes and groups to support the older LGBT community and enquired what was being doing locally to support these residents;
- Consideration needed to be given when designing spaces to maximise generational interaction noting the positive outcomes of this; and
- What was being done to address the poor health outcomes in older people.

The Professor of Sociology and Social Gerontology said that Manchester was recognised internationally for its work around this issue. He said that it was important that cities considered the requirements of urban growth and an ageing population, stating that recognising that 'ageing in place' was important for people and consideration needed to be given to how services were delivered and the local environment was designed to support this, commenting that the AFM approach was important to delivering this. He said that it was important to influence individual's health outlook, especially those in middle age so they accepted and considered that they would grow old.

The Professor of Sociology and Social Gerontology further commented that AFM allowed for the monitoring of changes in the ageing population and to identify and respond to the needs of specific groups, such as the LGBT and BAME population. He said that the Ambition for Ageing, a £10.2 million Greater Manchester level programme aimed at creating more age friendly places and empowering people to live fulfilling lives as they aged and this would focus on specific community groups.

The Professor of Sociology and Social Gerontology commented upon the importance of social infrastructure, such as libraries as community hubs to support intergenerational contact and address social isolation. He said that a lot of research on the health benefits of social infrastructure had been undertaken in the United States and he commented that he would forward the details of this research to the Group.

The Director of Population Health and Wellbeing said that good practice was shared amongst groups and this also helped identify gaps across neighbourhoods and assisted in identifying different funding streams.

The Executive Member for Adult Health and Wellbeing said that the report was a brief summary of ten years of work to deliver AFM. She said that the wider determinants of health, such as employment opportunities and housing was recognised and AFM provided a challenge to all strategies and policies across all partners.

Health Protection

The Director of Population Health and Wellbeing referred to the main points and themes within the report relating to Health Protection, which included:-

- Describing that Health protection was one of three core domains of public health, and following the transfer of public health functions to local government

in 2013, there was now a statutory duty for local authorities to ensure there were plans in place to protect the health of the population;
- Reporting the work of the Manchester Health Protection and Community Infection Control Team in 2017/18 and in the first six months of 2018 (1st April 2018 - 30th September 2018) and set out the key actions and challenges for the period ahead in delivering the health protection function with particular reference to Seasonal Influenza Vaccination Programme, Tuberculosis Management, Hepatitis A, Measles, Meningococcal Disease, Nurseries, School, University and Care Home Outbreaks Overview, Gram Negative Blood Stream Infection; and
- Information on future plans.

Some of the key points that arose from the Members' discussions were:-

- How was best practice shared across Greater Manchester; and
- Recent reports had suggested that there was a shortage of the flu vaccine and sought an update.

The Consultant in Health Protection (Greater Manchester) Public Health England (PHE) North West commented that PHE had a very good relationship with the Local Authority and this had allowed for quick and effective responses to issues when they arose. She said that following any incidents debriefs were arranged and key lessons learnt and actioned.

The Deputy Director for Population Health Wellbeing said that good practice in Health Protection was shared across local authorities and a report on this would be shared with Members.

In response to the question regarding availability of the flu vaccine the Director of Population Health and Wellbeing informed the Group that this was a national issue due to a supplier. He said that it is estimated that there was currently 70% of the vaccine that was currently required and additional batches of the vaccine are being released in tranches. He advised that the system was being managed locally to prioritise those requiring the vaccine.

Decision

To note the report and to thank all of the guests who had attended and contributed to the discussion.

HSC/PH/18/08 Feedback from Members on their findings

Members were invited to feedback on their findings and were invited to propose recommendations based on the evidence that they had considered. These recommendations would then inform the final report that would be submitted to the final meeting of the group for approval.

The Chair advised that Members would be invited to consider this and he would informally meet with the Members following the next meeting of the Health Scrutiny Committee to discuss the proposals for the final recommendations.

Decision

That the Group would informally meet following the next meeting of the Health Scrutiny Committee to discuss the proposals for the final recommendations.

HSC/PH/18/09 Terms of Reference and Work Programme

Members were invited to review and approve the terms of reference and work programme.

Decision

To agree the terms of reference and work programme.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee - 4 December 2018

Subject: Adult Respiratory

Report of: Dr Manisha Kumar, Clinical Director, Manchester Health and Care Commissioning

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Summary

Manchester Health and Care Commissioning (MHCC) is working collaboratively with partners on a respiratory work programme. The aims are to:

Improve health outcomes and quality of life for patients, support self-management, personalisation and early intervention in the community; and strengthen the quality of end of life care.

Tools and standards have been developed to support achievement of the aims. The programme links with other existing programmes of work e.g. smoking cessation and lung health checks and cross sector collaboration will continue to benefit the people of Manchester.

We will provide a separate report on the work on children's respiratory health in Manchester at a future Health Scrutiny Committee meeting.

Recommendations

The Health Scrutiny Committee is asked to note the content of this report and provide comments on the respiratory work programme.

Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable)

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 development of community Health Development Coordinators and support to community based solutions will support recruitment from within and for local populations

A highly skilled city: world class and home grown talent sustaining the city's economic success	Patient education is a theme throughout the respiratory work programme. This will empower the respiratory cohort to manage their disease effectively and to know what to do and who to contact in a crisis. Clinician education and upskilling of staff via formal events or clinics as well as informal arrangements are as a direct result of this collaborative programme of work.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	This paper demonstrates work streams which will lead to improved health outcomes, reduce health inequalities and reduce unwarranted variation.
A liveable and low carbon city: a destination of choice to live, visit, work	Providing excellent respiratory health care closer to home for patients. Developing and delivering high quality local services for local people. Leading the way on innovation for respiratory management.
A connected city: world class infrastructure and connectivity to drive growth	Learning from models elsewhere (Coventry – see Breathe Better Manchester) and sharing the Manchester approach with Greater Manchester and beyond.

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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.

None

1. Introduction

1.1 In 2017 Manchester Health and Care Commissioning (MHCC) identified respiratory as one of the key long term conditions to address poor health outcomes in Manchester. Manchester has **641,098** registered patients.

1.2 The below table shows the number of patients who are on the General Practice Quality Outcomes Framework (QOF) disease registers with Asthma and Chronic Obstructive Pulmonary Disease (COPD) as at 1 April 2018.

	MHCC patients	MHCC prevalence	Greater Manchester prevalence	England prevalence
Asthma	36,688	5.77%	6.41%	5.93%
COPD	12,647	1.97%	2.31%	1.91%

- 8,424 (23%) of asthma patients currently smoke
- 6,187 (48%) of COPD patients currently smoke
- 13,398 (11%) of current smokers have a respiratory condition

1.3 From the below data we can see an increase in emergency admissions for people with respiratory problems (this is for ALL respiratory problems not just asthma and COPD).

Year	Emergency Admissions	Number of unique patients	Emergency Admissions Cost	Total registered MHCC population
15/16	7555	6074	£9,554,251	603,419
16/17	8399	6742	£11,620,540	627,081
17/18	10240	8287	£14,928,827	641,098

2. Background

2.1 RightCare

The NHS RightCare teams work locally with systems to present a diagnosis of data and evidence across that population. NHS RightCare Delivery Partners and their teams work collaboratively with systems to look at the evidence to identify opportunities and potential areas where quality can be improved. This collaborative working arrangement helps systems to make improvements in both spend and patient outcomes.

2.2 The data benchmarks Clinical Commissioning Groups against ten similar CCGs based on various indicators (e.g. deprivation/ population demographic profile). The Manchester RightCare report can be found in appendix 1.

2.3 Rightcare Baseline data is from the January 2017 Commissioning for Value (CFV) packs (2015/6 information). RightCare showed Manchester at a variance of £10 million spend on respiratory diseases compared to the

Manchester top 5 peers; a high percentage being spent on emergency admissions.

2.4 It was recognised that in order to address respiratory inequalities we need to have a system wide approach to change. To facilitate this, health commissioners set up the Manchester Adult Respiratory Steering Group in May 2017. Membership of the group includes representatives from primary, community and secondary care, Population Health and Wellbeing, RightCare, British Lung Foundation and patient representation.

2.5 Through integrated working this steering group coordinates the implementation of the respiratory work programme. It acts as the 'formal body' to hold groups and organisations to account to oversee the system wide change to the delivery and management of respiratory care. Working on the principles of 'Our Manchester' we are looking at both an asset based approach across the city and a 'lifetime' approach across the life course of respiratory disease.

2.6 By following the programme of work the impact will be:

- Increased life expectancy
- Improve the patient's experience of care
- Decrease the number of lung cancer related deaths
- Decrease the number of lung cancers diagnosed through Accident & Emergency
- Enable people to manage their disease more confidently and know what to do when in crisis
- Decrease the number of smokers in Manchester
- Reduce the high number of respiratory emergency admissions

3. Approach

3.1 The Manchester Adult Respiratory Steering Group membership developed the Respiratory Plan on a Page (see appendix 2), the logic framework (see appendix 3) and the rainbow diagram for Our Healthier Manchester (respiratory disease) (see appendix 4). This identified work streams that the programme of work would need to focus.

4. Data – Overview

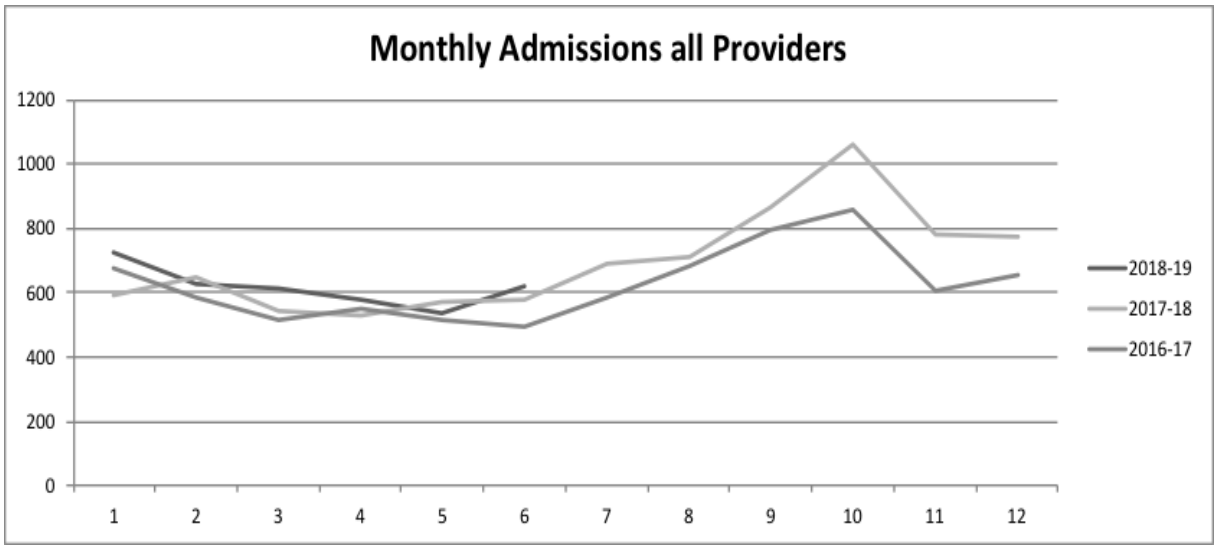
4.1 MHCC has produced a data analysis looking at respiratory emergency admissions for the first 6 months of 17/18 compared to the first 6 months of 18/19. In doing this MHCC is looking to try and identify possible shifts in demands on the system and identify pressure points across the system;

- Adult respiratory admissions are up 6.7% (+234) comparing month six 2018/19 against 2017/18
- 30.7% of respiratory emergency admissions in 2018/19 were for pneumonia*
- 28.9% were for chronic lower respiratory diseases

- 43% of the chronic lower respiratory diseases were due to COPD

*There are ongoing issues with a national shortage of the pneumococcal vaccination supply. However, practices continue to vaccinate all eligible patients, prioritising the high risk cohorts. MHCC advice is to order stock throughout the year and not align with giving the flu vaccine. This will help to ensure demand for the vaccine is more consistent across the year.

4.2 The analysis is clearly showing considerable pressure in emergency admissions for respiratory patients. As stated above there is already a 6.7% growth in the first 6 months of 2018/19. Based on previous years this early increase is concerning as we enter the second half of the year that historically for respiratory admissions sees the greatest demand. This second half increase can clearly be seen in the graph below looking at the last 3 years of data for Manchester patients.



4.3 It is worth noting that across the main providers we are seeing shifts around the number of respiratory emergency admissions.

Provider	Length of stay	2016-17	2017-18	2018-19	16/17 17/18 Variance	17/18 18/19 Variance
Pennine	Zero Days LOS	180	285	306	58.3%	7.4%
	1 Day LOS	151	160	236	6.0%	47.5%
	2+ Day LOS	545	505	560	-7.3%	10.9%
MFT Central	Zero Days LOS	264	336	348	27.3%	3.6%
	1 Day LOS	202	247	192	22.3%	-22.3%
	2+ Day LOS	875	891	879	1.8%	-1.3%
MFT South	Zero Days LOS	139	157	176	12.9%	12.1%
	1 Day LOS	144	159	171	10.4%	7.5%
	2+ Day LOS	657	568	592	-13.5%	4.2%
Other Providers	Zero Days LOS	42	40	70	-4.8%	75.0%
	1 Day LOS	31	42	39	35.5%	-7.1%
	2+ Day LOS	103	79	134	-23.3%	69.6%

4.4 The information in the above table is showing some interesting shift in demand and how providers are managing respiratory emergency admissions;

- Pennine is showing huge growth in 1 day length of stay, +47.5% in the first 6 months of 18/19 compared to the first 6 months of 17/18. MHCC has identified that the provider has opened more beds for emergency admissions and is working on flow improvements through the department.
- Manchester University NHS Foundation Trust (MFT) Central is showing a -22.3% decrease in respiratory 1 day length of stay. MHCC is in discussion with MFT to understand the reason for this shift when we can see overall growth in all emergencies at the trust.
- Manchester University NHS Foundation Trust (MFT) South however is seeing continuing growth across all length of stays for respiratory admissions and is in stark contrast compared to the central site.

4.5 MHCC recognises that there is considerable pressure in the area of adult respiratory emergency admissions across the providers, but it is evident that there are substantial variances in how the providers are managing these patients. MHCC is currently working with the providers and Population Health to further understand this data and will develop some in-depth patient level analysis to try and identify possible areas of improvements moving forward.

5. Primary Care Respiratory Standards

5.1 MHCC developed a set of Manchester wide standards, based on the Greater Manchester Standards for primary care. Respiratory is one area of focus. This is an 'offer' to Manchester patients and the public. All Manchester practices have agreed to deliver the standards to their registered population. This supports a standardised level of provision across the city and improves the quality of the service offer to Manchester patients. The current respiratory

standards will run from 2018 to 2020. The Manchester Respiratory Primary Care Standards focus on:

1. Chronic Obstructive Pulmonary Disease (COPD) patient reviews
2. Review of COPD patients following an exacerbation
3. Asthma reviews in adults
4. Asthma reviews in children
5. COPD Virtual Clinic for 2019/20
6. Pharmacotherapy for smoking cessation 2019/20

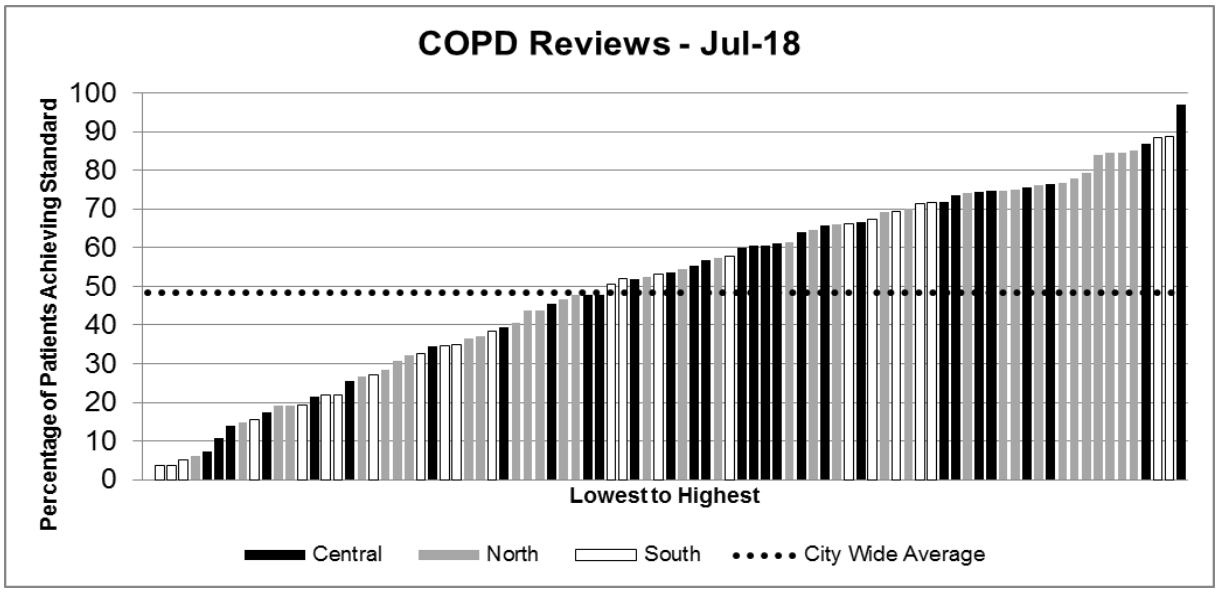
5.2 Manchester Standards are supported by EMIS (practice clinic system) templates, pre-populated forms, which support the elements of Quality Outcomes Framework (QOF) and the Standards together with appropriate coding. These templates also have embedded supporting documentation e.g. flare up plans for patients with COPD so that they know what to do when their condition is deteriorating. This continues the emphasis on enablement and self- care.

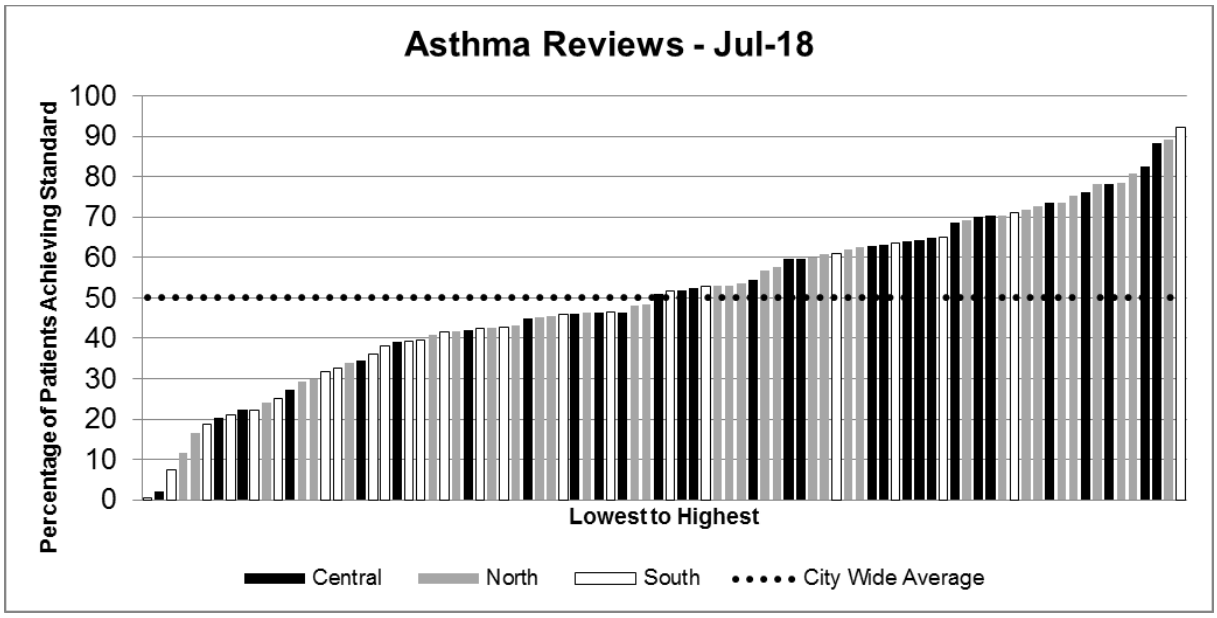
5.3 **Impact**

From the table below we can see the impact of increased primary care intervention on emergency admission rates for COPD patients. A higher level of intervention (see table below) leads to reduced emergency admission rates, reduced admission cost and a shorter hospital stay.

Intervention Level	Emergency Admission Rate (per 1,000 patients)	Cost per admission	Average Length of Stay
0 - None	113	£2,107	6
1 - Basic QoF	163	£2,089	5
2 – Primary Care Standards not delivered in full	78	£2,050	5
3 - Primary Care Standards delivered in full	85	£1,770	4

5.4 The following two graphs provide a citywide view of the percentage of adult patients who have had a COPD review or an asthma review. The neighbourhood view can be found in appendix 5.





5.5 It should be noted that there is some variation across the city and part of the work this year will be to analyse practice level achievement / variance, to learn from best practice and encourage appropriate coding of interventions carried out in primary care. There has, however, been citywide improvement since the roll out of standards.

5.6 Data to date shows that **24 per cent** more COPD patients received a review in the past twelve months.

5.7 Data to date shows that **15 per cent** more asthma patients received a review in the past twelve months.

6. Homecare

6.1 Data analysis completed for the recent Homecare procurement identified respiratory to the largest secondary care cost for people in receipt of Homecare. Further analysis showed that for this cohort (people receiving homecare between April 17 and March 18) there were 402 emergency admissions to hospital for respiratory at a cost of £1.35m. Broken down by description this showed that the largest reason for admission was for pneumonia (48%), followed by COPD (19%) and lower respiratory infection (12%).

6.2 Further work is currently under way to establish what percentage of this cohort are receiving a review as part of the Primary Care Respiratory Standards, which will inform us whether this cohort is sufficiently being targeted proactively within Primary Care.

7. COPD Virtual Clinic

7.1 The COPD Virtual Clinic model is an evidence-based multi-disciplinary approach to respiratory care, underpinned by a recognition that in order to change long-term outcomes, transformation of Primary Care management of respiratory conditions is needed with greater integration of specialist services with general practice. Primary and secondary care clinicians work together to ensure that patients receive optimal management and proactively manage those patients identified by pre-determined searches. The model supports and mentors practice respiratory prescribing and holistic management of patients as well as a focus on education and relationship-building.

7.2 A COPD Virtual Clinic involves case discussions between respiratory Consultants, Senior Pharmacists and primary care clinicians. It is regarded as a clinical session with a focus on patient management and education.

7.3 MHCC has worked with clinical colleagues at MFT to co-host the COPD Virtual Clinic. Ten clinics were held as a pilot across Manchester. The evaluation report has demonstrated the benefit in terms of education and training (for both primary and secondary care) as well as cost savings linked to medicines optimisation. By ensuring patients are on the best inhalers to manage their symptoms we can reduce medicines waste and long term side effects of treatment. In addition, patient care is optimised resulting in a direct improvement on management of their respiratory condition.

7.4 This model is now a product promoted by Health Innovation Manchester on a Greater Manchester footprint.

7.5 **Impact**

- Reduce respiratory management variation in Primary Care
- Upskilling of primary care clinicians
- Improved holistic management of patients
- Prescribing cost savings
- Focus on cost-effective non-pharmacological therapies

8. Spirometry

8.1 Quality assured spirometry is one of the main investigations used for diagnosing respiratory diseases such as chronic obstructive pulmonary disease (COPD) and asthma.

8.2 Recent investments have included the purchase of 36 spirometers which were distributed to practices who requested a machine. MHCC also funded spirometry education and training for primary care clinicians (35 places on a two-day course / 35 places on a refresher course).

8.3 **Impact**

- Early and accurate diagnosis of lung disease is absolutely vital in improving respiratory health.
- Improving the quality of spirometry will improve clinical diagnosis and the long term monitoring of those affected by respiratory disease.

9. Manchester Integrated Lung Service

9.1 Over the past few months MHCC has been working with respiratory colleagues across primary, community and secondary care and this work has culminated in the development of a co-produced service specification for the Manchester Integrated Lung Service (MILS).

9.2 The service is run by the community respiratory teams across the city, now known as the MILS Team. The service will manage COPD patients mainly during 2018/19 with a view to extending to other long term respiratory illness areas (bronchiectasis, interstitial lung disease and patients on oxygen) from April next year.

9.3 Key performance indicators (KPIs) have been jointly agreed and reporting is expected to start in January 2019.

9.4 **Impact**

Moving to community based models of care from a hospital-centric model:

- Team-based community care from doctor led out-patient clinics.
- Continuous community support from episodic management of crisis.
- Integrated seamless pathways of care from current disjointed care between providers.
- Proactive / preventative care from reactive care.
- ‘Patients as partners’ from ‘patients as recipients’.
- Carers being valued and supported from carers being unsupported.
- High-tech integrated data systems and use of technology from low-tech paper based systems.

10. Referral Management

10.1 Primary, Community and Secondary Care collaboratively produced the Manchester Respiratory Referral Criteria (see appendix 6). This covers the minimum information which should be contained in ALL respiratory referral

letters to improve quality of referrals and ensure that patients are directed to the most appropriate service on triage.

10.2 **Impact**

- Reduce variation in primary care
- Upskill primary care clinicians
- Patients attend community / acute services appropriately worked up
- Reduce new to follow-up ratio
- Reduce hospital activity and costs
- Improved patient experience (attend the right clinic first time)
- Right place, right person, right time, first time.

11. Pulmonary Rehabilitation (PR)

11.1 PR is a programme of exercise and education for people with long-term lung conditions. It combines physical exercise sessions with discussion and advice on lung health and is designed to help patients to manage the symptoms of their condition, including getting out of breath.

11.2 The referral process for PR has been reviewed and revised to streamline the process. All referrals into the community (including for PR) are processed under a referral to MILS. MHCC Communications and Engagement Team plan to work with the community services to produce a local video promoting pulmonary rehabilitation as well as using the opportunity to highlight health messages e.g. flu vaccination etc. Posters have been produced for display in general practice encouraging patients to seek a referral to PR.

11.3 **Impact**

- Increased awareness of PR by clinicians and patients
- Increased referrals to PR
- Improved patient understanding of COPD
- Patients feel better and breathe easier (everyday activities will become easier with improved fitness)
- An opportunity for patients to make new friends and learn from others who know what it is like to live with a lung condition
- Patients learn how to manage their condition better

12. Health Innovation Manchester (HIM)

12.1 All of the Greater Manchester's NHS trusts, Clinical Commissioning Groups and Councils are part of the Health Innovation Manchester network. HIM provide the skills and expertise to adopt an innovation from scoping the product to full implementation and delivery. MHCC is to work collaboratively with HIM on the priorities listed below.

12.2 **COPD Virtual Clinic**

A pilot has been carried out as documented in this paper and will continue under the Manchester Respiratory Standards for 2019/20.

12.3 **RightBreathe**

This is an app / website available to put on a desktop which clinicians can use in consultation or 'on the go' to demonstrate the appropriate inhaler technique. With so many inhalers on the market it can be difficult for a clinician to remember how every inhaler is taken, the app or website clearly demonstrates this. HIM are currently in discussions with RightBreathe creators to have the app / website localised to include the Greater Manchester Medicines Management Group (GMMMG) COPD pathway.

12.4 MHCC will work with HIM on the use of other digital technologies to support the work programme moving forward.

12.5 **Virtual Learning Hub**

This is a COPD virtual online learning hub hosted by the GP Excellence website and will be available to all healthcare professionals. This will include videos of COPD expert clinicians speaking about optimum management of the condition, with links to resources and frequently asked questions. There aims to be an online discussion forum and information about the GMMMG COPD pathway. This is scheduled to go live in January 2019.

12.6 **MyCOPD**

This is one of the few apps available that has been through the NHS Digital Accelerator Programme and is a comprehensive self-management tool for patients. The app has NHS England approved status and has a Medicines and Healthcare products Regulatory Agency (MHRA) license. Tiles on the app include pulmonary rehabilitation (useful for those who would find it difficult to attend a weekly session for 6 – 8 weeks), inhaler technique demonstration, management of anxiety, another useful tile is a weather report. MHCC has signed up to receiving the free licenses (20% of COPD register) available. Implementation of the free licenses and further scoping work will take place next year.

12.7 **Accident & Emergency (A&E) Audit**

MHCC is working with The NHS Utilisation Management Unit, part of Health Innovation Manchester, to design and carry out an audit of A&E attendances. The aim will be to look at a cohort of patients attending A&E at the Royal Manchester Children's Hospital and at Manchester University NHS Foundation Trust (MFT).

12.8 The aim of the audit is to understand why patients have chosen to attend A&E and if that attendance could have been clinically managed elsewhere e.g. primary or community care.

12.9 The audit is now underway and the results will be complete by January 2019 and the findings shared across the system.

12.10 Key findings of a similar audit carried out elsewhere found 4 broad reasons for presentation:

1) Reluctance to call for medical help then the decision was often made by others.
2) Learned experience to turn directly to A&E for breathlessness crisis.
3) If reviewed by a Primary Care clinician, directed to present to A&E for test / treatment / advice.
4) Primary Care clinician was unavailable.

12.11 MHCC has also requested that this work includes a retrospective audit in North Manchester where we have seen a 21.5% increase in respiratory admissions (at month 4). We do know that North Manchester General Hospital has opened more beds since last year but MHCC needs to understand further what is driving the high activity. The North Manchester community service (MILS – North) is a well-established, well led service who are proactive with patients.

13. Breathe Better – Community Respiratory Model

13.1 In order to address the long standing poor respiratory health outcomes across Manchester the need to deliver respiratory services in a radically different way has been recognised. There is good evidence emerging around the benefits of social prescribing in respiratory disease showing that in those who engage in groups integrated with respiratory services have better outcomes, including significant reductions in hospital admissions and GP contacts that those who do not.

13.2 Manchester's model is based on the 'Making Waves' Programme in Coventry which was described by the founder as 'throwing a party every month for patients, but having healthcare professionals involved'.

13.3 The proposed model is a community based model where patients would attend for social activities (e.g. bingo, quizzes) but receive Respiratory Consultant / other healthcare professionals review at the same time. There is a great opportunity to work alongside housing and Citizens Advice, and incorporate exercise, singing, British Lung Foundation Breathe Easy support groups etc. This model has delivered huge benefits for patients in Coventry including:

- Reduced unplanned COPD admissions
- Improvement in confidence
- Reduced social isolation
- Improved self-management and understanding of what to do in a crisis
- Improved mental health

13.4 The British Lung Foundation (BLF) Integrated BreatheEasy (IBE) study, a commissioned patient-led peer support model, found similar outcomes for patients, but in addition a health economic analysis showed:

- For every pound invested in the IBE groups there is a return of a minimum of £5.36, i.e. £4.36 in net gain through better health outcomes of participants.
- For every pound invested in the IBE groups, there is a net gain of £22.70 made up of the value of better health outcomes, the NHS cost savings and a range of wider social benefits.

13.5 Population Health colleagues have said that "this model would be a great project for the Health Development Coordinators to facilitate at neighbourhood level once they are in post and fits nicely with the objectives of the prevention programme. It is really important to get a 'neighbourhood conversation' going about this from the outset so it is owned and developed by the neighbourhood rather than a group that sits elsewhere."

13.6 The model will act as an alternative option to long-term hospital clinic follow-up and be a place that patients from the hospital can be safely 'discharged to', but it will also be open to direct referrals from GP practices and other healthcare professionals.

13.7 This work is at an early stage across the city. Dr Binita Kane is working closely with Wythenshawe Community Housing Group and a 'test' session was held on 29th November.

13.8 It is anticipated that the model will work with Galen Research (who help to improve healthcare through scientifically-based research outcome measures) looking at clinical and community based interventions for people with respiratory disease. It is important that services are evaluated in terms of value gained by patients as well as with regards activity and finance.

13.9 **Impact**

- Improving quality of life for people with breathing conditions.
- Improving knowledge and confidence of patients in managing their respiratory disease through better understanding of the disease.
- Improving health outcomes in people with respiratory disease.
- Improving mental health and reducing social isolation in people with respiratory disease.

14. Smoking / Air Quality

14.1 The Manchester Tobacco Plan has recently been published outlining our ambitions to decrease smoking prevalence in the city. We are working closely with Greater Manchester to support the CURE project and also planning community services to deliver tobacco addiction treatment.

C - CONVERSATION: have the right conversation every time
U - UNDERSTAND: understand the level of addiction
R - REPLACE: replace nicotine to prevent withdrawal
E - EXPERTS & BEST EVIDENCE-BASED TREATMENT: for all patients

14.2 Dr Murugesan Raja, MHCC Respiratory Clinical Lead, has appeared in communication videos raising awareness of the dangers of shisha smoking. One hour of shisha smoking can be as damaging as 100 cigarettes; other promotions includes awareness of the risks of poor air quality and what we can do to improve it. MHCC supports the Making Smoking History /smoke free spaces work programme, Stoptober, and to promote clean air in the city.

15. Partnership work in Greater Manchester

15.1 MHCC has been supporting Trafford Commissioners who are keen to adopt the approach Manchester has taken particularly with regards developing a community specification based on the Manchester Integrated Lung Service.

15.2 MHCC is also represented at the Greater Manchester Respiratory meetings for adults and children. A number of areas which have been developed in Manchester are being looked at for roll out across Greater Manchester in particular the Paediatric Management Plans and influenza outbreak in an adult care home - GP guide. Work carried out in central Manchester in 2015/16 to identify patients with COPD early in a GP setting is now also being looked at for possible roll out across Greater Manchester.

15.3 MHCC led the work with GMMMG on developing the Tobacco Addiction Pharmacotherapy Pathway and Tobacco Addiction Treatment – additional prescribing notes. MHCC also contributed to the development of their COPD and asthma management pathways.

15.4 This paper is to provide assurance to the Health Scrutiny Committee that MHCC and partners are continuing to lead on collaborative working across the system in managing the rising demand for respiratory health care.

16. Recommendation

16.1 The Health Scrutiny Committee is asked to note the content of this report and provide comments on the respiratory work programme.

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Manchester CCGS

Respiratory

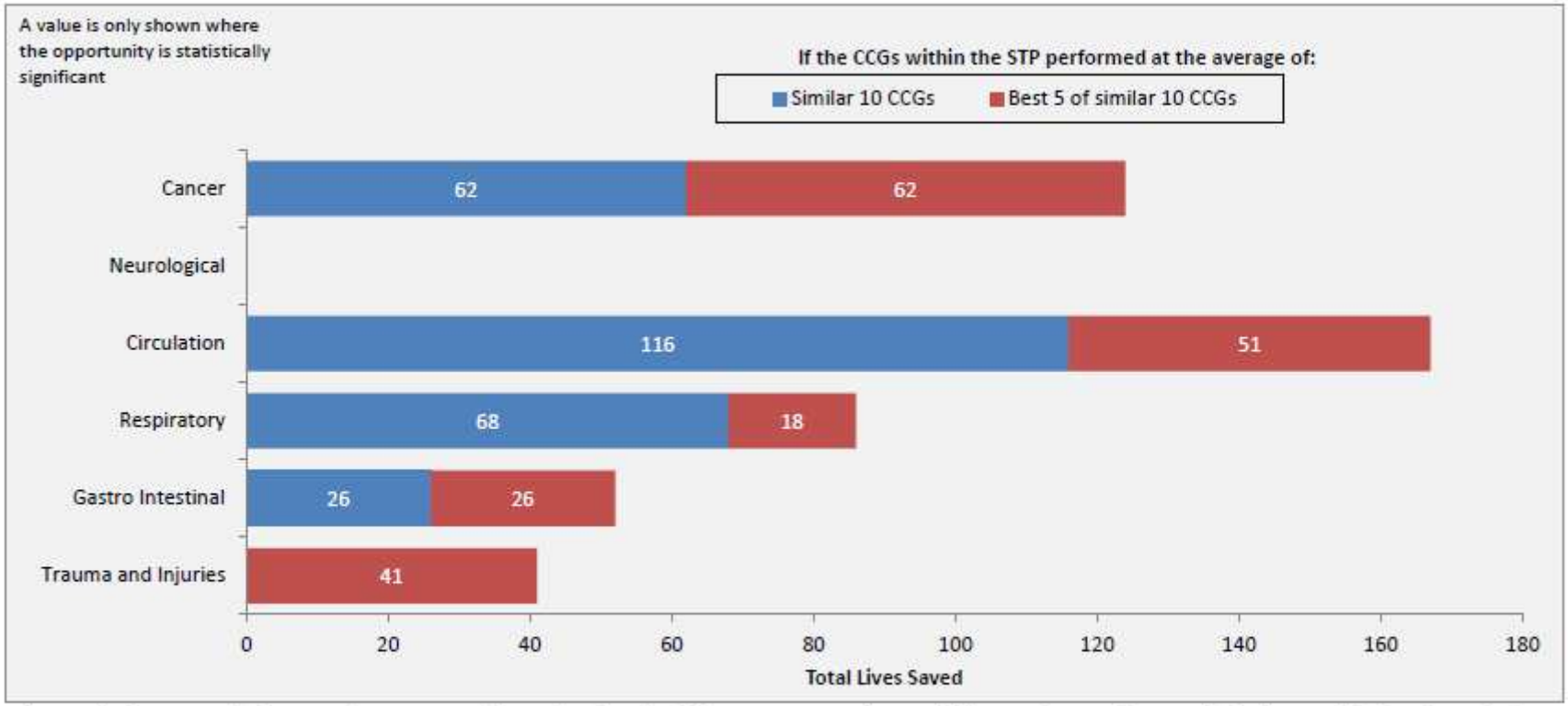
Which CCGs in Manchester - STP share headline opportunity areas?

NHS RightCare

Gastro-intestinal	Central Manchester, North Manchester, South Manchester
Respiratory	Central Manchester, North Manchester, South Manchester
Endocrine	Central Manchester, North Manchester, South Manchester
Neurological	Central Manchester, North Manchester
Circulation	South Manchester
Gastro-intestinal	Central Manchester, North Manchester, South Manchester
Respiratory	Central Manchester, North Manchester, South Manchester
Neurological	Central Manchester, North Manchester
Maternity	North Manchester, South Manchester
Endocrine	Central Manchester, South Manchester
Respiratory	Central Manchester, North Manchester, South Manchester
Neurological	Central Manchester, North Manchester, South Manchester
Endocrine	Central Manchester, North Manchester, South Manchester
Gastro-intestinal	Central Manchester, North Manchester
Circulation	Central Manchester

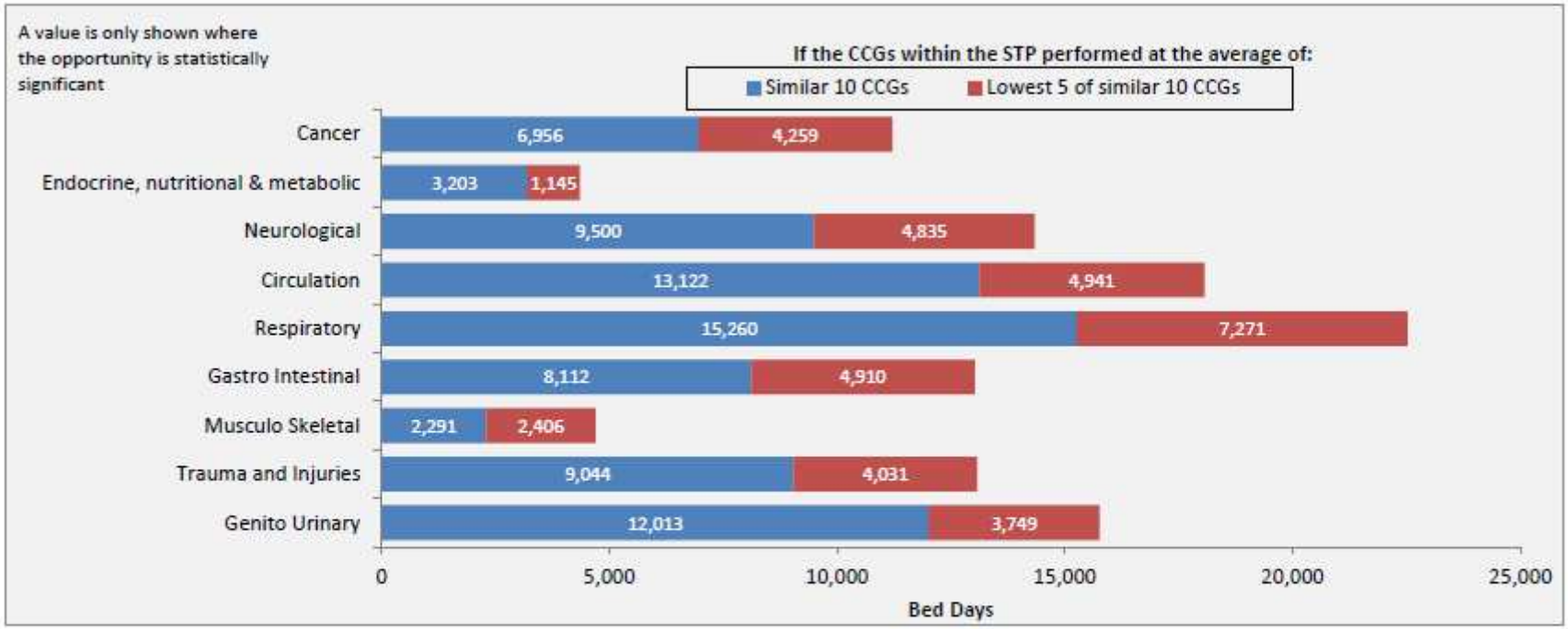
7

What are the potential lives saved per year?



The mortality data presented above uses Primary Care Mortality Database (PCMD) and is from 2012 to 2014. The potential lives saved opportunities are calculated on a yearly basis and are only shown where statistically significant. Lives saved only includes programmes where mortality outcomes have been considered appropria te.

How different are we on bed days?

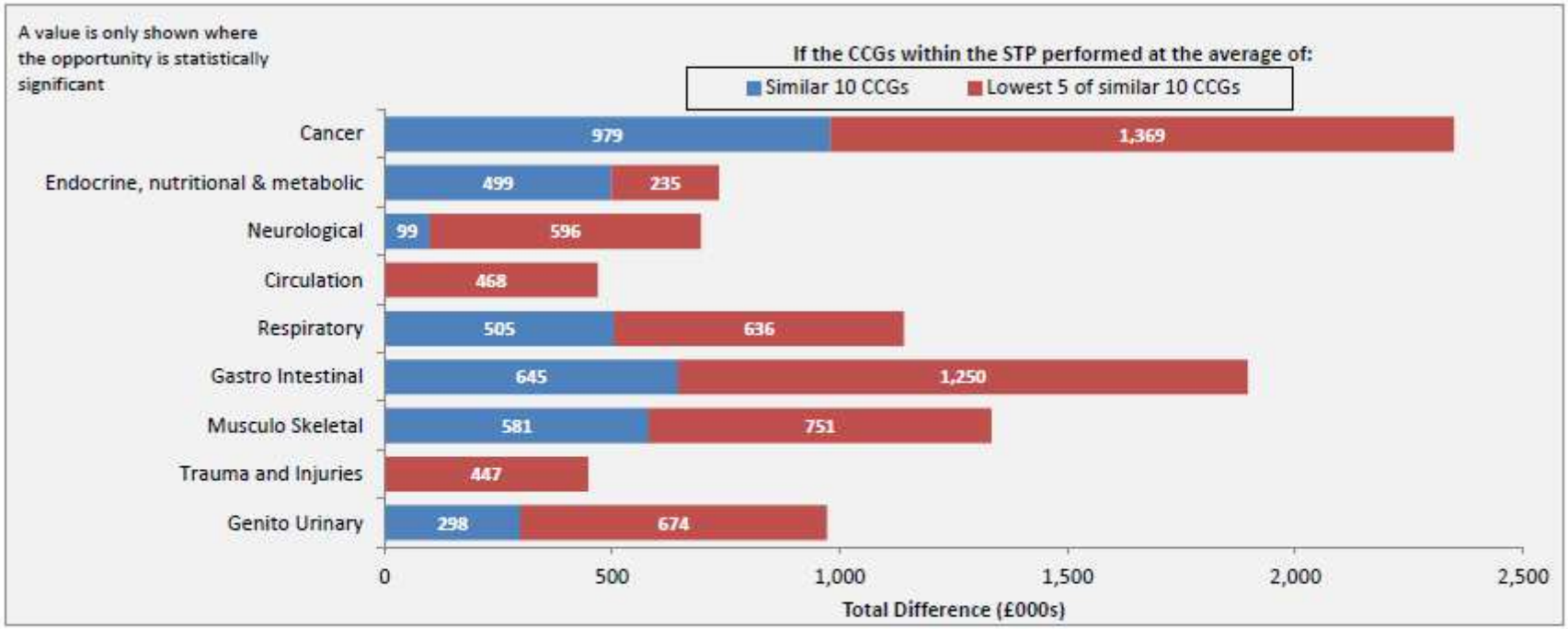


The bed days data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on admissions for any primary diagnoses that fall under the listed conditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning activity. These figures are a combination of elective and non-elective admissions.

Length of stay is derived from admission and discharge date. Spells that have the same admission and discharge date (including planned day cases) have a length of stay in SUS as zero. These have been recoded as a length of stay of 1 day in order to capture the impact of these admissions on total bed days for a CCGs.

How different are we on spend on elective admissions?

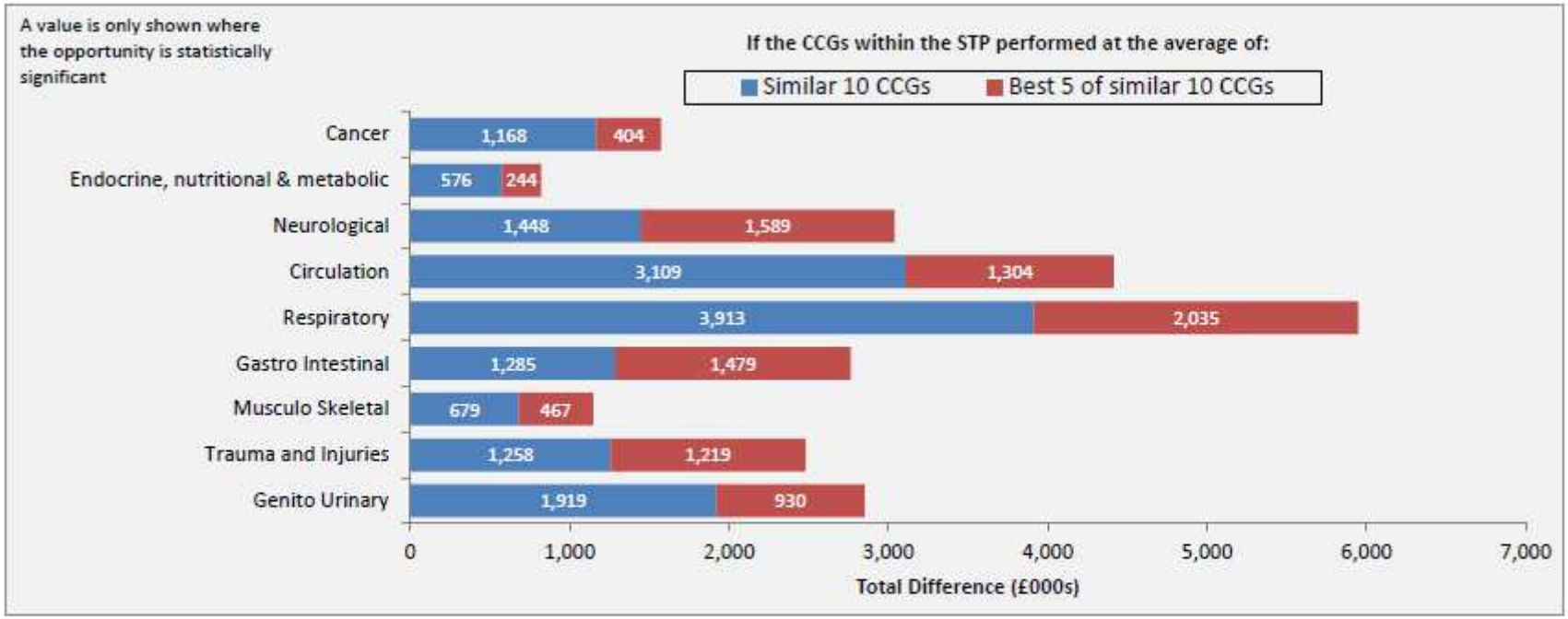


The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on expenditure on admissions for any primary diagnoses that fall under the listed co nditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

CCGs can explore this expenditure in more detail using the Commissioning for Value Focus Packs. For example, Neurological expenditure contains Chronic Pain, and the focus pack breaks this down by different types of Pain. CCGs should consider whether these admissions should be considered alongside other programmes e.g. CVD, Gastrointestinal, Musculoskeletal problems

How different are we on spend on non-elective admissions?



The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on expenditure on admissions for any primary diagnoses that fall under the listed co nditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

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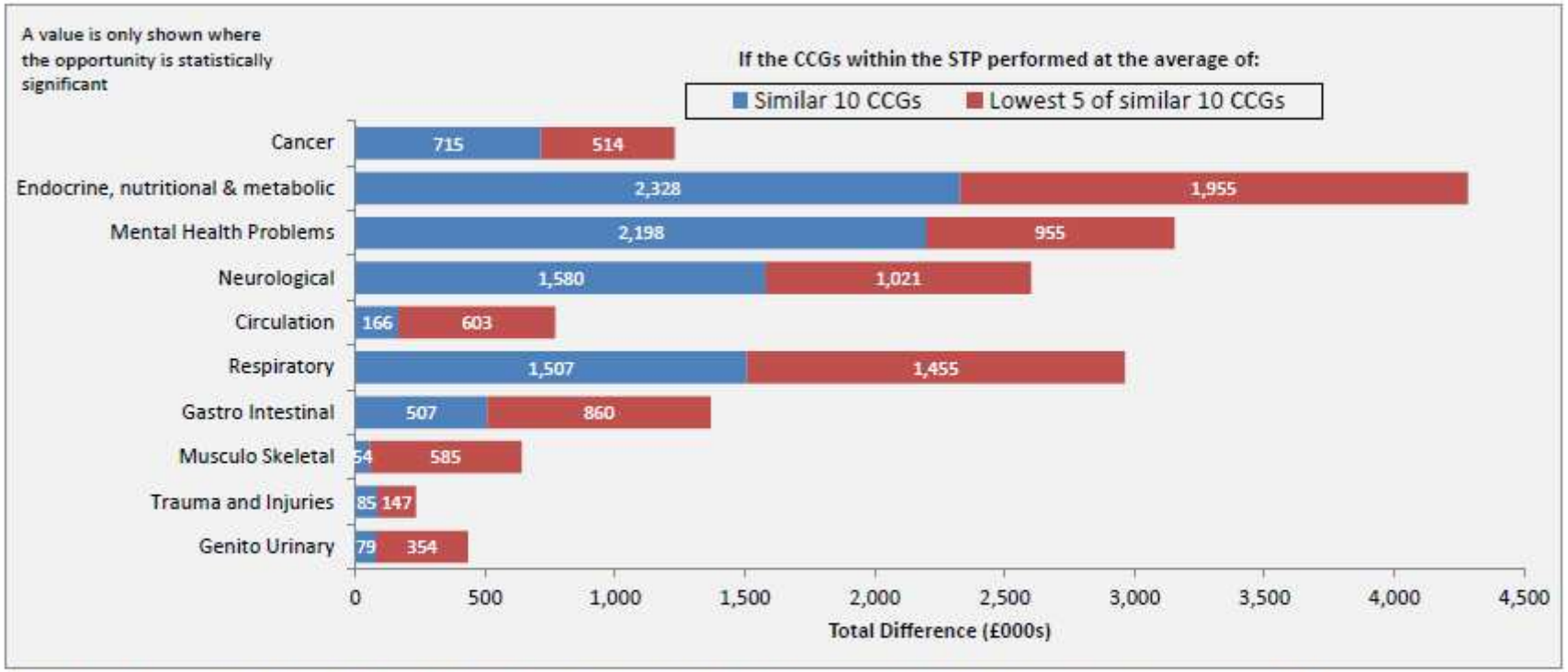
13

How different are we on spend on primary care prescribing?

NHS RightCare



The prescribing data presented above uses Net Ingredient Cost (NIC) from ePact.com provided by the NHS Business Services Auth ority and is from financial year 2015/16. Each individual BNF chemical is mapped to a Programme Budget Category and aggregated to form a programme total. The indicators ha ve been standardised using the ASTRO-PU weightings. Opportunities have been shown to the CCGs similar 10 and the lowest 5 CCGs. Prescribing opportunities are for local interpret ation and should be viewed in conjunction with the individual disease pathways.

More detailed analyses of prescribing data, outlier practices, and time trends can be produced rapidly using the following re source: http://www.OpenPrescribing.net

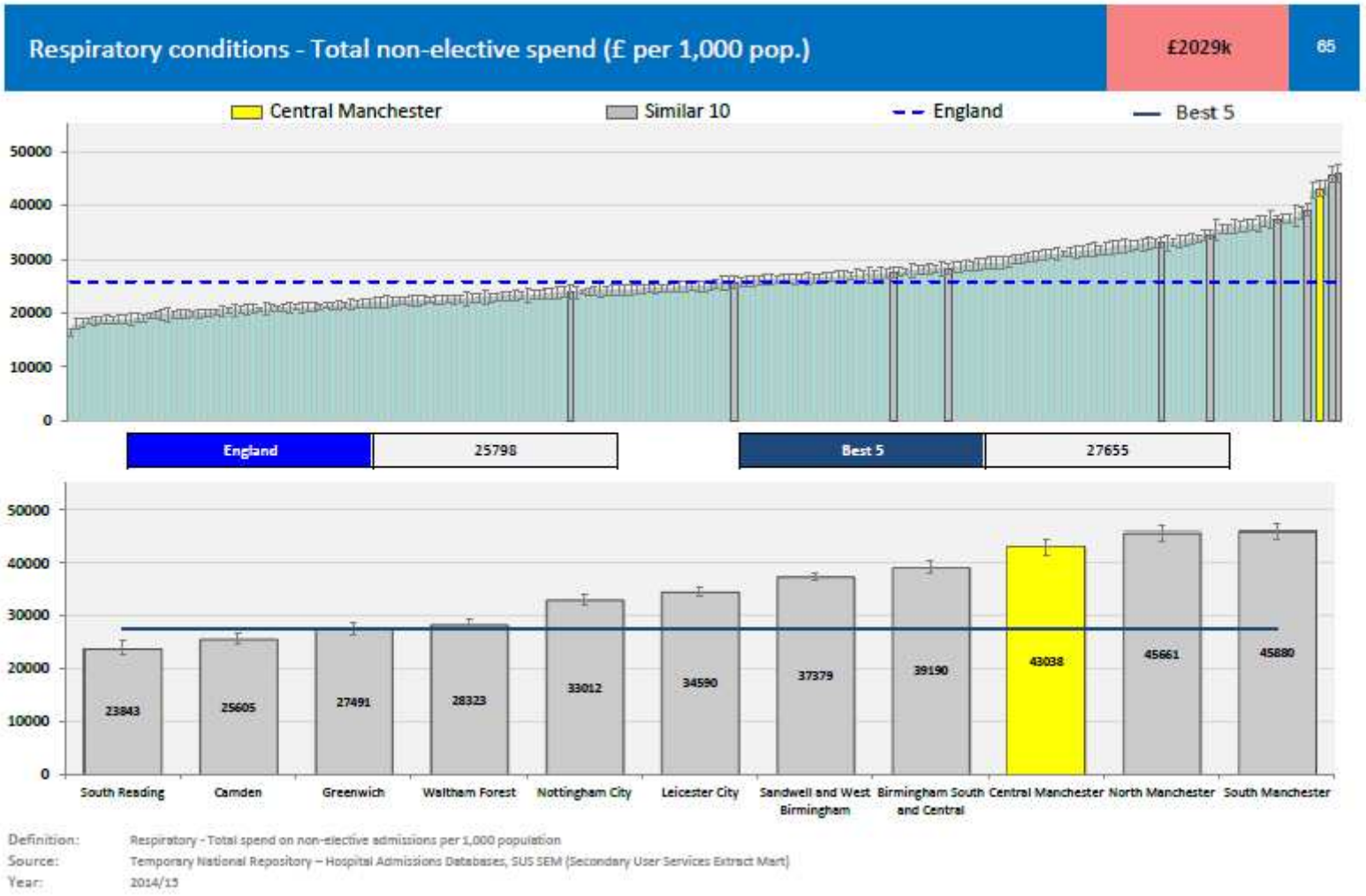
14

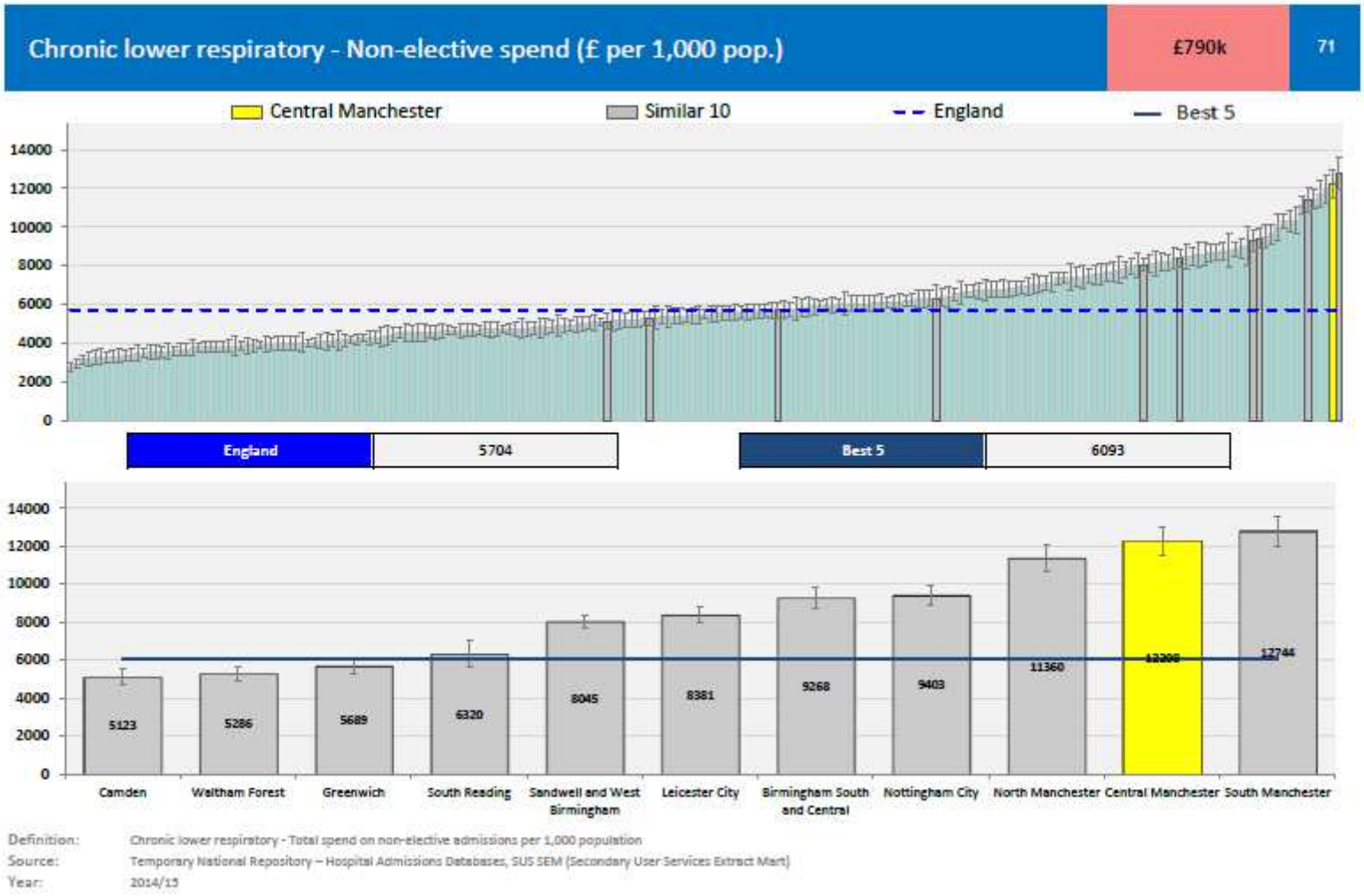
Improvement opportunities

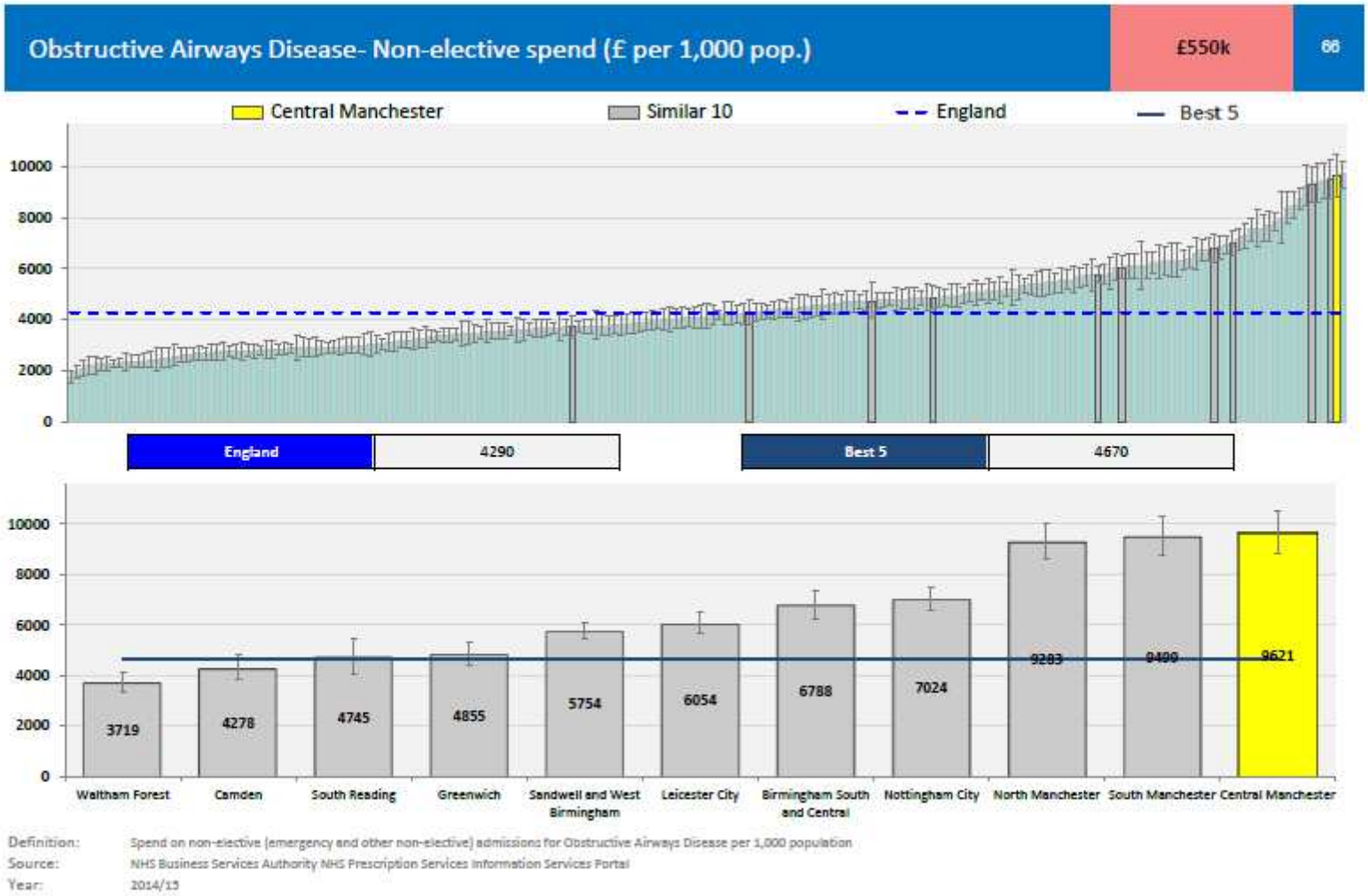
NHS RightCare

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Manchester STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

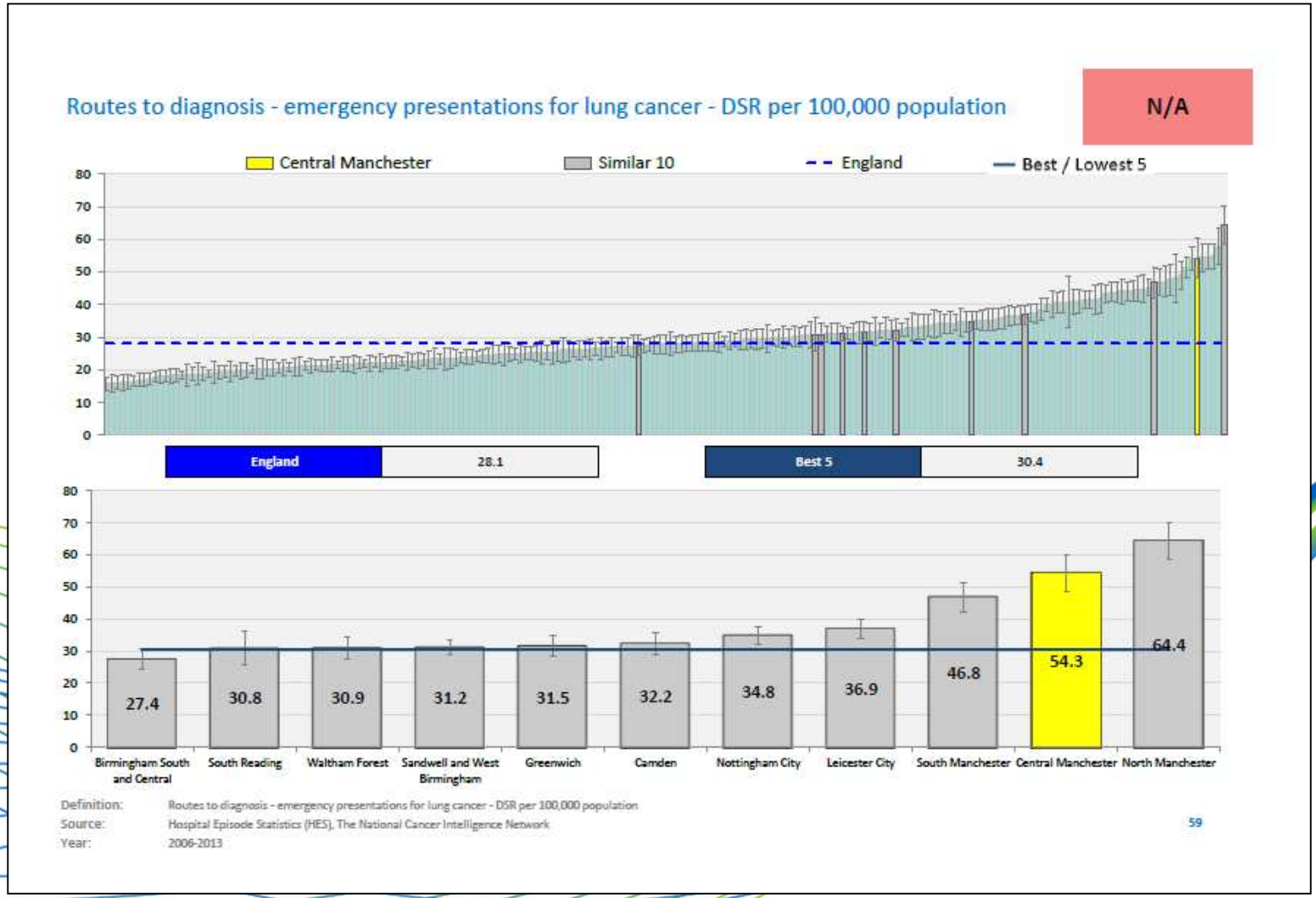
Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Respiratory System Problems	• Spend on elective and day-case admissions	1,142	• Respiratory - Rate of bed days	22,531
	• Spend on non-elective admissions	5,948	• Mortality from bronchitis, emphysema and COPD under 75 years	85
	• Spend on primary care prescribing	2,963	• Reported to estimated prevalence of COPD	2,043
			• % of COPD patients with a record of FEV1	803
			• % of COPD patients with review (12 months)	625
			• % patients (8yrs+) with asthma (variability or reversibility)	256
			• % asthma patients with review (12 months)	1,018
			• Emergency admission rate for children with asthma, 0-19yrs	504
			• % of COPD patients with a diagnosis confirmed by spirometry	257
Trauma & Injuries	• Spend on elective and day-case admissions	447	• Trauma and injuries - Rate of bed days	13,075
	• Spend on non-elective admissions	2,477	• Mortality from accidents all ages	41
	• Spend on primary care prescribing	232	• Injuries due to falls in people aged 65+	242
	• Spend on admissions relating to fractures where a fall occurred	548	• Unintentional and deliberate injury admissions, 0-24yrs	691
			• All fracture admissions in people aged 65+	45
			• Hip fractures in people aged 65+	15
			• Hip fractures in people aged 65-79	16
			• % fractured femur patients returning home within 28 days	15
			• Hip fracture emergency readmissions 28 days	23


Respiratory conditions - Total non-elective spend (£ per 1,000 pop.)
£2029k
65
Central Manchester
Similar 10
England
Best 5
50000
40000
30000
20000
10000
0
England
25798
Best 5
27655
23843
25605
27491
28323
33012
34590
37379
39190
43038
45661
45880
South Reading
Camden
Greenwich
Waltham Forest
Nottingham City
Leicester City
Sandwell and West Birmingham
Birmingham South and Central
Central Manchester
North Manchester
South Manchester
Definition: Respiratory - Total spend on non-elective admissions per 1,000 population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15


Chronic lower respiratory - Non-elective spend (£ per 1,000 pop.)
£790k
71
Central Manchester
Similar 10
England
Best 5
14000
12000
10000
8000
6000
4000
2000
0
England
5704
Best 5
6093
5123
5286
5689
6320
8045
8381
9268
9403
11360
12308
12744
Camden
Waltham Forest
Greenwich
South Reading
Sandwell and West Birmingham
Leicester City
Birmingham South and Central
Nottingham City
North Manchester
Central Manchester
South Manchester
Definition: Chronic lower respiratory - Total spend on non-elective admissions per 1,000 population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15


Obstructive Airways Disease- Non-elective spend (£ per 1,000 pop.)
£550k
66
Central Manchester
Similar 10
England
Best 5
10000
8000
6000
4000
2000
0
England
4290
Best 5
4670
3719
4278
4745
4855
5754
6054
6788
7024
9283
9490
9621
Waltham Forest
Camden
South Reading
Greenwich
Sandwell and West Birmingham
Leicester City
Birmingham South and Central
Nottingham City
North Manchester
South Manchester
Central Manchester
Definition: Spend on non-elective (emergency and other non-elective) admissions for Obstructive Airways Disease per 1,000 population
Source: NHS Business Services Authority NHS Prescription Services Information Services Portal
Year: 2014/15

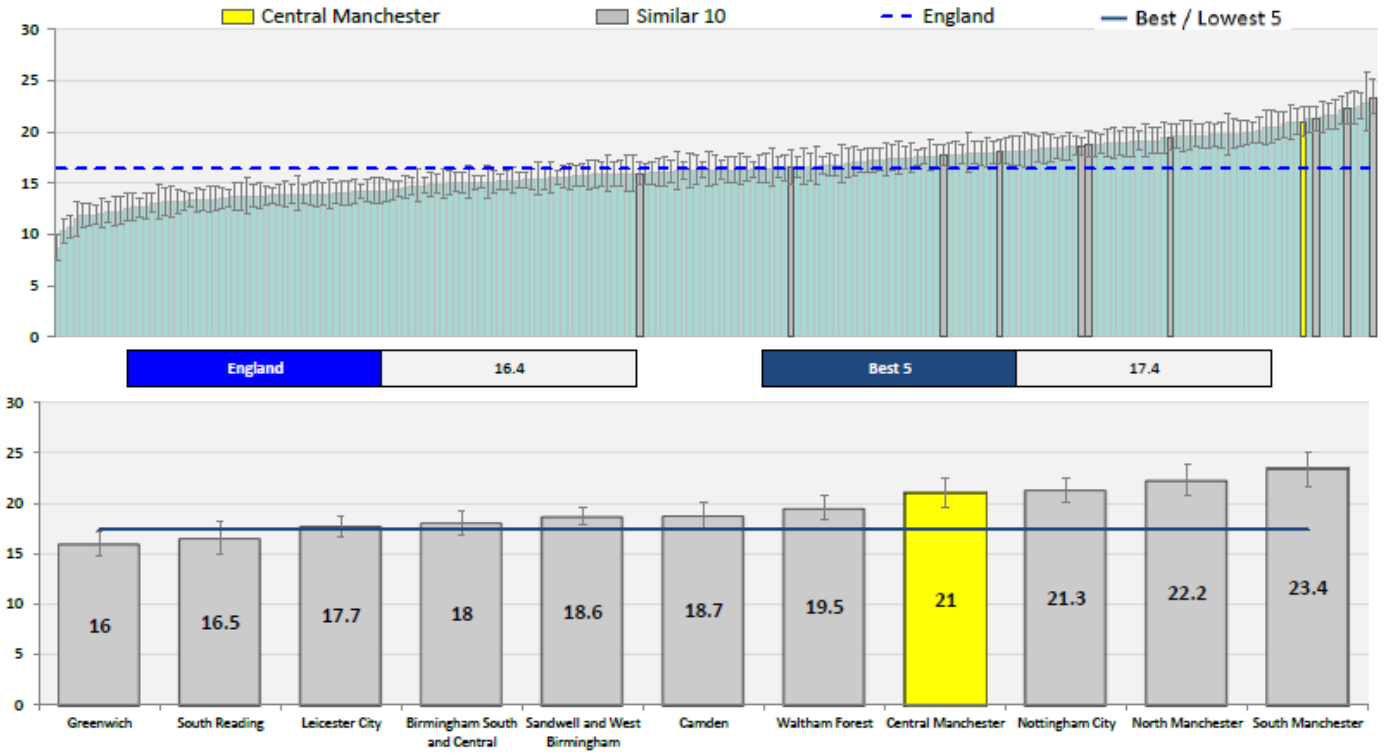
Detection


Routes to diagnosis - emergency presentations for lung cancer - DSR per 100,000 population
N/A
Central Manchester
Similar 10
England
Best / Lowest 5
80
70
60
50
40
30
20
10
0
England
28.1
Best 5
30.4
27.4
30.8
30.9
31.2
31.5
32.2
34.8
36.9
46.8
54.3
64.4
Birmingham South and Central
South Reading
Waltham Forest
Sandwell and West Birmingham
Greenwich
Camden
Nottingham City
Leicester City
South Manchester
Central Manchester
North Manchester
Definition: Routes to diagnosis - emergency presentations for lung cancer - DSR per 100,000 population
Source: Hospital Episode Statistics (HES), The National Cancer Intelligence Network
Year: 2006-2013
59

Prevention

The percentage of people aged 18+ who are self-reported occasional or regular smokers

6528 Ppl.



Definition: The percentage of people aged 18+ who are self-reported occasional or regular smokers
Source: General Practice Patient Survey (GPPS)
Year: July 2016

12

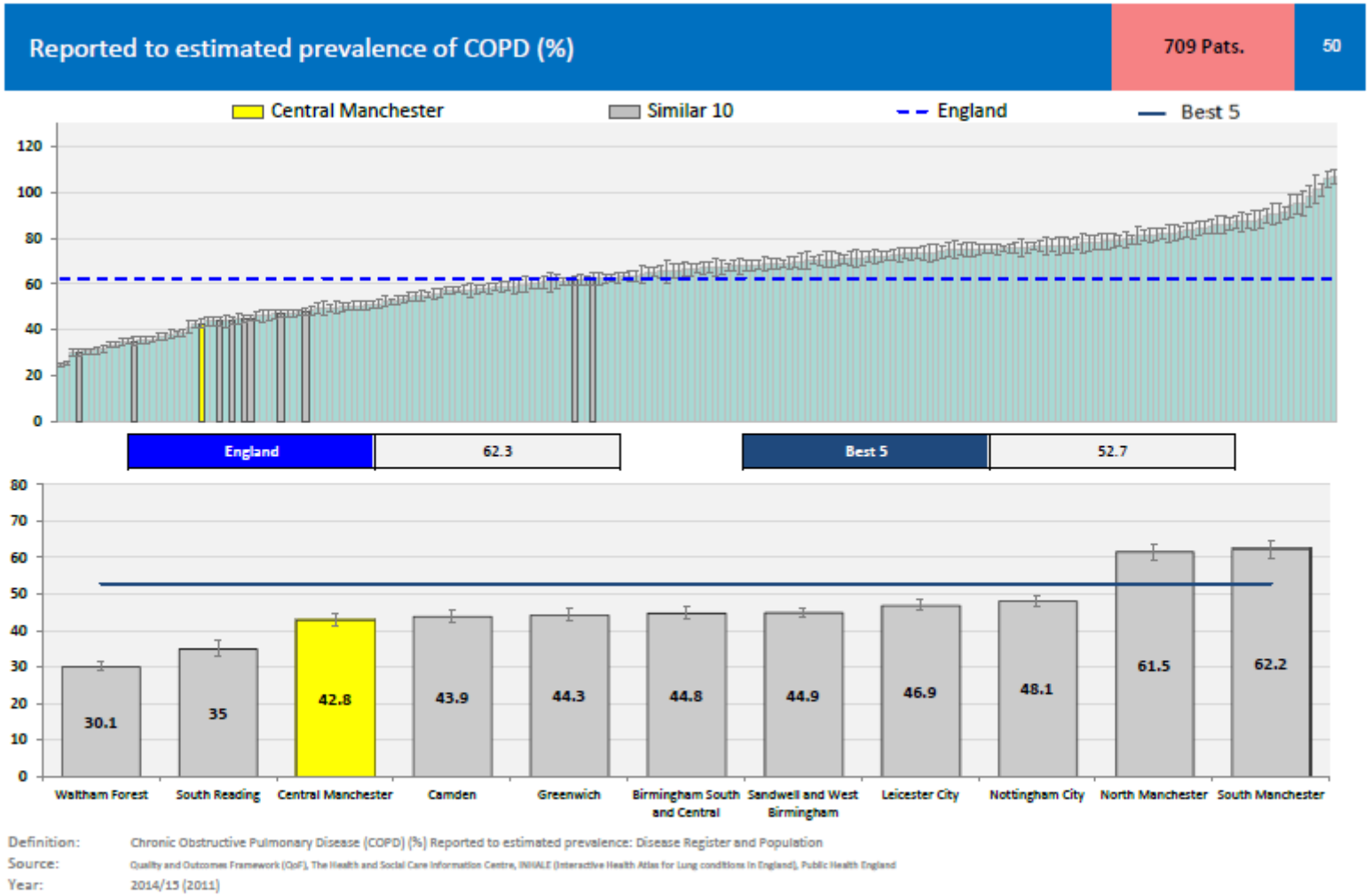
Smokers- support and treatment offered (%)

114 Pats. | 64

Definition: [illegible]

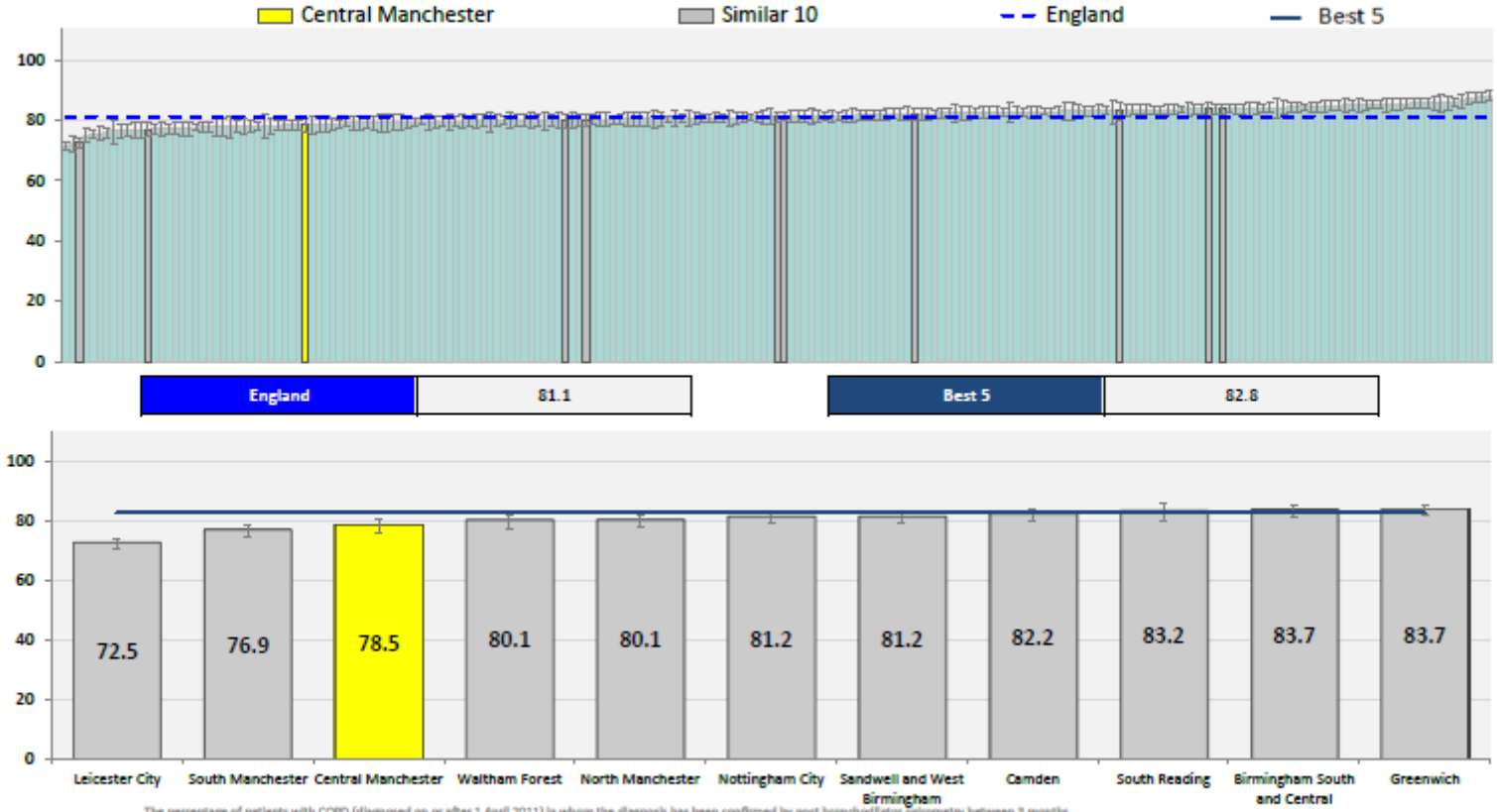
Source: Quality and Outcomes Framework, The Health and Social Care Information Centre

Year: 2014/15


Reported to estimated prevalence of COPD (%)
709 Pats.
50
Central Manchester
Similar 10
England
Best 5
120
100
80
60
40
20
0
England
62.3
Best 5
52.7
80
70
60
50
40
30
20
10
0
30.1
35
42.8
43.9
44.3
44.8
44.9
46.9
48.1
61.5
62.2
Waltham Forest
South Reading
Central Manchester
Camden
Greenwich
Birmingham South and Central
Sandwell and West Birmingham
Leicester City
Nottingham City
North Manchester
South Manchester
Definition: Chronic Obstructive Pulmonary Disease (COPD) (%) Reported to estimated prevalence: Disease Register and Population
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre, INHALE (Interactive Health Atlas for Lung conditions in England), Public Health England
Year: 2014/15 (2011)

COPD patients where diagnosis confirmed by spirometry (%)

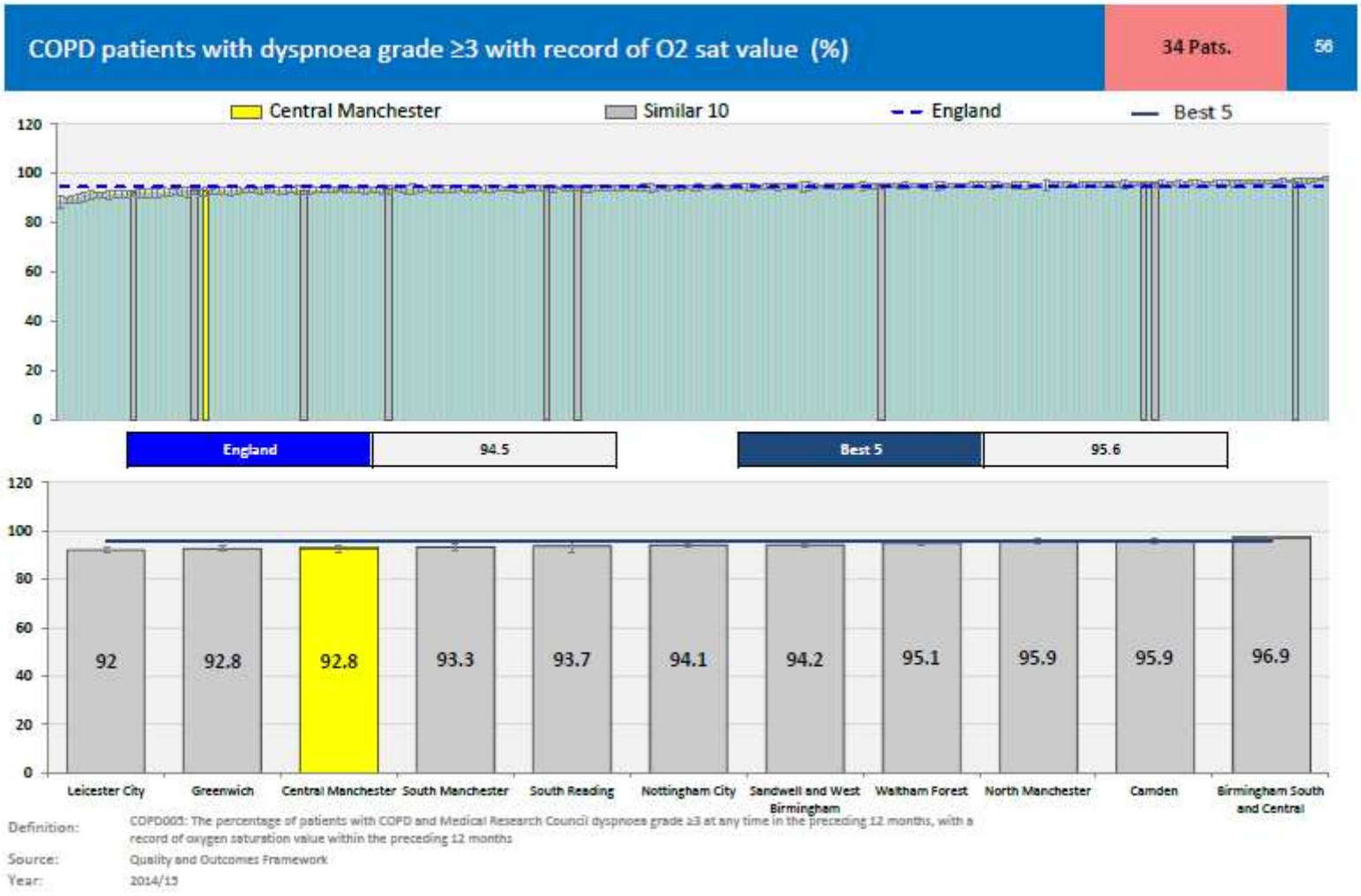
51 Pats. | 55



Definition: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months

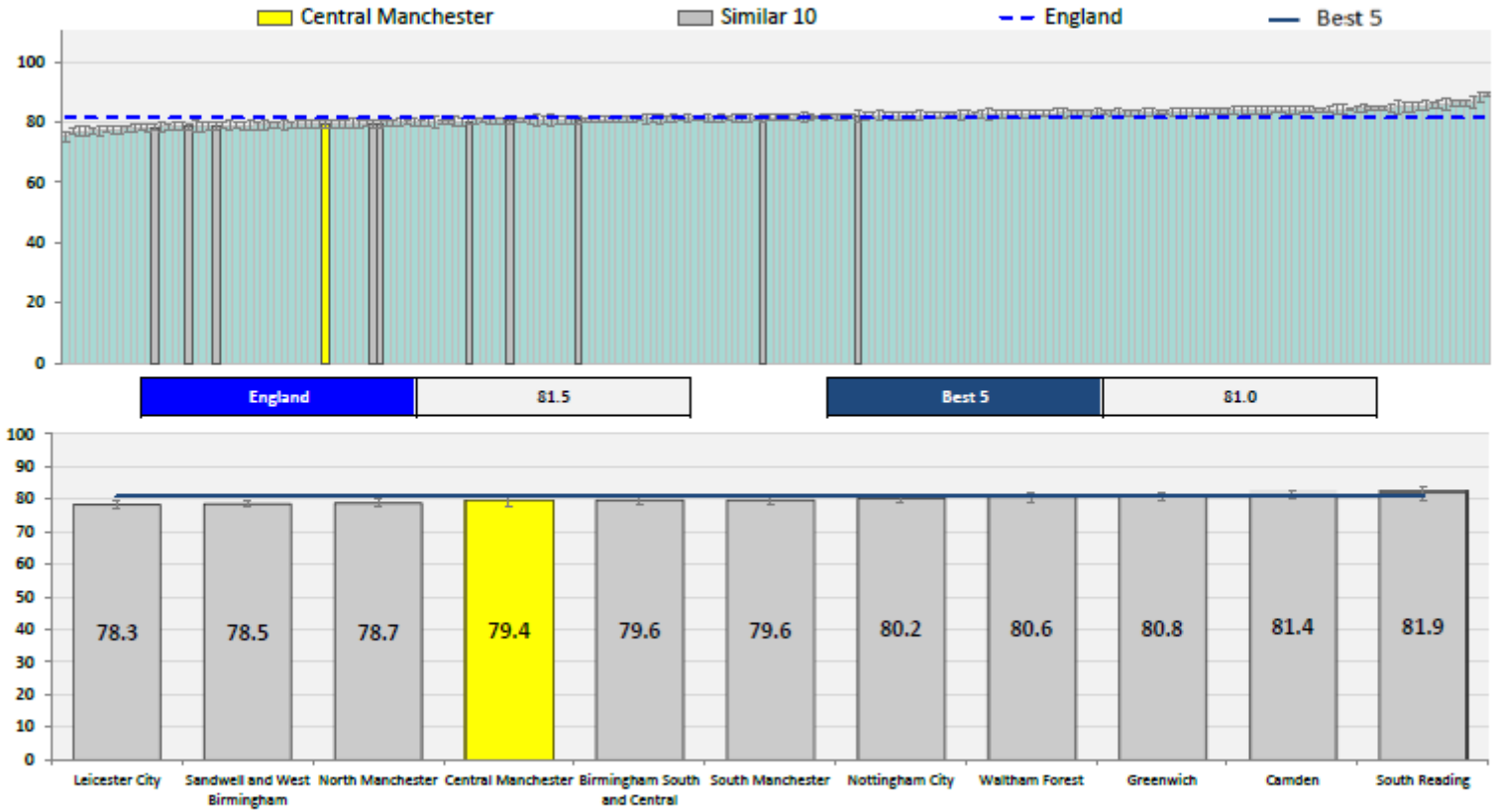
Source: Quality and Outcomes Framework

Year: 2014/15

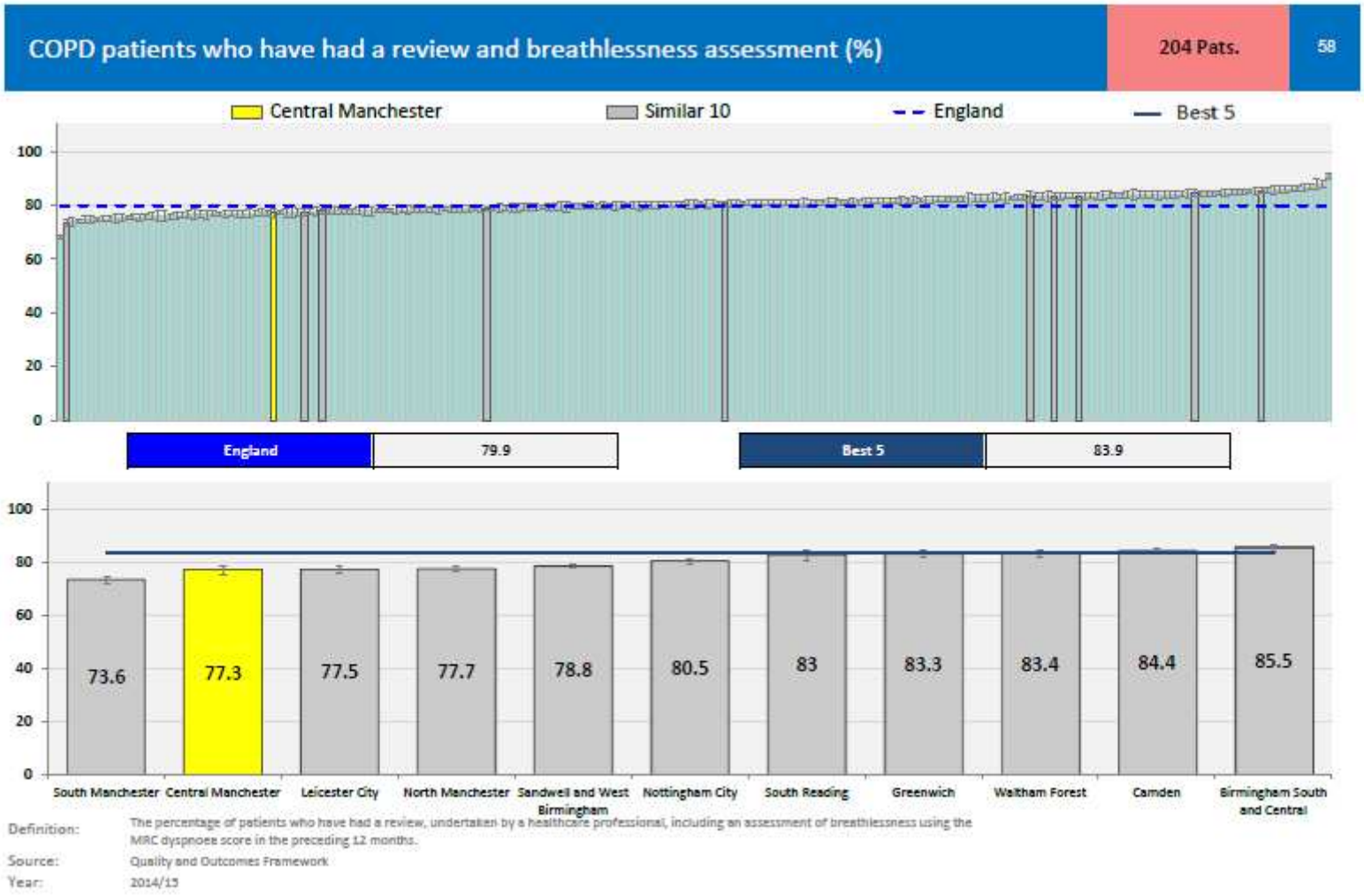

COPD patients with dyspnoea grade ≥3 with record of O2 sat value (%)
34 Pats.
56
Central Manchester
Similar 10
England
Best 5
120
100
80
60
40
20
0
England
94.5
Best 5
95.6
92
92.8
92.8
93.3
93.7
94.1
94.2
95.1
95.9
95.9
96.9
Leicester City
Greenwich
Central Manchester
South Manchester
South Reading
Nottingham City
Sandwell and West Birmingham
Waltham Forest
North Manchester
Camden
Birmingham South and Central
Definition:
COPD005: The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months
Source:
Quality and Outcomes Framework
Year:
2014/15

COPD patients who have had flu immunisation (%)

48 Pats. | 57

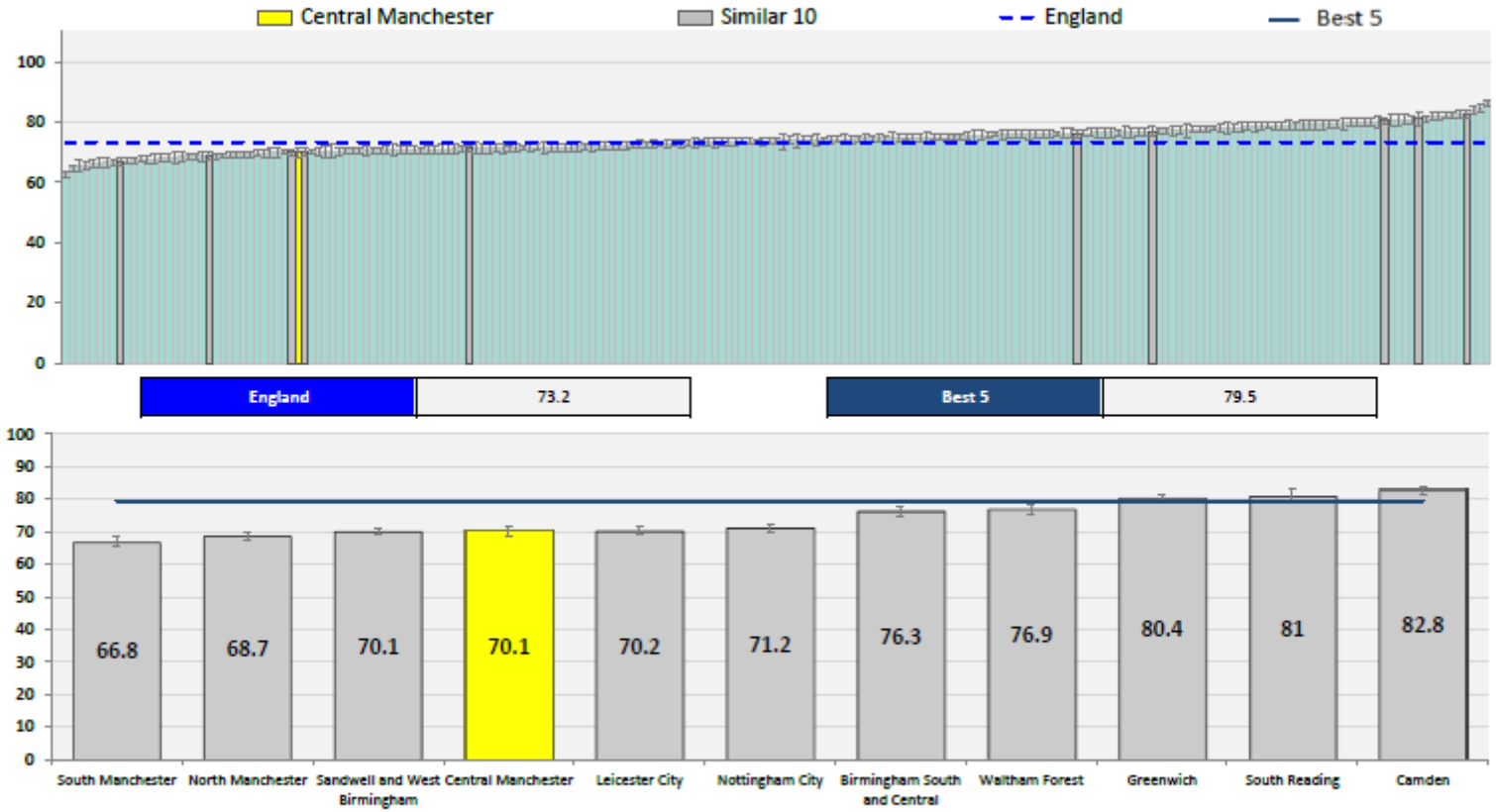


Definition: COPD007: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March
Source: Quality and Outcomes Framework
Year: 2014/15


COPD patients who have had a review and breathlessness assessment (%)
204 Pats.
58
Central Manchester
Similar 10
England
Best 5
100
80
60
40
20
0
England
79.9
Best 5
83.9
73.6
77.3
77.5
77.7
78.8
80.5
83
83.3
83.4
84.4
85.5
South Manchester
Central Manchester
Leicester City
North Manchester
Sandwell and West Birmingham
Nottingham City
South Reading
Greenwich
Waltham Forest
Camden
Birmingham South and Central
Definition:
The percentage of patients who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 12 months.
Source:
Quality and Outcomes Framework
Year:
2014/15

COPD patients with a record of FeV1 in the preceding 12 months (%)

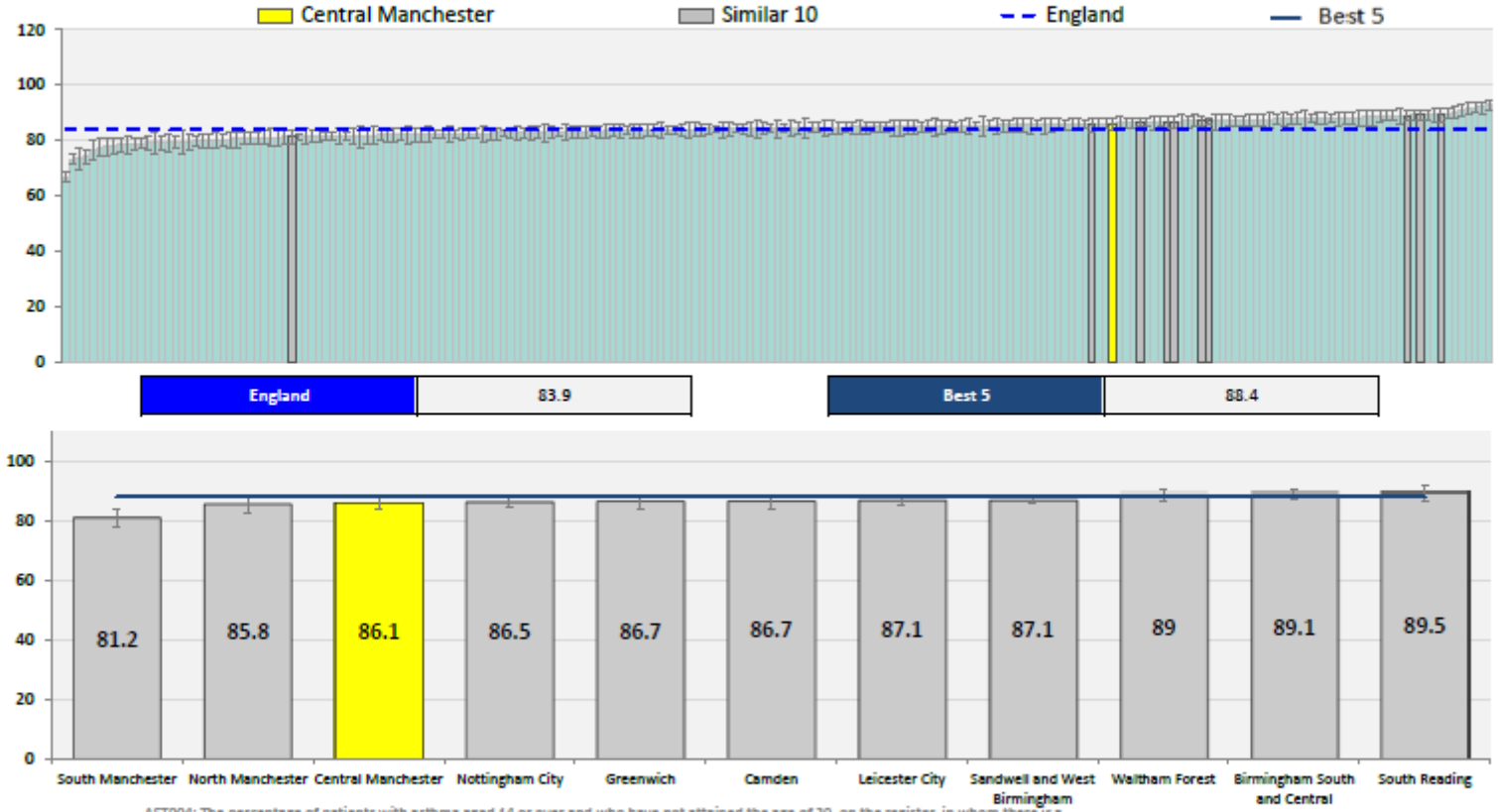
285 Pats. | 59



Definition: % of COPD patients with a record of FeV1 in the preceding 12 months
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre
Year: 2014/15

Asthma patients, 14-19, where smoking status is recorded (%)

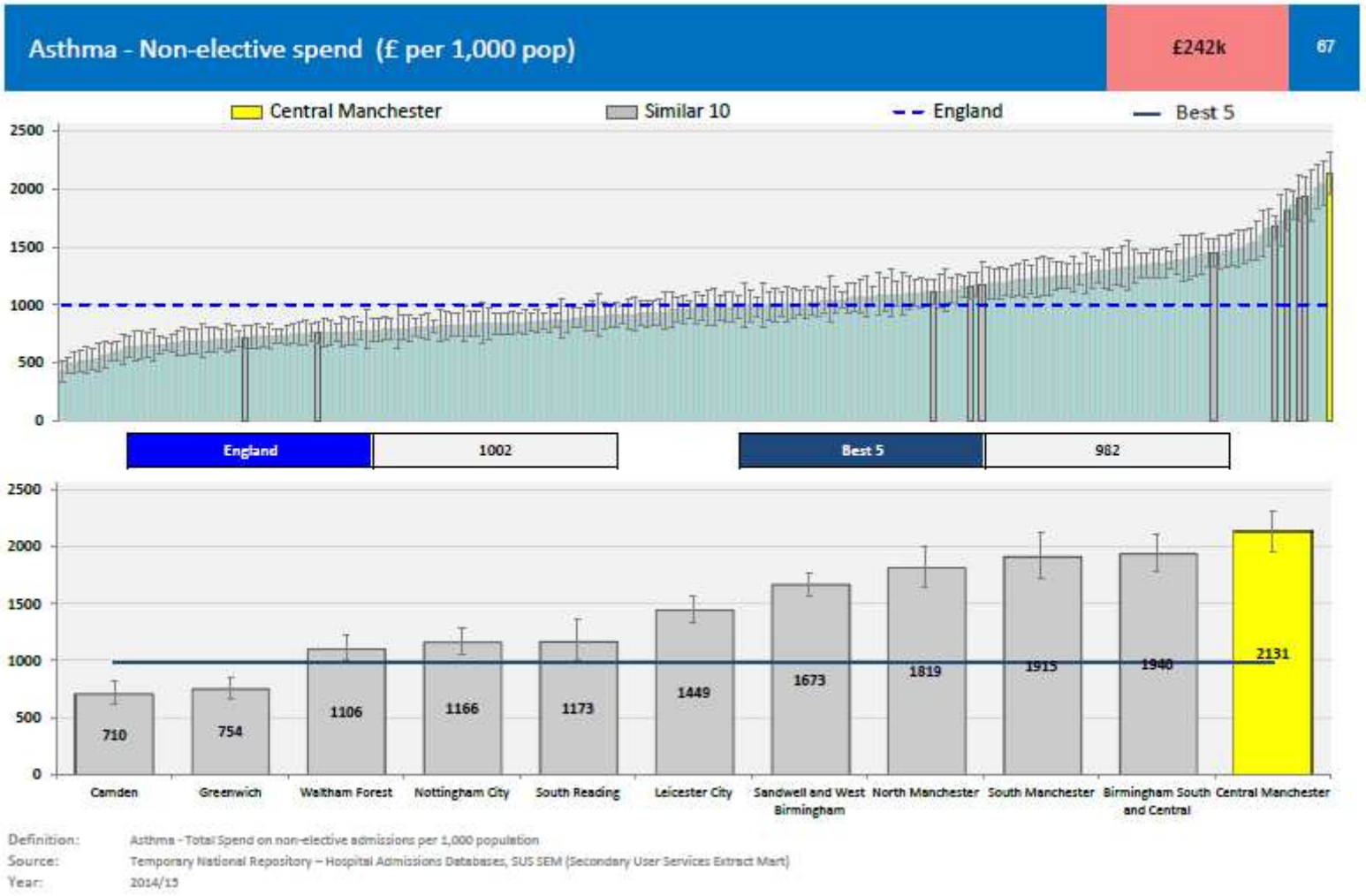
23 Pats. | 63

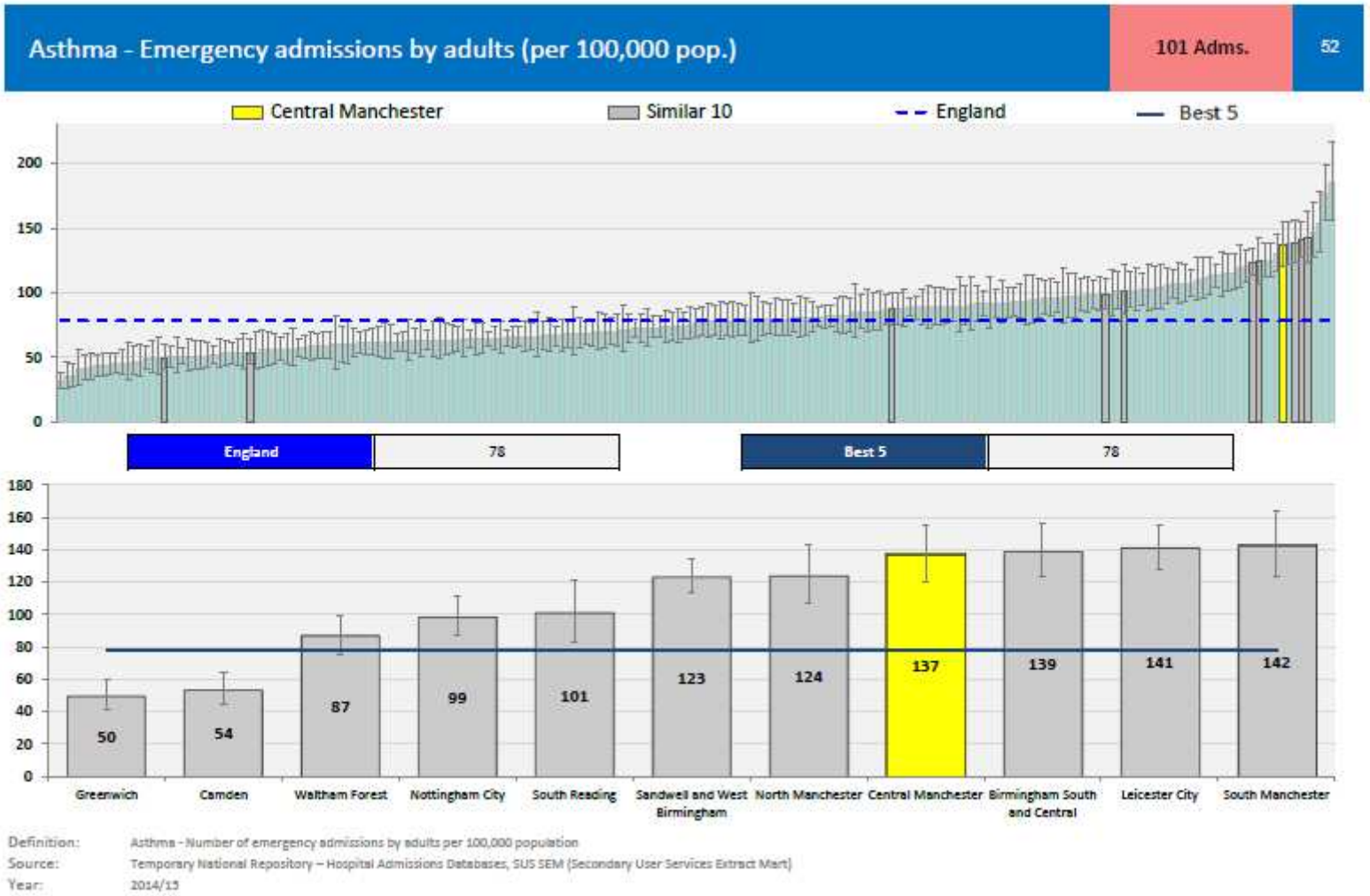


Definition: AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months

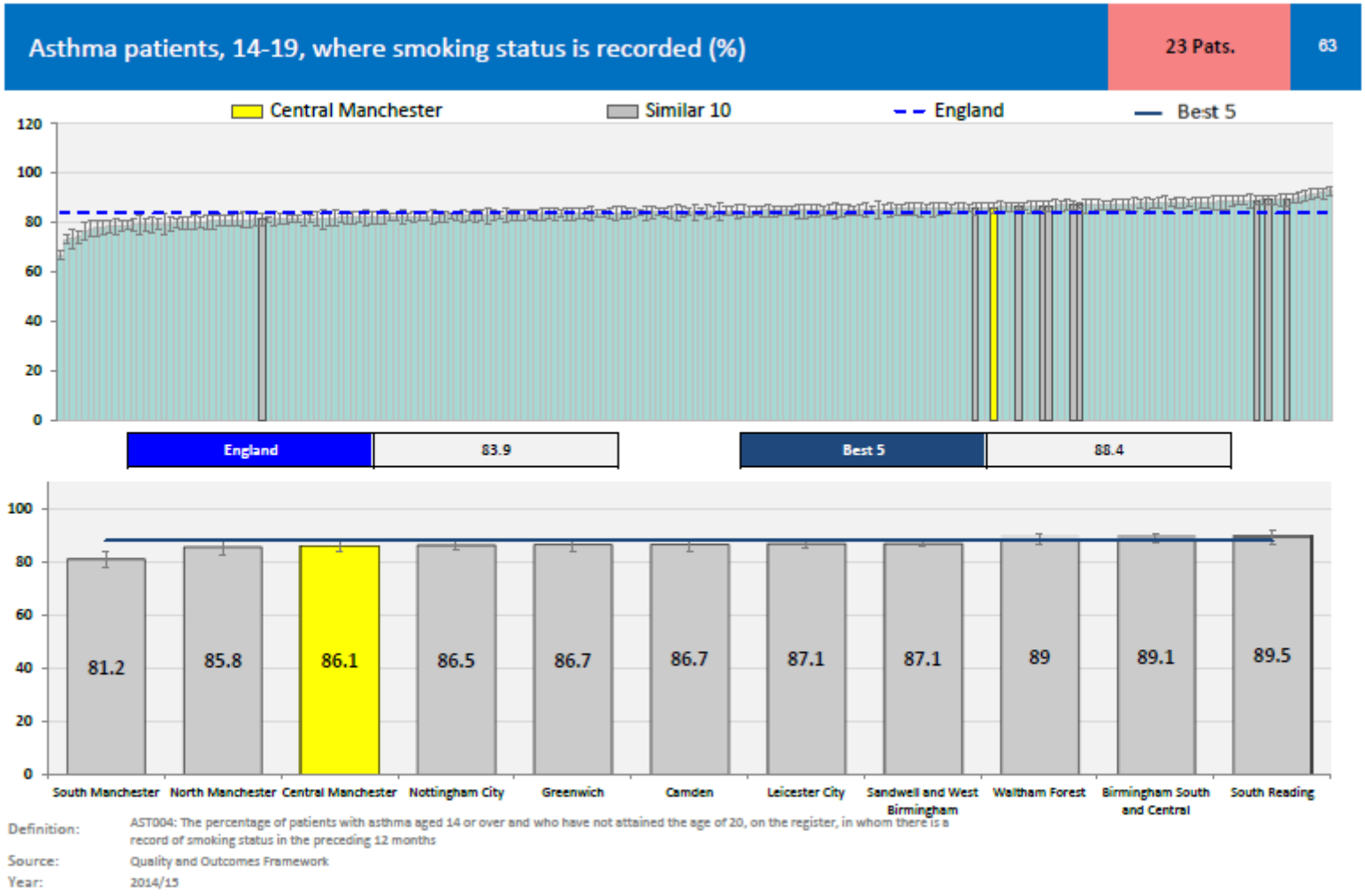
Source: Quality and Outcomes Framework

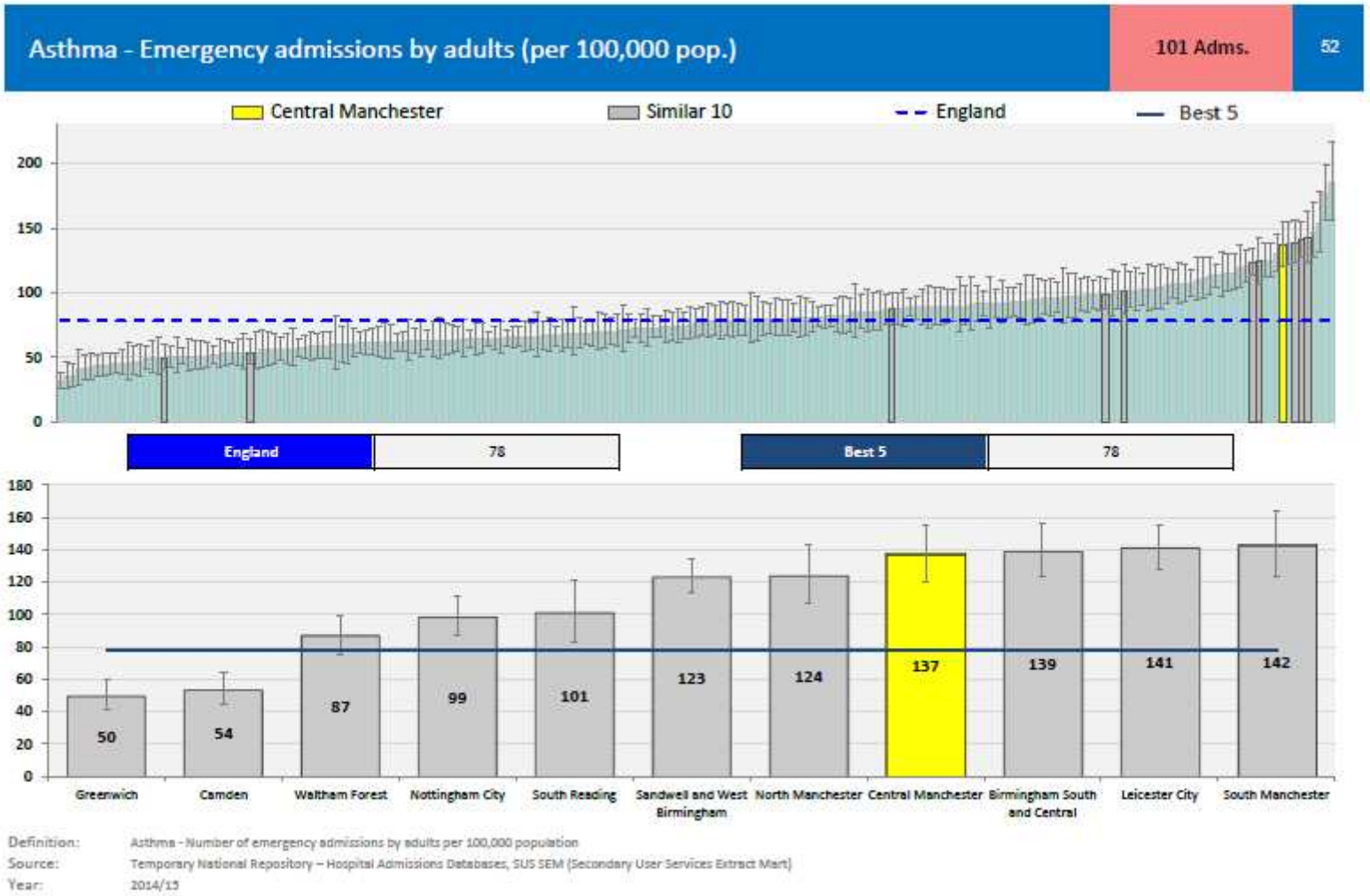
Year: 2014/15

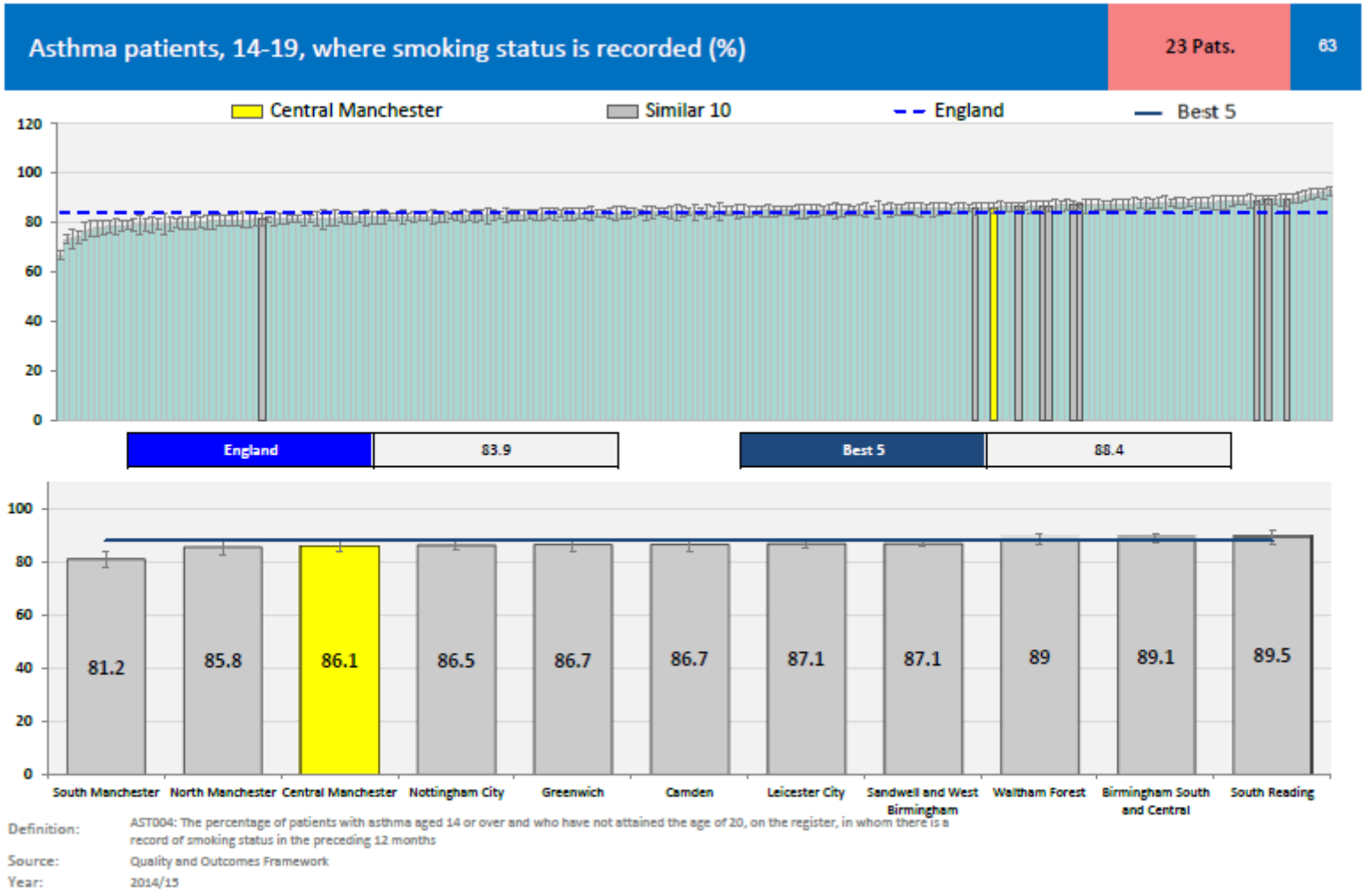

Asthma - Non-elective spend (£ per 1,000 pop)
£242k
67
Central Manchester
Similar 10
England
Best 5
2500
2000
1500
1000
500
0
England
1002
Best 5
982
710
754
1106
1166
1173
1449
1673
1819
1915
1940
2131
Camden
Greenwich
Waltham Forest
Nottingham City
South Reading
Leicester City
Sandwell and West Birmingham
North Manchester
South Manchester
Birmingham South and Central
Central Manchester
Definition: Asthma - Total Spend on non-elective admissions per 1,000 population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15



Definition: Asthma - Number of emergency admissions by adults per 100,000 population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

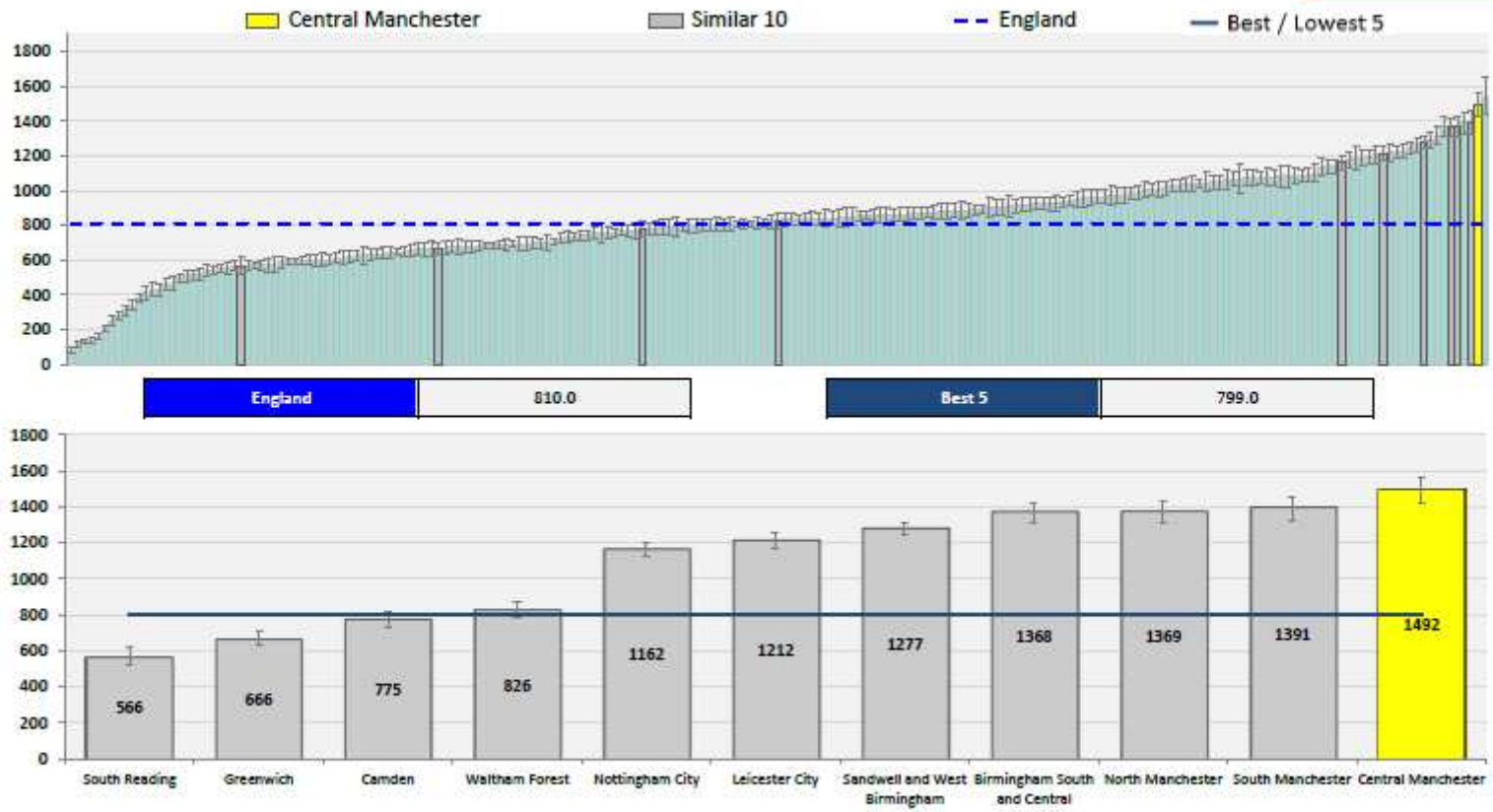

Asthma patients, 14-19, where smoking status is recorded (%)
23 Pats.
63
Central Manchester
Similar 10
England
Best 5
120
100
80
60
40
20
0
England
83.9
Best 5
88.4
100
80
60
40
20
0
81.2
85.8
86.1
86.5
86.7
86.7
87.1
87.1
89
89.1
89.5
South Manchester
North Manchester
Central Manchester
Nottingham City
Greenwich
Camden
Leicester City
Sandwell and West Birmingham
Waltham Forest
Birmingham South and Central
South Reading
Definition:
AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months
Source:
Quality and Outcomes Framework
Year:
2014/15


Asthma - Emergency admissions by adults (per 100,000 pop.)
101 Adms.
52
Central Manchester
Similar 10
England
Best 5
200
150
100
50
0
England
78
Best 5
78
180
160
140
120
100
80
60
40
20
0
50
54
87
99
101
123
124
137
139
141
142
Greenwich
Camden
Waltham Forest
Nottingham City
South Reading
Sandwell and West Birmingham
North Manchester
Central Manchester
Birmingham South and Central
Leicester City
South Manchester
Definition: Asthma - Number of emergency admissions by adults per 100,000 population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15


Asthma patients, 14-19, where smoking status is recorded (%)
23 Pats.
63
Central Manchester
Similar 10
England
Best 5
120
100
80
60
40
20
0
England
83.9
Best 5
88.4
100
80
60
40
20
0
81.2
85.8
86.1
86.5
86.7
86.7
87.1
87.1
89
89.1
89.5
South Manchester
North Manchester
Central Manchester
Nottingham City
Greenwich
Camden
Leicester City
Sandwell and West Birmingham
Waltham Forest
Birmingham South and Central
South Reading
Definition:
AST004: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months
Source:
Quality and Outcomes Framework
Year:
2014/15

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

1547 Adm.



Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions
Source: NHS Digital
Year: 2015/16 (Provisional)

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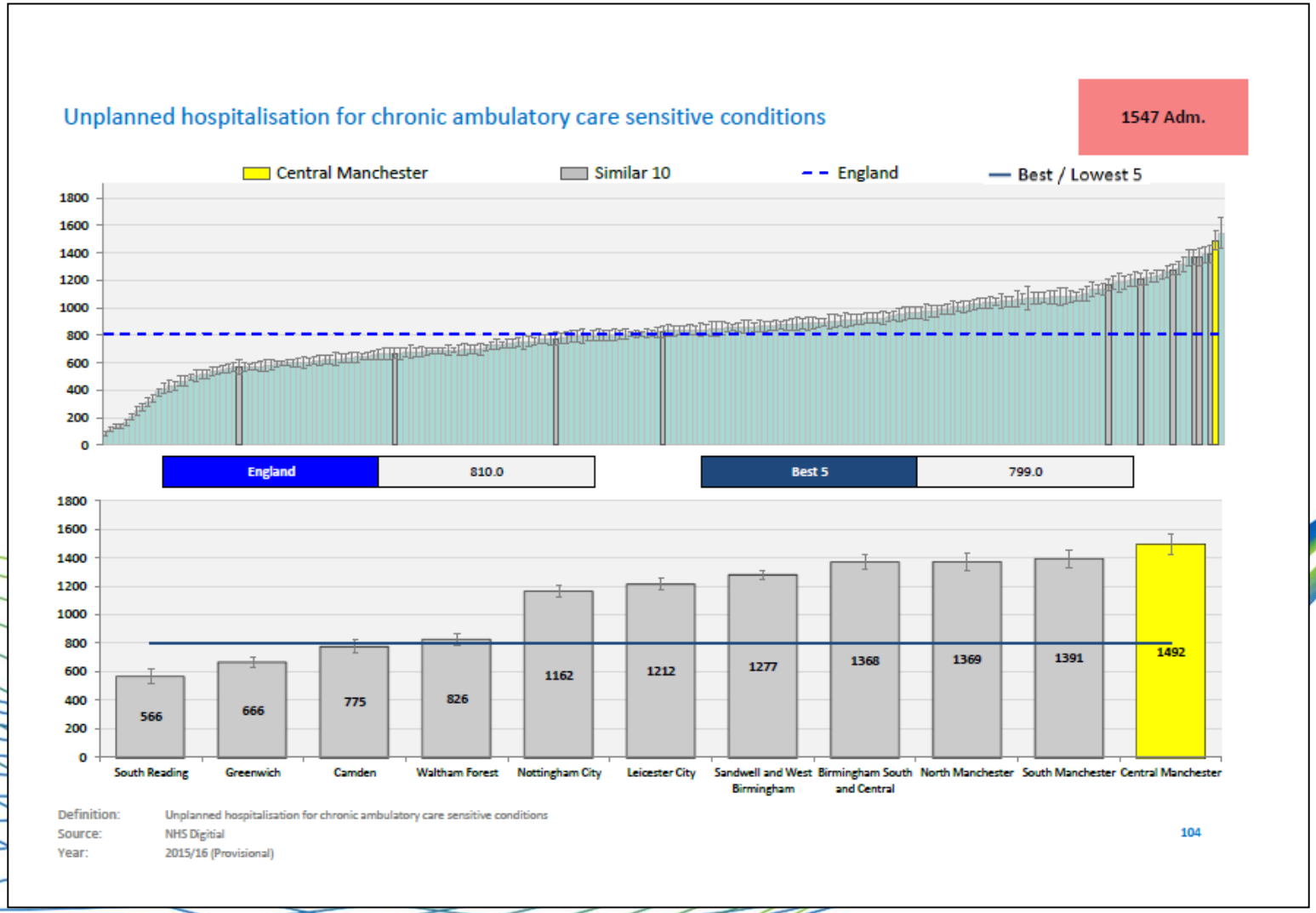
Intermediate Care (Step up/Step down)



Cross Cutting: Education of staff, patients and communities. Our Manchester – working collaboratively / asset based approach / system wide solutions						
The interventions	**Improved COPD detection**	**COPD Best practice management**	**Optimisation of Asthma management**	**Smoking cessation**	**Holistic approach management of respiratory disease / Supported self management**	**End of Life identification and management**
The opportunities	Late diagnosis has a substantial impact on symptom control, quality of life, clinical outcome and cost. Undiagnosed people receive inappropriate or inadequate treatment. 835,000 people currently diagnosed with COPD in the UK and an estimated 2,200,000 people with COPD who remain undiagnosed, (equivalent to 13% of the population of England aged 35 and over)	To ensure that people with COPD, across all social groups, receive safe and effective care, which minimises progression, enhances recovery and promotes independence. A Virtual clinic model aimed at promoting best prescribing practice showed that 10 practices demonstrated savings in prescribing. It also demonstrated savings in non elective admission costs. Currently there is variance of £10m spend on respiratory diseases as compared to the top 5 CCG peers (a high percentage is identified as emergency admissions)	Prompt and accurate diagnosis, shared decision making regarding treatment, and on-going support / enablement reduces the need for unscheduled health care and risk of death In 2016/17, there were 704 emergency admissions for children with a primary diagnosis of asthma. This represented a cost of £530k. Analysis shows the most 'at risk' group were children between the ages of 3 and 11, with over 76% of admissions falling within this age group.	To reduce the number of people who develop COPD by ensuring they are aware of the importance of good lung health and well-being, with risk factors understood, avoided or minimised, and proactively address health inequalities Engage with Tobacco Control Strategy	Early detection of lung cancer 40% of people with COPD also have heart disease, and significant numbers have depression and/or anxiety disorder. Engage with British Lung Foundation and establish Breathe Easy groups across Manchester. Air Quality / GM Air Quality Action Plan / Clean Air Day evaluation report / No Idle Zones	To enhance quality of life for people with COPD, across all social groups, with a positive, enabling, experience of care and support right through to the end of life. Education programme to identify when COPD patients are approaching the last year of life. MCIP Lung Health Check (screening) programme.
The Evidence	Early intervention reduces mortality and morbidity Men aged 20-64 employed in unskilled manual occupations in England and Wales are around fourteen times more likely to die from COPD than men employed in professional roles, COPD accounts for a large proportion of the gap in life expectancy - with the worst health and deprivation and the average – around 8% of the gap for men and 12% of the gap for women	Premature mortality from COPD in the UK was almost twice as high as the European average in 2008. COPD kills about 25,000 people a year in England and Wales. Recent figures showed that COPD accounted for 4.8% of all deaths in England between 2007 and 2009. Manchester spends over £6m more on non-elective admissions than their Right Care peers.	25% of Disability Adjusted Life Years (DALYS) are attributable to risk factors common to respiratory disease. Manchester spends almost £3m more on prescribing than their Right Care peers. Manchester is the highest in the country for asthma non-elective spend.	Smoking is the primary cause of preventable morbidity and premature death, accounting for over 80,000 deaths in England in 2009, and kills about half of all lifetime users Right Care data shows that South Manchester has the highest percentage of people aged 18+ who are self-reported occasional or regular smokers. Smoking is the major preventable risk factor for COPD.	c. 90% of people with severe COPD were unable to participate in socially important activities such as gardening, two-thirds were unable to take a holiday because of their disease and one-third had disabling breathlessness Breathe Easy groups provide support, advice and guidance for people living with a long term lung condition. To educate people to manage their condition and improve their quality of life both mentally (reduces isolation) and physically. Known pollution 'hot spots' in Manchester . 20 schools and nurseries in Manchester in areas where the level of air pollution is above legal limits (which is still above safe levels).	Reduce under 75 mortality rate from respiratory diseases considered preventable from 47 per 100,000 in 2012-14 to 44 per 100,000 in 2020-22 (compared with an expected level of 50 per 100,000). Achievement will result in 168 fewer early deaths from respiratory disease considered preventable compared with the projected level. People dying from a respiratory disease are less likely to die in their own home than the population as a whole. 69.5% of deaths from respiratory disease occurred in a hospital compared with just 19.1% in the deceased's own home. (In total, 26.4% of **all** deaths occurred in the deceased's own home).
The Risk Condition	COPD / Lung Cancer	COPD & Asthma	COPD & Asthma	Smoking	Multiple Long Term Conditions	COPD
The Outcomes	• Reduce mortality associated with COPD(improved life expectancy) • Increased prevalence in line with expected numbers.	• Reduction in the number of non-elective admissions for respiratory disease	• Medicines Optimisation • Reduction in the numbers of Unscheduled admissions • Improved School attendance with asthma as a reason for absence	• More people supported to quit smoking • Reduce smoking prevalence in Manchester to 15% or less by 2020/21 (current rate is 22.7%)	• Increased uptake of Flu pneumococcal vaccination • Improved Enablement scores ((patient experience) • Reduction in the percentage of lung cancers diagnosed at a late stage • Reduced social isolation	• People die in their preferred place of care. • Increased number of patients on the Palliative Care Register • Reduction in number of hospital admissions within the last year of life
Primary Care Management / Community Care Management / Respiratory Steering Groups (all partners) / Education / Information Technology / Data Dashboards / Communication & Engagement						

RESPIRATORY LOGIC CHAIN FRAMEWORK

Aim	• Address the long standing poor Respiratory Health outcomes (and high spend) across Manchester. • Focus on making system changes to address the variance and opportunity identified by RightCare. • Fewer people will die from Respiratory disease. 168 fewer early deaths from Respiratory disease by 2021 (LCO Prospectus 2017)						•
Programme element / work stream	**Why are we doing this? (Issue)**	**What will we do? (Objective)**	**How will we do it? (Process)**	**How will we know if we are doing it? (Service Outputs)**	**How will we know if our work is making a difference? (Individual / Neighbourhood Outcomes)**	**How will we measure progress? (outcome KPIs and measures)**	
Practice variation	Known variation in patient experience and clinical outcomes for respiratory diseases between GP practices and neighbourhoods	Address unwarranted variation in clinical and operational practices within GP practices in Manchester	Identify the 10 'worst' and best performing practices Review PCOT interim evaluation report and scope potential of model to support unwarranted variation Develop Service Specification and Business Case	Unwarranted variation in clinical and operational practices being reduced	Reduced variation in patient experience Reduced variation in clinical and health outcomes Increased consistency between neighbourhoods	Measures of reduced variation in clinical and health outcomes e.g. absolute (or relative) gap between the average performance of the 10 'worst' and best performing practices in respect of prevalence and case finding, non-elective admissions, secondary care referrals and vaccination	

Community Services Review	To understand what is currently being offered in the community and if there is a potential to expand the service and provide more community care. In order avoid attendance at high cost A&E out of normal working hours. Data shows attendance at A&E (but not admitted) after 4.00 pm M-F and at weekends.	Conduct a full review of all current community services and look at possible recommendations for service redesign and delivery.	Information gathering from providers across the city Analysis of hospital and community services activity Develop Service Specification and Business Case	Service Specification and Business Case agreed More patients being managed within the community setting	Reduced attendance at hospital services of patients with Respiratory conditions Improved management of respiratory conditions in the community Improved patient self-management and experience	Rate of emergency admissions for respiratory conditions. % patients feeling more able to self-manage their respiratory condition	
Practice Standards	Respiratory condition management varies across the city therefore a need to address the variance.	Introduce a set of yearly standards with a focus on immunisation, COPD, Asthma and neighbourhood working To achieve best practice of Respiratory management across GP practices in Manchester.	Clinically design the respiratory standards of best practice for Manchester. Engage with and fund GP practices to sign up to the Standards. Design a respiratory dashboard to support monitoring of progress	Increased sign up to GP practice standards Routine monitoring via the dashboard established Peer review process established Reduced variation in respiratory disease management between GP practices	Reduced variation in patient experience Reduced variation in clinical and health outcomes Increased consistency in service offer across neighbourhoods Reduction in unplanned admissions to hospital *Query care plans*	% GP practices signing up to standards (target = 100%) Measures of reduced variation in patient experience (to be agreed) Measures of reduced variation in clinical and health outcomes Measures of increased consistency of service offer at neighbourhood level (to be agreed) Rate of unplanned hospital admissions for respiratory conditions	
Programme element / work stream	**Why are we doing this? (Issue)**	**What will we do? (Objective)**	**How will we do it? (Process)**	**How will we know if we are doing it? (Service Outputs)**	**How will we know if our work is making a difference? (Individual / Neighbourhood Outcomes)**	**How will we measure progress? (outcome KPIs and measures)**	

Communications and engagement with GP Practices	Communication and engagement key to improvement and delivery of better respiratory outcomes. Currently limited engagement with GP practices.	Audit of system to understand what GP practices currently provide (management, education, resources). Support work on GP standards and practice variation. Work collaboratively with local clinicians	Build close relationships with GP colleagues through patch meetings and link meetings Develop and undertake Survey Monkey questionnaire Provide regular communications and updates Hold citywide practice engagement event	Larger and more regular attendance at patch meetings and link meetings Feedback and analysis from Survey monkey questionnaire. Increased sign up to GP practice standards	Greater engagement of GP Practices Reduction in practice variation	% of GP practices report feeling more involved and engaged	
IT Development (My COPD & MyAsthma apps)	Evidence from other areas of UK demonstrates improved self-care and respiratory condition management through use of IT tools such as apps for patient use. No current innovation within IT to improve respiratory outcomes.	Implement IT tools such as apps for patient use	Scope models from other areas. Seek evidence Trial and implement	Go live of apps Patient take-up and use of apps	Improved self-management of respiratory conditions Improved patient confidence of self-management	% patients feeling more able to self-manage their respiratory condition Qualitative data from service users and patient focused groups. Data collection from apps.	
Implement Respiratory Triage across Manchester	Evidence of successful implementation from North Manchester shows that triage enables patient referrals to be directed to the most appropriate service first time, therefore reducing inefficiency in the system.	Implement respiratory triage across Manchester with MICG.	Engagement with all stakeholders. Sharing of triage criteria	Respiratory Triage has gone live via MICG Volume of patient flows through triage system	Improved quality of referrals. Patients seen in the right clinic first time therefore leading to less appointments i.e. fewer unnecessary appointments. Improved patient experience (being seen in the right place at the right time) Improved engagement and feedback from stakeholders.	MICG data Patient-centred experience measures (to be agreed)	

Working with RightCare	To adhere to NHS England planning guidance and the CCGs assurance framework	Work with RightCare delivery partner to implement best practice models across the system in order to achieve best outcomes for patients and address variation in health outcomes and financial spend as highlighted by RightCare	Involve RightCare delivery partner in Respiratory workstreams to identify opportunities for system change.	Unwarranted variation in clinical and operational practices are reduced.	An improvement in peer and national rating (Manchester has been identified as the worst in the country in some Respiratory related illnesses).	MHCC will have an improved RightCare score in the commissioning for value statistics nationally	
Stop Smoking	Smoking remains a significant contributor to premature deaths and ill-health in Manchester	We will engage with targeted high risk groups e.g. Taxi Drivers to provide 'Specialist Stop Smoking' Services. Engage with Manchester Practices to communicate available pathways and services for patients in different areas of Manchester.	Work with Manchester Tobacco Alliance and align our work programme with the Manchester Tobacco Control Plan and the Greater Manchester Tobacco Plan Use population data to identify high risk groups. Explore RightCare networking opportunities and engage with other areas within GM to learn from best practice.	Reduction of number of smokers within Manchester and increased uptake of Stop Smoking services.	Increased life expectancy and reduction in COPD and Asthma emergency presentations.	Through GP data and hospital data.	
Programme element / Workstream	**Why are we doing this? (Issue)**	**What will we do? (Objective)**	**How will we do it? (Process)**	**How will we know if we are doing it? (Service Outputs)**	**How will we know if our work is making a difference? (Individual / Neighbourhood Outcomes)**	**How will we measure progress? (outcome KPIs and measures)**	
Respiratory End of Life Care							
Homelessness							
Children's Respiratory							

Our Manchester

Our Healthier Manchester

Respiratory Disease

2017/18: Foundation
2019/20: Performing
2021/22: Mature
2026/27: Vision

Improve the health and wellbeing of people in Manchester with respiratory disease

Community based models of care from a hospital centric model	**Emphasis on patient experience, education, self-management and prevention**
All staff groups work together to upskill, educate and support in the care of respiratory patients	**High quality patient care throughout the disease cycle**

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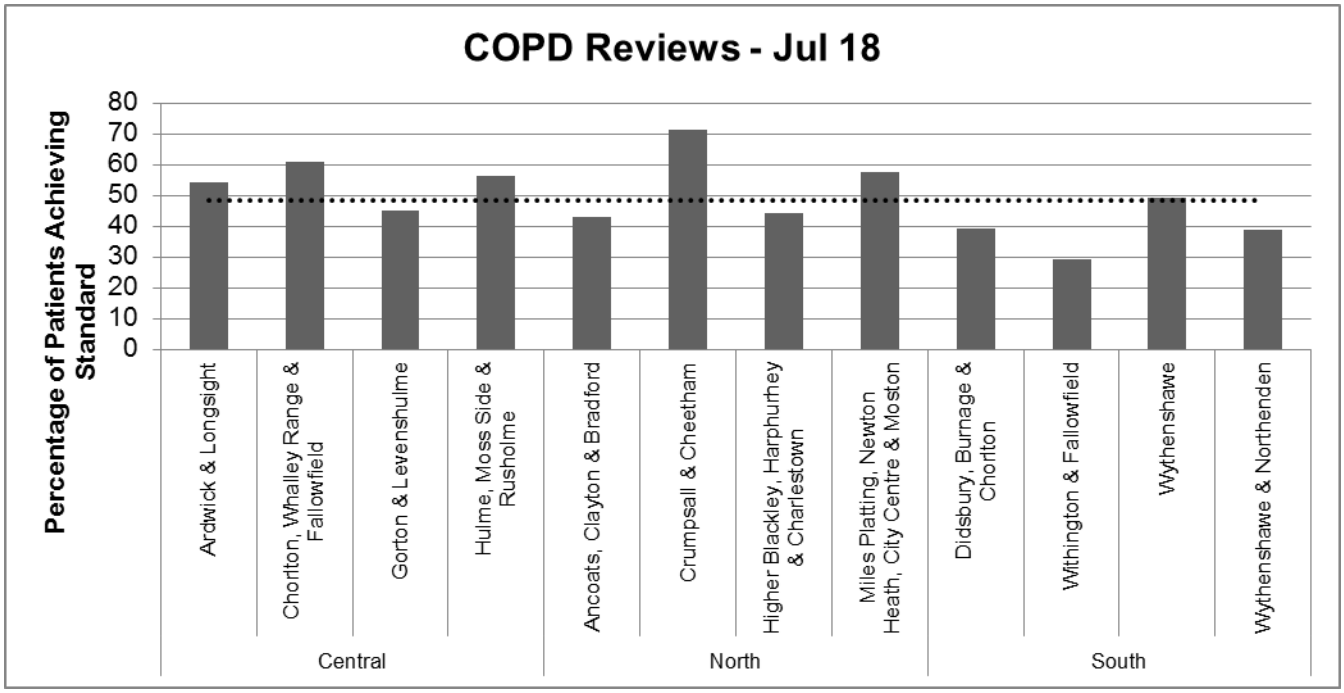
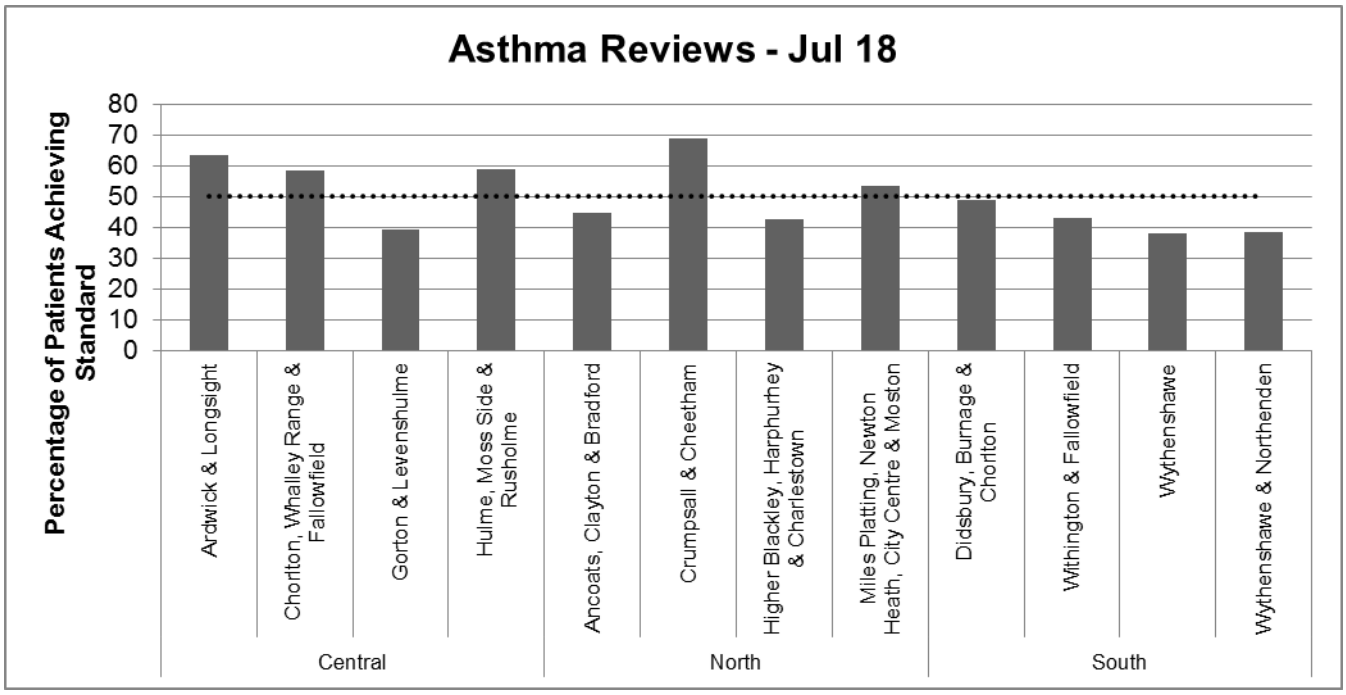
Percentage of COPD patients reviewed by neighbourhood



Percentage of Asthma patients reviewed by neighbourhood



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Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

Respiratory Referral Criteria

All referrals to contain

- Reason for referral
- Clinical question being asked
- Smoking history

Secondary Care Respiratory Referrals for Consultant Opinion

COPD

- Respiratory history
- MRC breathlessness score
- Exacerbation history (last 12 months) plus admission history
- Up to date medication list
- Most recent spirometry

Asthma

- Respiratory/ allergy history
- Exacerbation history (last 12 months) plus admissions history
- RCP 3 questions
- Occupational history
- Up to date medication review
- Number of courses of steroids / antibiotics prescribed in the last 12 months
- Number and name of inhalers prescribed in the last 12 months
- Optimised on medication as per GMMMG guidance
- Recent PEFR and spirometry
- FBC (historical test is sufficient)

Chronic Cough (defined by cough lasting > 8 weeks)

- Recent CXR
- Respiratory/ atopic history
- Stop ACE-I and review after 3 months
- List of medication trials and duration:
  - Suspected post-nasal drip or allergic rhinitis: trial of steroid-nasal spray +/- antihistamine (6 weeks)
  - Suspected reflux related cough- BD PPI plus ranitidine 300mg at night for 8 weeks
  - Suspected asthma – confirm diagnosis. 30mg Prednisolone for 10 days and an 8 week trial of inhaled steroid 200mcg bd (BDP equivalent), assess response
- Recent PEFR and spirometry
- FBC
- NorthWest Cough Network pathway embedded here:

North West Cough Network Pathway.do

Breathlessness

- History- including full cardiac history
- Bloods including FBC (consider BNP if available)
- Recent CXR (within 1 month of referral date)
- Recent spirometry
- FBC, U&E, TFTs

Sleep clinic

- Epworth Score (clear reason for referral if Epworth score is <11)
- Recent BMI and collar size (within the last 1 month)
- Driving (licences held)
- Occupation
- FBC/TFT

Manchester Integrated Lung Service (MILS)

All MILS Referrals

If NEW to the MILS service require the most recent spirometry as confirmation of COPD diagnosis

MILS - Pulmonary Rehabilitation

- Disease - COPD, ILD, Bronchiectasis
- MRC score
- Recent spirometry
- Patient has consented to exercise
- No unstable cardiovascular disease
- Medical history

MILS - Chronic support

- Recent spirometry
- Medication list

MILS – Oxygen

- Disease
- Pulse oximetry at rest and on exercise
- Referral for LTOT or AMB

MILS – Urgent Referrals

Patients with an exacerbation of COPD who require MILS support to prevent hospital admissions - Please note that this is for patients requiring to be seen on the day. Please do NOT process via The Care Gateway but contact the services directly.

<u>Urgent</u> referrals to the Manchester Integrated Lung Service

Locality	Contact telephone number	Contact email	Hours of operation
Manchester Foundation Trust – South	0161 998 7070 Request to speak to a member of the Manchester Integrated Lung Service.* Switchboard will contact the service. *The service was previously known as CRT.	Smu-tr.communityrespiratoryteam@nhs.net	8.00 am – 6.00 pm 7 days per week
Manchester Foundation Trust – Central	0161 276 6035	centralmanc.copdteam@nhs.net	8.30 am – 4.30 pm 7 days per week
Pennine	0161 720 4709	Pah-tr.aras.team@nhs.net	9.00am – 5pm 7 days per week

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Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 4 December 2018

Subject: Final Report and Recommendations of the Public Health Task and Finish Group

Report of: The Public Health Task and Finish Group

Summary

This report presents the findings of the detailed investigation undertaken by the Public Health Task and Finish Group.

Recommendations

The Health Scrutiny Committee is asked to note the findings of the Task and Finish Group and endorse the eight recommendations as set out in section 7 of the report.

Wards Affected: All

Contact Officers:

Name: Lee Walker
Position: Scrutiny Support Officer
Telephone: 0161 234 3376
Email: l.walker@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 the contact officer above.

Copies of the reports and meeting minutes for this Task and Finish Group are available via the Council's web-site:

For the meeting of 26 June 2018 see:

www.manchester.gov.uk/meetings/committee/130/overview_and_scrutiny_public_health_task_and_finsh_group

For all meetings after 26 June 2018 see:

https://democracy.manchester.gov.uk/ieListMeetings.aspx?CId=161&Year=0

Foreword by Councillor Wilson, Chair of the Public Health Task and Finish Group

The Health Scrutiny Committee set up the Public Health Task and Finish Group to look into what we were doing as a Council in the area and what we could be doing better.

In 2015, the Chancellor of the Exchequer announced an in-year cut of £200m to the Public Health Grant followed by real-term cuts averaging 3.9% per year over the following five years. Following the devolution of responsibility for public health to local authorities, these cuts have had severe consequences for Councils' delivery of public health up and down the country.

Manchester has one of the lowest life expectancies and one of the highest number of preventable deaths per capita of any local authority in the UK. There are also vast health inequalities within the city. For example, life expectancy is 8.1 years lower for men and 7.0 years lower for women in the most deprived areas of Manchester than in the least deprived areas. The biggest contributors to these stark statistics are 'lifestyle factors'. Manchester has relatively high levels of smoking, alcohol abuse and physical inactivity and rates of smoking and alcohol consumption are higher in the more deprived parts of our city.

This being the case, the main line of enquiry of the group's work has been how to reduce smoking and alcohol abuse and increase levels of physical activity so that Mancunians can live longer and we can reverse the stark health inequalities both within our city and compared to the rest of the country.

Underfunding of Public Health is a ticking timebomb. For the most part, the consequences of cuts made by this government won't manifest themselves for years but when they do, they will result in more premature deaths and the will hit the poorest communities hardest. We have called for proper funding of public health and explored other ways Manchester City Council can use the resources it does have more effectively.

Councillor James Wilson
Chair of the Public Health Task and Finish Group

1.0 Introduction

1.1 The World Health Organisation defines public health as “the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society” (Acheson, 1988; WHO).

Public health is about helping people to stay healthy, and protecting them from threats to their health, so that everyone is able to make healthier choices, regardless of their circumstances, and to minimise the risk and impact of illness. In recognition of the importance of public health Members of the Health Scrutiny Committee agreed to establish a Member led Task and Finish Group to examine specific issues around public health.

1.2 The Committee subsequently agreed the Terms of Reference and Work Programme at their meeting of 5 December 2017.

1.3 The Health Scrutiny Committee considered the Manchester Population Health Plan 2018-2027 at their meeting of 22 May 2018. (See minutes of the Health Scrutiny Committee 22 May 2018, ref. HSC/18/18). The Members’ discussions that arose on those measures designed to improve the health outcomes of Manchester residents was to inform the work of the Task and Finish Group.

1.4 At the May 2018 meeting the Chair of the Group recommended that the Work Programme of the Group would be amended to include specific consideration of alcohol; tobacco and healthy living.

2.0 Membership

2.1 The membership of the Task and Finish Group was approved by the Health Scrutiny Committee at their meeting of 22 May 2018 as:

Councillor Curley
Councillor Holt
Councillor Lynch
Councillor Mary Monaghan
Councillor Riasat
Councillor Wills
Councillor Wilson (Chair)

3.0 Objectives

3.1 The objectives and key lines of enquiry were agreed by the Health Scrutiny Committee at their meetings of 5 December 2017 (See minute ref. HSC/17/62) and subsequently amended at the meeting of 22 May 2018 (See minute ref. HSC/18/21). The Terms of Reference were further reviewed and amended at the first meeting of the Group held 26 June 2018 (See minute ref. HSC/PH/18/02). The full terms of reference are attached as an Appendix to this report. The agreed objectives were:

- To review current Public Health and Population Health objectives, including self-care and health protection;

- To review good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester;

- To review current academic research in the area of Public Health and Population Health; and

- To inform future discussions on Public Health and Population Health at the Health Scrutiny Committee.

4.0 Key Lines of Enquiry

4.1 The key line of enquiry identified was:

Evidence is to be gathered from a range of stakeholders, including Public Health England; Manchester University Urban Collaboration on Health; and the Manchester Institute for Collaborative Research on Ageing (MICRA).

5.0 Evidence Gathering Process

The Group held three meetings to consider evidence and hear from a number of invited witnesses. The full detail of what the Group considered at each meeting can be found in the work programme, attached as an Appendix to this report.

Formal Meetings and Themes

5.1 Meeting 1: 26 June 2018

Theme: Public Health Objectives and consideration of the Public Health Annual Report

The Group received the 2016/17 Manchester Public Health Annual Report (PHAR) that provided a summary of the work of the public health team across the life course and specialist areas (e.g. health protection) that the team is responsible for. The organisation of the team is entirely consistent with the Greater Manchester Population Health Plan Framework and the Manchester Health Care Commissioning directorate structures. The team, however, has been renamed as the Population Health and Wellbeing Team.

The PHAR informed the development of the Manchester Population Health Plan which had been considered by the Health Scrutiny Committee at their meeting of 22 May 2018 (See Health Scrutiny Committee minutes 22 May 2018, ref. HSC/18/18).

The Population Health and Wellbeing Team would co-ordinate action against the five priorities contained within the Manchester Population Health Plan and

continued to deliver statutory functions and mandated responsibilities on behalf of the City Council. The five priorities were:

- Priority 1 – Improving outcomes in the first 1,000 days of a child's life.
- Priority 2 – Strengthening the positive impact of work on health.
- Priority 3 – Supporting people, households and communities to be socially connected and make changes that matter to them.
- Priority 4 – Creating an age-friendly city that promotes good health and wellbeing for people in mid and later life.
- Priority 5 – Taking action on preventable early deaths.

At this meeting the Group agreed to focus on three particular aspects of Public Health at their next meeting. The three specific areas were: Alcohol, Tobacco and Active Lifestyles.

5.2 Meeting 2: 18 September 2018

Theme: Examples of good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester to address the issues of alcohol; tobacco and healthy living (active lifestyle)

At this meeting the Group considered the measures taken to address tobacco control noting that there was estimated to be just under 91,500 smokers aged 18 and over in Manchester, which is higher than the national average. The impact of this resulted in 5,999 smoking related hospital admissions per year costing £5.4m per year to the NHS in Manchester. In addition, lost productivity caused by smoking related illness, disability or death was estimated to cost the city approximately £106.2m per year.

The Group discussed the models of smoking cessations services, discussed the use of e-cigarettes as a means of quitting smoking noting that whilst the consensus was that the use of these devices had assisted people to stop smoking further research was required as to the long term impact of these on people's health.

The Group further discussed the need for cessation services to meaningfully engage with local communities and that communities needed to be involved in the design of such services.

The Group then considered the issue of active lifestyle noting that Manchester Health and Social Care Partnership, the Councils Sport and Leisure service and Sport England were working to align the physical and health agendas in the city. This approach would result in a new strategy and partnership arrangements; the creation of a not for profit organisation with responsibility for implementing the Sport and Physical Activity strategy; a new leisure facility operating contract.

The Group discussed the Greater Manchester Moving plan, a pioneering comprehensive plan to reduce inactivity and increase participation in physical activity and sport that is aligned to the Greater Manchester Population Health

Plan priority themes and wider reform agenda. Noting that the plan is aimed at children outside of the school setting, adults between the ages of 40 and 60 with long terms health conditions and people who were out of work or at risk of losing their job.

The Group also heard the views from representatives from the Greater Manchester Health and Social Care Partnership, Public Health England, Cancer Research UK and the University of Manchester who had attended to contribute to the discussions.

The Group agreed to defer consideration of the alcohol and alcohol related harm to the next meeting.

5.3 Meeting 3: 26 October 2018

Theme: Public Health and Population Groups: Ageing Population; Health Protection and Infection Control and Alcohol related harm (deferred from the previous meeting)

Alcohol Related Harm

At this meeting the Group considered the issue of alcohol related harm, noting that the most up-to-date estimates (from 20145/15) suggest that 2.4% of adults aged 16 and over living in Manchester are alcohol dependent. Based on the latest Office for National Statistics estimate, this is equivalent to around 10,230 adults in the city. It is further estimated that 28% of adults in Manchester are binge drinkers, compared to 17% nationally. 32% of adults in Manchester are estimated to drink over 14 units of alcohol per week (the recommended safe limit for alcohol with at least 2 alcohol free days), compared to 26% nationally.

The Group heard of the response to this challenge noting the work of the Communities in Charge of Alcohol Project; the Manchester Integrated Drug and Alcohol Service provided by Change, Grow, Live (CGL) that had been operational since 1 April 2016. The Manchester Community Safety Strategy 2018-2021 identified “reducing the crime caused by alcohol and drugs” as one of its five priorities for the life time of the strategy and that Manchester City Council had established a member/officer night time economy group that continued to meet to address issues relating to the city’s vibrant night life.

The Group also heard the views from representatives from the Greater Manchester Health and Social Care Partnership, Public Health England and the University of Manchester who had attended to contribute to the discussions.

Age Friendly Manchester Programme

The Group considered the Age-Friendly Manchester (AFM) programme that aimed to improve the quality of life for older people in the city and to make the city a better place to grow older. Noting that a cornerstone of the AFM

programme is to increase social participation among older residents, support collaborative networks, and improve the health and quality of life for older people. The Group also considered the initiatives to deliver the ambitions to create an age-friendly city that promoted good health and wellbeing for people in mid and later life by creating more age-friendly neighbourhoods; creating age-friendly services and promoting age equality by addressing the negative images and portrayal of ageing.

The Group also heard the views from representatives from the University of Manchester who had attended to contribute to the discussions.

Health Protection

Health protection is one of three core domains of public health, and following the transfer of public health functions to local government in 2013, there is now a statutory duty for local authorities to ensure there are plans in place to protect the health of the population. The Director of Public Health (DPH)/Director of Population Health and Wellbeing has the lead role for health protection, supported by a Consultant in Public Health. The Community Infection Control Team (CICT) support the DPH and provide a community infection control service.

The Group learnt of the highlights of the work of the Manchester Health Protection and Community Infection Control Team in 2017/18 and in the first six months of 2018 (1 April 2018 - 30 September 2018) and learnt of the key actions and challenges for the period ahead in delivering the health protection function with particular reference to Seasonal Influenza Vaccination Programme, Tuberculosis Management, Hepatitis A, Measles, Meningococcal Disease, Nurseries, School, University and Care Home Outbreaks Overview, Gram Negative Blood Stream Infection.

The Group also heard the views from representatives from the Public Health England who had attended to contribute to the discussions.

6.0 Agreement of Final Report and Recommendations

The Group considered the final report that presented the findings of the investigation undertaken by the Group. Members were asked to consider the content of the report and the recommendations and make any amendments.

The final report, which would contain any amendments made by the Members would then be submitted to the next available meeting of the Heath Scrutiny Committee. The Health Scrutiny Committee would be asked to endorse the recommendations contained within section 7 of this report.

7.0 Conclusions and recommendations

Following careful consideration of all of the evidence presented throughout the course of this investigation the Public Health Task and Finish Group agreed the following recommendations:

Recommendation 1:
Public health funding pays for a range of local services and interventions that help prevent ill health for all Manchester citizens. The Group note that regrettably, public health funding has been reduced over previous years and therefore calls upon the Council to lobby the government for greater funding for public health.

Recommendation 2:
The Group recognise that Manchester has above average rates of smoking in all age groups and the highest premature mortality rate in the country for the three major smoking related conditions; lung cancer, heart disease and stroke. Noting that there are just under 6,000 smoking related hospital admissions per year costing approximately £5.4 million per year to the NHS in Manchester.

Smoking is the single largest cause of health inequalities in Manchester and we recommend that the Council establish a 'Stop Smoking' service in line with NICE guideline NG92, published March 2018.

Recommendation 3:
Noting that that there is debate around the use of Nicotine Inhaling Products (e-cigarettes) with e-cigarettes being thought to be 95% safer than smoking normal cigarettes because they do not contain tobacco (Source: PHE/CRUK). However, there still appears to be widespread confusion about how safe e - cigarettes are, relative to normal cigarettes.

We therefore recommend that the Council works with health partners to establish an evidence base on the use of e-cigarettes as an aide to stopping smoking.

Recommendation 4:
Noting the good work of the Communities in Charge of Alcohol project we recognise the changes in alcohol consumption, with an increase of alcohol consumption in the home. We therefore recommend that public health focus on raising awareness on the harms to those citizens who consume a higher than recommended (and potentially harmful in the long term) level of alcohol, but who may not consider themselves as having an issue with alcohol and would not be covered by addiction services.

Recommendation 5:
That the Manchester City Council statement of licensing policy be amended to include the promotion of public health as a specific licensing objective and recognise Public Health as a Responsible Authority.

Recommendation 6:
Recognising the many publicity campaigns that are delivered on a variety of public health issues, Officers are recommended to co-ordinate the delivery of these campaigns in Manchester and across Greater Manchester in order to gain the best return on investment.

Recommendation 7:
Recognising the important work of The Age-Friendly Manchester programme and the significant contribution this makes to citizen's experience and health outcomes we recommend that all Council strategies are coordinated to include consideration of this programme.

Recommendation 8:
The Group support the strengthening of the health protection function of the Director of Public Health and the Community Infection Control Team across the Greater Manchester footprint, and we welcome the establishment of the new Manchester Health Protection Group that will provide oversight and management of all health protection activity in the city.

We recommend that best practice is shared across Greater Manchester between all partners involved with this activity to continue to improve the rates of immunisation across the general population.

8.0 Acknowledgements

The Public Health Task and Finish Group would like to thank the following people for their advice and support during their investigation:

Councillor Bev Craig, *Executive Member for Adult Health and Wellbeing*
David Regan, *Director of Population Health and Wellbeing*
Marie Earle, *Strategic Commissioning Manager, Public Health, Manchester Health and Care Commissioning*
Dr Melanie Sirotkin, *North West Centre Director, Public Health England*
Dr Rebecca Wagstaff, *Deputy Director, Health and Wellbeing, Public Health England North West*
Professor Arpana Verma, *Head of the Division of Population Health, Health Services Research and Primary Care, The University of Manchester*
Sarah Price, *Greater Manchester Director of Population Health*
Jane Pilkington, *Deputy Director for Population Health*
Roisin Reynolds, *Senior Advisor, Greater Manchester Health and Social Care Partnership*
Hayley Lever, *Strategic Manager, Greater Manchester Moving*
Stacey Arnold, *Local Public Affairs and Campaigning Manager Cancer Research UK*
Dr Caroline Rumble, *Consultant in Health Protection, Public Health England North West*
Professor Christopher Phillipson, *Professor of Sociology and Social Gerontology, Manchester Institute for Collaborative Research on Ageing, The University of Manchester*
Leasa Benson, *Clinical Lead Health Protection – Community Infection Control Team, Manchester Population Health and Wellbeing Team, Manchester Health and Care Commissioning*

Title	Public Health Task and Finish Group
Membership	Councillors Curley, Holt, Lynch, Mary Monaghan, Riasat, Wills and Wilson (Chair)
Executive Member	Councillor Craig, Executive Member for Adult Health and Wellbeing
Strategic Director	David Regan, Director of Population Health and Wellbeing
Lead Officers	David Regan, Director of Population Health and Wellbeing
Contact Officer	Lee Walker, Scrutiny Support Unit
Objectives	The Task and Finish Group acknowledges the variation in health outcomes of Manchester residents. The group will seek to understand the range and impact of Public Health and Population Health initiatives on Manchester residents. 1. To review current Public Health and Population Health objectives, including self-care and health protection. 2. To review good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester. 3. To review current academic research in the area of Public Health and Population Health. 4. To inform future discussions on Public Health and Population Health at the Health Scrutiny Committee.
Key Lines of Enquiry	Evidence is to be gathered from a range of stakeholders, including Public Health England; Manchester University Urban Collaboration on Health; Manchester Institute for Collaborative Research on Ageing (MICRA).
Operation	This Task and Finish Group will report its findings to the Health Scrutiny Committee by submitting minutes to the Committee. The Committee will be asked to endorse any recommendations from the Task and Finish Group. A final report will be submitted to the Committee presenting the findings and recommendations of the Task and Finish Group.
Access to Information	Meetings of this Task and Finish group will be open to members of the press and public except where information which is confidential or exempt from publication is being considered. Papers for the Task and Finish group will be made available to members of the press and public on the Council's website and the main entrance to the Town Hall except where information which is confidential or exempt from publication is being considered.
Schedule of Meetings	To be agreed.
Commissioned	September 2017

Health Scrutiny Committee - Public Health Task and Finish Group
Work Programme

Meeting 1: 26 June 2018 2018, 2pm in the Council Chamber, Level 2 Town Hall Extension				
Item	Purpose	Lead Executive Member	Lead Officer	Comments
Public Health Objectives	The Committee will receive a report that gives a current overview of Public Health and Population Health objectives and priorities.	Councillor Craig	David Regan Director of Population Health and Wellbeing	
Terms of Reference and Work Programme	To review and agree the Subgroup's terms of reference and work programme, and consider any changes or additions that are necessary.		Lee Walker Scrutiny Support Officer	

Meeting 2: 18 September 2018, 2pm in the Council Chamber, Level 2 Town Hall Extension				
Item	Purpose	Lead Executive Member	Lead Officer	Comments
Examples of good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester	To review Public Health good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester to address the issues of alcohol; tobacco and healthy living.	Councillor Craig	David Regan Director of Population Health and Wellbeing	Invite to Professor Melanie Sirotkin, Public Health England and Professor Arpana Verma, University of Manchester

Terms of Reference and Work Programme	To review and agree the Subgroup's terms of reference and work programme, and consider any changes or additions that are necessary.		Lee Walker Scrutiny Support Officer	

Meeting 3: 26 October 2018, 2pm in the Council Chamber, Level 2 Town Hall Extension				
Item	Purpose	Lead Executive Member	Lead Officer	Comments
Public Health and Population Groups: Ageing Population	To consider the role and impact of Public Health and Population Health initiatives on the ageing population. The group will hear from Prof Chris Philipson Manchester Institute for Collaborative Research on Ageing An invitation will be sent to the Lead Member for Age Friendly Manchester. The group with also consider the issue of Health Protection and Infection Control and will hear from Public Health England clinicians. The group with also receive information on screening services.	Councillor Craig	David Regan Director of Population Health and Wellbeing Paul McGarry, Strategic Lead Age Friendly Manchester	Invitation to be sent to Prof Chris Philipson, Manchester Institute for Collaborative Research on Ageing & Dr Caroline Rumble, Public Health England
Alcohol related harm	To consider the section of the report on alcohol related harm that was deferred from the meeting of 18 September 2018.	Councillor Craig	David Regan Director of Population Health and Wellbeing	

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Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 4 December 2018

Subject: Overview Report

Report of: Governance and Scrutiny Support Unit

Summary

This report provides the following information:

- Recommendations Monitor
- Key Decisions
- Items for Information
- Work Programme

Recommendation

The Committee is invited to discuss the information provided and agree any changes to the work programme that are necessary.

Wards Affected: All

Contact Officers:

Name: Lee Walker
Position: Scrutiny Support Officer
Telephone: 0161 234 3376
E-mail: l.walker@manchester.gov.uk

Background document (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.

None

1. Monitoring Previous Recommendations

This section of the report contains recommendations made by the Committee and responses to them indicating whether the recommendation will be implemented, and if it will be, how this will be done.

Date	Item	Recommendation	Response	Contact Officer
4 September 2018	HSC/18/36 Manchester Public Health Annual Report 2018	The Chair discuss with the Chair of the Neighbourhoods and Environment Scrutiny Committee and the Executive Member for Executive Member for the Environment, Planning and Transport how best to report to the Committee that activities that are undertaken as part of her portfolio to improve air quality.	The Chair will update the Committee with how this is to be progressed.	Lee Walker Scrutiny Support Officer
4 September 2018	HSC/18/36 Manchester Public Health Annual Report 2018	The Director of Population Health and Wellbeing and Director of Public Health encourage schools and partners to develop green travel plans that are to be implemented and monitored.	The Starting Well/Developing Well Team in the Directorate of Population Health and Wellbeing at Manchester Health and Care Commissioning (MHCC) are working with the Manchester Local Care Organisation who provide Community Health Services (Health Visiting, School Nursing, Healthy Schools) to take forward this recommendation. The team will map existing work taking place and explore further options with air quality work in other children and young people settings (e.g. Early Years and Youth provision). An action plan will be agreed by 30 November 2018.	David Regan Director of Public Health
6 November	HSC/18/47 Prepaid Financial	Request that information on the Risk Register be circulated to the Committee.	A response to this recommendation has been requested and will be reported back to	Zoe Robertson Strategic Lead

2018	Cards - Adult social care (MLCO)		the Committee via the Overview report.	

2. Key Decisions

The Council is required to publish details of key decisions that will be taken at least 28 days before the decision is due to be taken. Details of key decisions that are due to be taken are published on a monthly basis in the Register of Key Decisions.

A key decision, as defined in the Council's Constitution is an executive decision, which is likely:

- To result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates, or
- To be significant in terms of its effects on communities living or working in an area comprising two or more wards in the area of the city.

The Council Constitution defines 'significant' as being expenditure or savings (including the loss of income or capital receipts) in excess of £500k, providing that is not more than 10% of the gross operating expenditure for any budget heading in the in the Council's Revenue Budget Book, and subject to other defined exceptions.

An extract of the most recent Register of Key Decisions, published on **20 November 2018**, containing details of the decisions under the Committee's remit is included below. This is to keep members informed of what decisions are being taken and, where appropriate, include in the work programme of the Committee.

Decisions that were taken before the publication of this report are marked *

Decision title	What is the decision?	Decision maker	Planned date of decision	Documents to be considered	Contact officer details
Adult Social Care – Provider National Living Wage 2017/18 Fee Increase for Care Homes, Extra Care, Learning Disabilities and Mental Health services Ref: 2017/07/18E	Proposed increases are • 5% Care Homes • 3% Extra Care, LD and MH The increases proposed above when added to the previously agreed Homecare increases would be within the £4.26m allocated through the budget process.	City Treasurer	October 2018 or later	National Living Wage Briefing Note.	Michael Salmon 0161 234 4557 m.salmon@manchester.gov.uk
Review of adult social care commissioned services fees Ref: 2017/01/24B	To approve an update to fees for providers for implementation 2018/19.	Strategic Director of Adult Social Services	March 2018 or later	Report and recommendation	Lucy Makinson 0161 234 3430 l.makinson@manchester.gov.uk
Framework Agreement / Contract for the Provision of Homecare Services Ref: 2018/07/02B	The appointment of Providers to deliver Homecare Services	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report and Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080

Contract for the Provision of Advice Services 2018/08/16A	The appointment of a Provider to deliver Advice Services	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report and Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080
Contract for the Provision of Housing Related Support for Young People, Homelessness and Drug and Alcohol Services 2018/08/16B	The appointment of Provider to deliver	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report & Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080

Subject **Care Quality Commission (CQC) Reports**

Contact Officers Lee Walker, Scrutiny Support Unit
Tel: 0161 234 3376
Email: l.walker@manchester.gov.uk

Please find below reports provided by the CQC listing those organisations that have been inspected within Manchester since the Health Scrutiny Committee last met:

Provider	Address	Link to CQC report	Date	Types of Services	Rating
AIK Care Ltd	Good Companions (Manchester) 94 Withington Road Whalley Range Manchester M16 8FA	https://www.cqc.org.uk/location/1-2750639591	23 October 2018	Homecare agencies	**Overall: Inadequate** Safe: Inadequate Effective: Inadequate Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate
Abbotsford Care Home Ltd	Abbotsford Nursing Home - Manchester 8-10 Carlton Road Whalley Range Manchester M16 8BB	https://www.cqc.org.uk/location/1-128317035	27 October 2018	Nursing Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Requires Improvement

Mr Mohedeen Assrafally & Mrs Bibi Toridah Assrafally	Polefield Nursing Home 77 Polefield Road Manchester M9 7EN	https://www.cqc.org.uk/location/1-2279393745	26 October 2018	Nursing Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Inadequate
EHC Harnham House Ltd	Jigsaw Independent Hospital Harnham House, 134 Palatine Road West Didsbury Manchester M20 3ZA	https://www.cqc.org.uk/location/1-130053897	23 October 2018	Hospitals – Mental Health / Capacity	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Anchor Trust	Wellington Lodge 334a Waterloo Road Cheetham Manchester M8 0AX	https://www.cqc.org.uk/location/1-126242409	1 November 2018	Residential Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

The National Autistic Society	Mainwaring Terrace 1, 2, 3, 5 Mainwaring Terrace Northern Moor Manchester M23 0EW	https://www.cqc.org.uk/location/1-134620821	1 November 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Good Well-led: Requires Improvement
Respite (North West Ltd)	Albert Road 24 Albert Road Manchester M19 2FP	https://www.cqc.org.uk/location/1-4536460488	1 November 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Not stated Responsive: Not stated Well-led: Requires Improvement
Viewpark Care Home Ltd	Viewpark Care Home Limited 685 Moston Lane Moston Manchester M40 5QD	https://www.cqc.org.uk/location/1-118097737	1 November 2018	Residential Home	**Overall: Inadequate** Safe: Inadequate Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate

CareBility Ltd	CareBility Piccadilly Business Centre, Aldow Enterprise Park, Blackett Street Manchester M12 6AE	https://www.cqc.org.uk/location/1-3823452441	1 November 2018	Homecare Agencies	**Overall: Inadequate** Safe: Inadequate Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate
Manchester City Council	DSAS- South Network 157 -159 Hall Lane, Baguley Manchester M23 1WD	https://www.cqc.org.uk/location/1-2840121187	10 November 2018	Homecare Agencies	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Inadequate

Health Scrutiny Committee
Work Programme – December 2018

Tuesday 4 December 2018, 10am (Report deadline Thursday 22 November 2018)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Budget 2019/20 Refresh Process: Update for Scrutiny Committees	The Committee will receive a report that sets out the timetable and proposed budget process for 2019/20 and include Directorate budget reports/business plans for consideration.	Councillor Ollerhead	Carol Culley	
Respiratory disease	This report will focus on the issue of respiratory disease and the response to these.	Cllr Craig	Nick Gomm	
Transition from young people's services to adults services	This report will provide members of the Committee with information on the support available for those young people transitioning from young people's services to adult's services. This will focus on a range of services including Learning Disabled Services and Mental Health Services.	Cllr Craig	Nick Gomm Dave Regan Craig Harris	Invitation to be sent to Paul Marshall, Strategic Director of Children's Services
Final report of the Public Health Task and Finish Group	To receive the findings and recommendations of the Public Health Task and Finish Group.	Cllr Craig	Lee Walker	
Overview Report			Lee Walker	

Tuesday 8 January 2019, 10am (Report deadline Thursday 27 December 2018) **** DUE TO CHRISTMAS BREAK PLEASE CAN AS MANY REPORTS AS POSSIBLE BE SUBMITTED BY FRIDAY 21 DECEMBER ****				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Delivering the Our Manchester Strategy	This report provides an overview of work undertaken and progress towards the delivery of the Council's priorities as set out in the Our Manchester Strategy for those areas within the portfolio of the Executive Member for Adult Services.	Cllr Craig	-	
Diabetes Care	To receive an update report on Diabetes care.	Cllr Craig	Nick Gomm	See minutes of January 2015. Ref: HSC/15/03
Quality Performance and Primary Care	This report will focus on how quality performance is measured and reported throughout the delivery of Primary Care across Manchester. This will include information on how the Care Quality Commission (CQC) inspect and assess the delivery of Primary Care.	Cllr Craig	Nick Gomm	
Overview Report			Lee Walker	

Tuesday 5 February 2019, 10am (Report deadline Thursday 24 January 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Single Hospital Service – Progress report	To receive a progress report on the implementation of the Single Hospital Service. This report will provide an update on the benefits realised through the delivery of this programme.	Cllr Craig	Peter Blythin, Director, Single Hospital Service Programme	This item was previously considered 17 July 2018.
Refreshed budget and business plans	The Committee will consider the refreshed budget and business plans for the Directorate of Adult Services, following consideration of original proposals at its December 2018 meeting.	Cllr Ollerhead Cllr Craig	Carol Culley, Dave Regan and The Executive Director of Commissioning & DASS	
Overview Report			Lee Walker	

Items To be Scheduled				
Item	Purpose	Executive Member	Strategic Director/ Lead Officer	Comments
Autism Developments across Children and Adults	To receive an update report on Autism Developments across Children and Adults. This item was considered by the Health Scrutiny Committee at their January 2015 meeting.	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of January 2015. Ref: HSC/15/03 Invitation to be sent to the Chair of Children and Young People Scrutiny Committee.
Update on the work of the Health and Social Care staff in the Neighbourhood Teams	To receive an update report describing the work of the Health and Social Care staff in the Neighbourhood Teams.	Cllr Craig	The Executive Director of Commissioning & DASS	
Manchester Health and Care Commissioning Strategy	To receive a report on the Commissioning Strategy for Health and Care in Manchester. The Committee had considered this item at their July 2017 meeting.	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of July 2017. Ref: HSC/17/31
Public Health and health outcomes	To receive a report that describes the role of Public Health and the wider determents of health outcomes.	Cllr Craig	David Regan	
Manchester Macmillan Local Authority Partnership	To receive a report on the Manchester Macmillan Local Authority Partnership. The scope of this report is to be agreed.	Cllr Craig	David Regan	See Health and Wellbeing Update report September 2017.Ref: HSC/17/40

Mental Health Grants Scheme – Evaluation	To receive a report on the evaluation of the Mental Health Grants Scheme. This grants programme is administered by MACC, Manchester's local voluntary and community sector support organisation, and has resulted in 13 (out of a total of 35) community and third sector organisations receiving investment to deliver projects which link with the Improving Access to Psychological Therapies (IAPT) services in the city.	Cllr Craig	Nick Gomm Professor Craig Harris	To be considered at the March 2019 meeting. See minutes of October 2017. Ref: HSC/17/47
Primary Care Access in Manchester	To receive an update report on access to Primary Medical Care in Manchester; both in core and also extended hours. Representatives from Healthwatch Manchester will be invited to attend this meeting.	Cllr Craig	Nick Gomm	Invitations to Healthwatch Manchester. See minutes of February 2018. Ref: HSC/18/11
Care Homes	To receive a report that provides information on the provision of care homes in the city. The report will further describe the actions taken to respond to any findings of Inadequate or Requires Improvement following an inspection by the Care Quality Commission (CQC).	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of 17 July 2018. Ref: HSC/18/33
The Our Manchester Carers Strategy	To receive an update report on the delivery of the Our Manchester Carers Strategy.	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of 17 July 2018. Ref: HSC/18/31
Single Hospital Service progress report	To receive a bi-monthly update report on the delivery of the Single Hospital Service.	Cllr Craig	Peter Blythin, Director, Single Hospital Service Programme	See minutes of 17 July 2018. Ref: HSC/18/32