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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 8 January 2019
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 allow Members an opportunity to [a] declare any personal, prejudicial or disclosable pecuniary interests they might have in any items which appear on this agenda; and [b] record any items from which they are precluded from voting as a result of Council Tax/Council rent arrears; [c] the existence and nature of party whipping arrangements in respect of any item to be considered at this meeting. Members with a personal interest should declare that at the start of the item under consideration. If Members also have a prejudicial or disclosable pecuniary interest they must withdraw from the meeting during the consideration of the item.

4. Minutes 5 - 12
To approve as a correct record the minutes of the meeting held on 4 December 2018 .

5. Adult Diabetes 13 - 92
Report of Dr Manisha Kumar, Clinical Director, Manchester Health and Care Commissioning

This report provides the Committee with an update on the activities to reduce inequalities in diabetes care and outcomes for the people of Manchester.

6. Primary Medical Care in Manchester 93 - 112
Report of Dr Manisha Kumar, Clinical Director, Manchester Health and Care Commissioning

This report provides information on how quality in Primary Medical Care in Manchester is assessed and improved and also provides an update on Primary Care access.

7. Delivering the Our Manchester Strategy 113 - 124
Report of the Executive Member for Executive Member for Adults, Health and Wellbeing

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.

8. Overview Report 125 - 138

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

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

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This agenda was issued on **Friday, 28 December 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 4 December 2018

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

Councillor S. Murphy, Deputy Leader
Councillor Craig, Executive Member for Adults, Health and Wellbeing
Councillor Bridges, Executive Member for Children's Services
Councillor Midgley, Assistant Executive Member for Adults, Health and Wellbeing
Nick Gomm, Director of Corporate Affairs, Manchester Health and Care Commissioning
Craig Harris, Executive Director of Nursing and Safeguarding, Manchester Health and Care Commissioning
Dr Manisha Kumar, General Practitioner and Clinical Director, Manchester Health & Care Commissioning
Dr Binita Kane, Consultant Chest Physician, Manchester University NHS Foundation Trust South, Clinical Lead for Health Innovation Manchester Respiratory Programme
Martina McLoughlin, Senior Manager, Commissioning and Service Redesign, Manchester Health & Care Commissioning
Matthew Conroy, Primary Care Information Manager, Manchester Health & Care Commissioning

Apologies: Councillor Holt, Paul

HSC/18/49 Minutes

The minutes of the meeting held on 6 November 2018 and the minutes of the Public Health Task and Finish Group were submitted for approval and note. Cllr Riasat requested that his attendance at both meetings be recorded.

Decision

1. To approve the minutes of the meeting held on 6 November 2018 as a correct record subject to the above amendment.

2. To note the minutes of the Public Health Task and Finish Group meeting held on 26 October 2018 subject to the above amendment.

HSC/18/50 Update on Revenue Financial Strategy and Business Plan Process 2019/20

The Committee considered a report of the Chief Executive and the City Treasurer which provided an update on the Council's financial position and set out the next

steps in the budget process. The report summarised Officer proposals for how the Council could deliver a balanced budget for 2019/20.

In conjunction to the above, the Committee also received and considered the Manchester Health and Care Commissioning Pooled Budget 2019/20, Including Adult Social Care, which set out in broad terms the directorate's key priorities, key activities and Homelessness Business Planning: 2019/20, which was a refresh of the directorate's Business Plans for 2018/20 in the context of current resources, challenges and opportunities.

Taken together, the report and the directorate Business Plan illustrated how the directorate would work together and with partners to deliver Our Plan and progress towards the vision set out in the Our Manchester Strategy.

Homelessness Business Planning: 2019/20

The Deputy Leader addressed the Committee regarding the issue of homelessness in Manchester stating that the impact of austerity and welfare reform had a significant impact on the levels of homelessness and people who sleep rough, and this presented a significant challenge. She described how Manchester was responding to this challenge by investing in preventative services, utilising the Social Impact Bond that was funding available from the Ministry for Housing, Communities and Local Government (MHCLG) that was conditional on achieving positive outcomes through a payment by results model. She further advised that properties were being purchased to accommodate families and commented that the legal lessons learnt from this exercise would inform any future purchases to reduce the time taken to secure these.

Members noted the Cold Weather funding from the MHCLG of £35,000 for cold weather winter provision for people who sleep rough and commented that this was an inadequate amount for the scale of the challenge. A Member further enquired if any impact assessments of Universal Credit had been undertaken. The Strategic Lead for Homelessness responded by saying that the Welfare Reform Board did monitor and analyse the impact of Universal Credit and information on this would be shared with the Committee. She further commented that they were currently lobbying the MHCLG for additional funding and a decision on this was pending. In response to a comment from a Member regarding the provision of hot water at a facility she said that she was unaware of any issue, however she would make appropriate enquiries.

Members then discussed the issue of Private Sector Landlords and the use of retaliatory Section 21 Notices (eviction notices) if a tenant complained about disrepair in a property. The Deputy Leader responded by saying that she acknowledged the comments made and that the Executive Member for Housing and Regeneration was undertaking work around this issue as part of a broader piece of work around the Private Rented Sector. She said that inspections of private properties were undertaken before placing people in them and officers would reject a property if unsuitable and then work with the landlord to improve the property conditions. She said that discussions were also currently underway with Housing Providers to utilise their experience to undertake property inspections.

A Member enquired how the different needs of the homeless population were met, noting that families would have different needs to single people and may also have other complex needs. The Strategic Lead for Homelessness said this was recognised and the Manchester Homelessness Partnership brought together a number of different statutory organisations and voluntary groups with lived experience to inform the response to the issue homelessness. The Director of Population Health and Wellbeing further advised that there was a multi-agency approach to delivering health and mental health services for homeless people and made reference to the Urban Village Medical Practice Homeless Healthcare Service based at the Ancoats Primary Care Centre.

Manchester Health and Care Commissioning Pooled Budget 2019/20

The Executive Member for Adults, Health and Wellbeing said that despite the continued reduction in funding from central government for Adult Social Care the Council remained committed to improving the health outcomes of all Manchester residents and protect services for vulnerable people.

The Director of Adult Social Care said the delivery of the new models of care that would be achieved through the Local Care Organisation would reduce the number of non-elective hospital admissions. The Director of Adult Social Care said this would also be supported by the introduction of assistive technology to support people in their home, when appropriate and the Executive Member for Adults, Health and Wellbeing commented that a report on assistive technology would be provided to the Committee at an appropriate time. A Member commented that technology across all health and social care providers needed to be appropriate to ensure that information could be shared and accessed by all staff delivering health and care.

In response to a question regarding staff engagement and Trade Union involvement the Director of Adult Social Care commented that the workforce were the most valuable asset to delivering the ambitions of the Local Care Organisation, and the duty of care to staff was taken very seriously. She explained that asset based staff and team training had been delivered that had included resilience training and Trade Unions had been fully consulted with. In response to a comment from a Member regarding the use of agency staff the Director of Adult Social Care said that they were seeking to reduce the number of agency staff where possible.

The Director of Population Health and Wellbeing responded to a comment from a Member regarding the actions on preventable early deaths by saying that the Population Health Plan that had been submitted to the May meeting of Health Scrutiny Committee had outlined how this would be addressed, along with the other priorities identified.

Decisions

The Committee notes the reports and request that the comments of the Committee be taken into consideration when the final business plans were produced.

HSC/18/51 Adult Respiratory

The Committee considered the report of the Clinical Director, Manchester Health and Care Commissioning(MHCC) that described how MHCC were working collaboratively with partners with the ambition 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.

The Clinical Director referred to the main points of the report which were: -

- Describing the work of NHS RightCare teams, who worked locally with systems to present a diagnosis of data and evidence across the population to identify opportunities and potential areas where quality could be improved;
- A description of the work streams identified by the Manchester Adult Respiratory Steering Group;
- A data analysis of respiratory emergency admissions for the first 6 months of 17/18 compared to the first 6 months of 18/19, noting the considerable pressure in emergency admissions for respiratory patients and how providers were managing these admissions;
- A description of the Primary Care Respiratory Standards developed by MHCC;
- The work underway to review how these standards were applied to those in receipt of Homecare;
- A description of the COPD (Chronic Obstructive Pulmonary Disease) Virtual Clinic and the impact of this innovation;
- An update on the procurement and distribution of spirometers, noting that Spirometry was a simple test used to help diagnose and monitor certain lung conditions by measuring how much air you could breathe out in one forced breath;
- A description of the Manchester Integrated Lung Service;
- A description of the collaborative work undertaken by Primary, Community and Secondary Care to produce the Manchester Respiratory Referral Criteria that covers the minimum information that should be contained in all respiratory referral letters;
- A description on Pulmonary Rehabilitation, a programme of exercise and education for people with long-term lung conditions;
- The programmes developed through Health Innovation Manchester (HIM);
- The activities to address smoking including information on the CURE Project;
- An update on the developments in relation to social prescribing with a description of the Breathe Better model; and
- Information on the partnership work undertaken in Greater Manchester.

Members welcomed the report and noted the information that had been provided that gave the numbers of COPD and Asthma reviews undertaken at a ward level, and requested that this information, along with other relevant health data is shared with local Members.

In response to a comment regarding the difference in figures relating to these reviews across wards the Clinical Director Members commented that establishment of Neighbourhood Teams would address the issue of variation across the city. The

Chair sought clarification as to why some practices appeared to be undertaking significantly more reviews than others. The Primary Care Information Manager responded by saying that this was primarily due to Practices not recording the information correctly on the system. He advised that this information was collected periodically and enquiries were made to individual practices if their returns were low. He said advice and training was offered to those sites to ensure this information was accurately recorded, he also added that Practices were paid for delivering these reviews so it was in their own interest to accurately record this work.

The Clinical Director commented that the majority of GP practices in Manchester were rated as 'Good' or as 'Outstanding' by the Care Quality Commission (CQC), and the couple that were rated as 'Require Improvement' related to improvements around issues of practice management rather than the delivery of care for their patients. She said that for those few practices rated as 'Require Improvement' support was provided to help them address any issues identified. She commented that if Members wished to view the latest CQC reports these could be viewed via their website.

Members discussed the issue if shisha smoking, noting that one hour of shisha smoking could be as damaging as 100 cigarettes and asked what was being done to regulate these premises. The Chair informed the Committee that the Neighbourhoods and Environment Scrutiny Committee would be considering a report on this topic in the new year and asked that the report be circulated to the Committee when this was available.

The Director of Population Health and Wellbeing responded to a comment from a Member regarding the lack of reference within the report to air quality and emissions by commenting that the Manchester Public Health Annual Report 2018 addressed the issue of air quality. He added that the Manchester Health and Care Commissioning Board had considered a report on this issue at their October meeting and this linked into activities at a Greater Manchester level to address this issue of poor air quality. In addition, he commented that the issue of shisha smoking was also being addressed by the Manchester Tobacco Alliance who worked collaboratively with GPs and enforcement agencies.

Decision

The Committee notes the report and request that any future update report include information on the recording of activities undertaken at GP practices.

HSC/18/52 Young people moving in to adult services

The Committee considered the report of the Strategic Director of Children and Education Services, Executive Director of Nursing and Safeguarding, Manchester Health and Care Commissioning and the Director of Population Health and Wellbeing that provided an overview of work that was being done and work that was planned to improve the experience and outcomes of those young people moving from children and young people services to adult services and to improve the experience for their families and carers too.

The Executive Director of Nursing and Safeguarding referred to the main points of the report which were: -

- Describing the services for children and young people and the developments that brought together children and adult social workers under the same management, based in the same team;
- Describing the impact of The Care Act 2014 and the changes that this brought about;
- Describing the 4+1 review process and the strengths and challenges identified and what was being done to address these;
- The work undertaken around the transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) and Complex Placements;
- Work delivered around young people's specialist substance misuse services and the integration of the Eclypse service into the wider integrated adult drug and alcohol service that has afforded the opportunity to develop the approach to supporting young adults who may require treatment beyond the age of 18; and
- Information on reproductive and sexual health services for young people.

Members commented that it needed to be recognised that the transition from services could be a very stressful and worrying period for those in receipt of services, their families and carers and everything should be done to make this transition as seamless as possible. The Executive Member for Adults, Health and Wellbeing said this was acknowledged and understood and the approach adopted was a holistic one. She further commented that she was committed to working with her Executive colleagues to improve transiton.

In response to comments from Members regarding Learning Disables citizens the Director of Adult Services said that a lot of work had been undertaken by the Assistant Executive Member to better integrate services. She said that this work had been overseen by the Learning Disability Partnership Board and that a report on this activity would be reported to the Committee at an appropriate time.

The Assistant Executive Member for Adults, Health and Wellbeing commented upon the work undertaken with teams to improve the transition period with the various teams working much more closely together. She further commented that the workshops that had been arranged to consider this area of work had included parents and carers so that their opinions and experiences were captured. A Member asked that Members be invited to any workshops so they could observe the work that undertaken. The Member further commented that when an update report was submitted for consideration that this would include anonymous case studies.

The Executive Member for Children's Services commented that whilst he recognised the improvements described, he acknowledged that more needed to be done and that he was committed to working with colleagues to achieve this. He described that transition needed to reviewed in a broad sense to ensure that no individual 'fell through the gaps' when they reached a certain age.

A Member commented that many services had different age eligibility criteria that made transitions difficult to navigate, especially for those individuals with complex

needs. The Executive Director of Nursing and Safeguarding acknowledged this comment and advised that services operated within a legislative framework that did not always integrate together, however the ambition was to deliver an all age service that removes barriers.

The Director of Adult Services said that the lessons learnt and good practice adopted in other authorities would be adapted to meet the needs of Manchester residents with an emphasis on collaborative working. She further commented that the voice of the service user and their families was included in the design and commissioning of services.

In response to a request for further information on CAHMS the Executive Director of Nursing and Safeguarding said that a report was being considered by the Children and Young People Scrutiny Committee that afternoon and recommended that this report be circulated to the Committee for information. A Member commented that where appropriate scrutiny committees should work together to jointly scrutinise those areas, such as CAHMS that cut across the remit of both committees. The Chair noted this comment and advised the Members that he would discuss this at the next scrutiny coordination meeting.

In response to a question regarding autism the Executive Director of Nursing and Safeguarding said that a working group had been established to review autism services with the view to refresh the Autism Strategy. He said this work was currently at an early stage and that a report would be provided to the Committee on this activity at an appropriate time.

Decision

The Committee notes the report and request that a progress report is submitted for consideration in six months' time.

HSC/18/53 Final report and recommendations of the Public Health Task and Finish Group

The Committee received the final report and recommendations of the Public Health Task and Finish Group and were invited to note the findings of the investigation and endorse the eight recommendations.

Councillor Wilson, Chair of the Task and Finish Group commented upon the importance of Public Health in improving the health outcomes of Manchester residents and called for continued lobbying of central government for a fairer funding deal for Manchester. In response to comments from Members regarding other wider determinants of health he said that he acknowledged this and said that the Group had agreed to focus on the specific areas as described in the report.

The Executive Member for Adults, Health and Wellbeing acknowledged the comments regarding the wider determinants of health, such as housing conditions and reassured the Committee that work was continuing to address these issues.

Decisions

The Committee: -

1. Note the findings of the Public Health Task and Finish Group;

2. Endorse the eight recommendations of the Public Health Task and Finish Group; and

3. Recommend that the Executive Member for Adults, Health and Wellbeing provide an update report on the implementation of these recommendations to the Committee at an appropriate time.

HSC/18/54 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.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 8 January 2019

Subject: Adult Diabetes

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

Summary

Manchester Health & Care Commissioning (MHCC) is working collaboratively with partners on a diabetes work programme to reduce inequalities in diabetes care and outcomes for the people of Manchester. The main aim is of improving health outcomes and quality of life for all those at risk of, or living with diabetes in Manchester, through supported self-management, personalisation and early optimal interventions. The three key aims are to prevent onset (in type 2 diabetes (T2D)), prevent progression and prevent the complications of diabetes.

Work streams, tools, standards, pathways and education resources have been developed to support the achievement of these aims.

Approach

MHCC has recently established a diabetes steering group to coordinate a system wide approach to ensure that the vision and aims for diabetes care in Manchester are implemented. The group has wide representation from all stakeholders including both primary and secondary care sectors, population health, voluntary organisations and people living with diabetes.

Through integrated working this steering group will co-ordinate the implementation of the diabetes work programme acting as a formal body to oversee the whole system approach on the delivery and management of diabetes care based on the Greater Manchester Best practice Guidance Document.

Tackling Diabetes Together
Diabetes Clinical Best Practice Strategy 2018-2023

This document was published by Greater Manchester Health and Social Care Partnership in April 2018. The majority of the MHCC Diabetes Steering Committee are also active members on the strategy working party. It is anticipated that ensuing diabetes work outputs for MHCC will be in alignment with and benchmarked against this best practice guidance. See Appendix 1

Recommendations

The Health Scrutiny Committee is asked to note the content of this report and provide comments on the diabetes 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 Diabetes work programme. This will empower people with Diabetes 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 Diabetes health care closer to home for patients. Developing and delivering high quality local services for local people. Leading the way on innovation for Diabetes management.
A connected city: world class infrastructure and connectivity to drive growth	Collaborative working with Diabetes UK and the Primary Care Diabetes Society which ensure Manchester is at the forefront of knowledge on Nationwide initiatives and developments.

Contact Officer:

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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.

Manchester Health and Care Commissioning (MHCC) was formed in the 2017/18 time period through the merger of North, Central and South Manchester CCGs and Manchester City Council to form a single commissioning function for health, public health and adult social care services for local people. In addition, on October 2017 Manchester University NHS Foundation Trust (MFT) was created through the merger of Central Manchester Foundation Trust and University Hospital of South Manchester with North Manchester planning to merge into MFT in the near future. This is facilitating a more collaborative approach to reducing variation in care across Manchester to include diabetes care. Therefore data for Manchester as one commissioning organisation is sparse, as many national audit data still includes the separated CCGs of North, South and Central Manchester and individual hospital sites. We hope that the committee will recognise this caveat when reading this document.

Introduction

Diabetes is a long-term condition that impacts significantly on the morbidity and mortality of those living with it. Type 1 diabetes (T1D) is currently non-preventable whereas type 2 diabetes (T2D), can often (but not always) be preventable and is predominantly a progressive disorder defined by deficits in insulin secretion and action that lead to abnormal glucose metabolism and related metabolic derangements.

T1D is defined as an absence of insulin production there are other rare causes of diabetes that include pancreatic and genetic factors.
Significant complications include those which are macrovascular for example, cardiovascular disease (CVD) and those which are microvascular to include nephropathy, retinopathy, neuropathy and erectile dysfunction. Diabetes causes over 1,000 premature deaths in Greater Manchester each year.

People with diabetes have a 55% higher chance of having a myocardial infarction; a 34% increased risk of having a stroke; a 164% increased risk of having renal replacement therapy; a 221% increased risk of having major amputation above the ankle and a 337% increased risk of having a minor amputation than someone without diabetes. Sight deterioration is not uncommon, with diabetic retinopathy affecting a third of people.

Many people can develop depression following diagnosis and many women experience complications in pregnancy and at birth due to diabetes.
Almost ten percent of the UK health care budget is spent on treating diabetes: 90% of this on treating its related long term complications. This financial burden calculation does not include monies spend on other related health economic impacts such as unemployment and disability allowances and social care.

The impact on individuals, their families and carers can be significant however, we know that early, appropriate intensive lifestyle and medical treatment of all risk factors in diabetes can bring positive long term benefits and there is now early data to show that in T2D we could be looking at lifestyle approaches to put diabetes into remission if diagnosis is made early in the disease progression. Therefore, the aim of diabetes management is to give a timely, holistic approach to include the aim of prevention, early diagnosis, possible remission and the management of not just hyperglycaemia but also cardiovascular and additional risk factors so that we can add ‘years to life and life to years’.

Background

Manchester has a registered population of 640,000 with this figure set to increase by 90,000 in the next 10 years. Although there is variation between areas of Manchester, overall the health of people in Manchester is generally worse than the England average, with life expectancy at 65 years also lower for both men and women. Manchester is in one the 20% most deprived local authorities in England with 36% of children in Manchester now living in low income families.

Around two-thirds of the life expectancy gap between Manchester and England is

predominantly due to three broad causes of death: Circulatory diseases, cancers and respiratory diseases which can all be linked to poor lifestyle which is also a key predictor of outcomes for diabetes.

Although the population of Manchester contains a smaller proportion of older people than other areas of the country, those that do reside in Manchester tend to have poorer physical and mental health and greater frailty. 33.4% of the resident population of Manchester come from ethnic minority backgrounds compared with 14.6% for England. Certain BME ethnicities are known to be increased risk factors for T2D. Literacy age is as low as nine years in some areas of the city. Poorer mental health can also impact on diabetes and Manchester sees an average of 16% of persons reporting moderate or extreme anxiety or depression compared to 12% nationally.

The above information represents specific challenges to the delivery of optimal diabetes care in Manchester which MHCC are striving to overcome. https://manchesterccg.nhs.uk/wp-content/uploads/14L_CCG_Annual_Report_2017-18_FINAL.pdf

Diabetes Prevalence
The table below shows the identified prevalence of persons who are on the General Practice Quality Outcomes Framework (QOF) disease registers with diabetes

	Diabetes Prevalence 17years+ by Locality (QOF %)		
	Manchester	Greater Manchester	England
2015/16	6.32	6.98	6.54
2016/17	6.35	7	6.67

A review of the GP QOF register identified 6% of the population to be diagnosed with Type 1 diabetes (T1D), whilst 94% of people to be diagnosed with T2D. This is similar to the national average.

Prevalence rates for diabetes, in particular, T2D, are set to increase on local, regional, national and global levels.

National data illustrates that Manchester's expected diabetes prevalence rates are set to increase as below serving to underline the very relevance of the current forward planning by the Manchester diabetes steering group.

Year Manchester	Expected Prevalence
2018	7.6% (33,043)
2020	7.7% (33,824)
2025	8.0% (36,355)
2035	8.5% (41,754)

Despite actual and predicted prevalence rates, public health modelling data frequently highlights gaps between the number of people expected to have diabetes and those who are actually diagnosed. For example, in the UK, there are

approximately 3.7million people diagnosed with diabetes, and yet a further 1 million people with diabetes but as yet undiagnosed.

https://www.diabetes.org.uk/professionals/position-statements-reports/statistics/diabetes-prevalence-2017

Work is in place within MHCC to look at ensuring more timely diagnosis of diabetes as evidence is strong in relation to improved health outcomes with early diagnosis and management.

The tables below quantify the difference between the average length of stay for both people with and without diabetes.

For emergency admissions, the average length stay in 2018 is nearly twice as long for those with diabetes and average cost per stay rises by £805 per person.

For elective admissions, average length of stay in 2018 for someone with diabetes is increased by a day and costs by £279 per stay.

Manchester CCG Population Emergency Admissions in 2018-19 (Apr-Nov)

Type	Diabetes	Patients	Activity	Cost	LoS	Avg Los	Avg Cost
Adult	No	486685	27462	£45,934,145	117826	4.3	£1,673
Child	No	140898	8782	£7,651,770	8195	0.9	£871
Adult	Yes	24512	4326	£9,918,337	28015	6.5	£2,293
Child	Yes	206	54	£82,557	156	2.9	£1,529
All	No	627583	36244	£53,585,915	126021	3.5	£1,478
All	Yes	24718	4380	£10,000,894	28171	6.4	£2,283

Manchester CCG Population Elective Admissions in 2018-19 (Apr-Nov) - not including Daycases

Type	Diabetes	Patients	Activity	Cost	LoS	Avg Los	Avg Cost
Adult	No	486685	4782	£11,971,547	13338	2.8	£2,503
Child	No	140898	506	£599,693	722	1.4	£1,185
Adult	Yes	24512	706	£1,880,065	2567	3.6	£2,663
Child	Yes	206	4	£5,461	9	2.3	£1,365
All	No	627583	5288	£12,571,239	14060	2.7	£2,377
All	Yes	24718	710	£1,885,527	2576	3.6	£2,656

Year on year emergency admissions data in those with diabetes, despite showing an increase in admissions (possibly related to a generalised increase in diabetes prevalence) does encouragingly show that the average length of stay is lowering and that average costs per stay, despite UK inflation levels are not escalating.

	Emergency admissions	Total cost of admissions	Average cost per admission	Average length of stay
2015/16	482	£803,714.05	£1,667	5.3
2016/17	499	£846,905.05	£1,697	5.1
2017/18	521	£877,766.67	£1,685	4.6

We will look at current initiatives to improve inpatient care later within this document.

Prevention of Onset

Children

At year six, 25.1% (1,422) of children in Manchester are classified as obese, worse than the England average of around 20%. As reflected in the GM Strategy document MHCC is fully supportive of the work outlined in The Population Health Plan (2017-2021). The plan contains commitments to the production of a comprehensive physical activity plan and a comprehensive plan for better nutrition and healthy weight. These plans will include the role of schools and colleges in encouraging children to develop healthy lifestyles; the move to more environments that are more conducive to people maintaining a healthy weight; and innovations such as the Manchester Cooking Project, exercise on referral schemes and other social prescribing initiatives.

See Appendix 2: Greater Manchester Combined Authority Population Health Plan 2017-2021

Adults

Prevention is key to improving outcomes and reducing treatment costs. The aim of the NDPP is to support those with non-diabetic hyperglycaemia with the tools and self-management skills to take control of their health and prevent the onset of T2D. Individuals are offered education through one to one interviews and group sessions. Those eligible are identified by primary care as persons who are not currently diagnosed with diabetes, but are identified to have non-diabetic hyperglycaemic (NDH) ie a HbA1c within the range of 42-47mmol/mol inclusive.

In Manchester 36,000 people are expected to have NDH. National studies have shown that up to 20% could progress to T2D in a year without intervention. However, sustained weight loss and or increased activity could result in reduced rates of progression.

The National Diabetes Prevention Programme is an ongoing national programme which began in 2016 and was rolled out in Manchester in August 2017.

In year 1, 96% of practices engaged with the NDPP programme. Almost 10,000 individuals have been identified as having NDH and added to practice registers. Provider reporting from August 2018 identified that 2239 eligible self-referrals were received, with 1457 initial assessments booked; of which 1312 initial assessments attended, with 595 patients attending the wellbeing sessions which meant that 27% of those eligible attended.

The mobilisation team have worked closely with the provider to ensure practices are supported through the process and are mobilised in practice cluster groups to ensure the programme is delivered locally.

The Health and Equality Report from the provider in Year 1 of mobilisation indicates 87% of the population attending the programme in Manchester are from the bottom 2 quintiles of the Index of Multiple Deprivation. This indicates the service is working towards addressing some of the health inequalities in Manchester based on deprivation.

Mobilisation for year 2 is underway which started in September 2018 and to support this programme of work, it is included within the Manchester Standards. We await initial results of NDDP in terms of weight loss and progression rates locally and initial 2 year national data is expected to be presented early next year.

See NHS England website for further details on the programme: https://www.england.nhs.uk/diabetes/diabetes-prevention

Diagnosis

As previously mentioned, in the section relating to prevalence, local, national and global population health modelling statistics show that there is a significant population of persons with diabetes and as yet undiagnosed. This predominantly relates to T2D by nature of its often-insidious onset rather than T1D which is often rapid and highly symptomatic in presentation with possible life threating hyperglycaemia resulting in diabetic ketoacidosis.

In increasing diagnosis rates and timely diagnosis of T2D the NHS Health Checks are integral in helping identify people with diabetes particularly as the service is able to provide outreach in hard to engage with populations. Data to October 2018 however, shows low uptake of the NHS Health Checks.

For further details see : https://www.healthcheck.nhs.uk/commissioners_and_providers/data/north_of_england/north_west/?la=Manchester&laid=84

Last quarter - October 2018

Total eligible population 2018-2019	140261
Number of people who were offered a NHS Health Check	3979 (2.8%)
Number of people that received a NHS Health Check	1344 (1%)
Percentage of people that received an NHS Health Check of those offered	33.8%

The Manchester Primary Care Standards has encompassed the NHS Health checks within the “Winning Hearts and Minds” section which relates to early detection of long term conditions. The desire is to increase the health checks from 7% offered and 4% received to 20% offered and 10% received each year.

Practices are being encouraged to focus on those at highest risk and there is focus on those with severe mental health issues as this is a particularly high risk cohort for T2D. Practices are being asked to undertake the following:

- **NHS Health Check identification and referral**
- **NHS Health Check completion**

The impact of the addition of NHS Health Checks into the Primary Care Standards is difficult to quantify at present as roll out only began in August 2018. However the initial programme will run until 2020 and initial findings are positive as more people are attending for a Health check.

There is on-going work supporting a revamp of the NHS Health Checks at Greater Manchester level to include using digital tools which can search patient electronic registers to look for those with high risk factors for diabetes so that focused screening may be beneficial. This will be coordinated at a GM level to ensure all eligible patients are invited.

In future, all people who have a Q Diabetes score (a measure of the risk of developing diabetes) >4%, who have not previously been diagnosed with diabetes, will be invited for a Health Check at least every five years. See Appendix 1.

Primary Care Prevention of Progression and Complications

Quality and Outcomes Framework

Practices continue to deliver the Quality and Outcomes Framework for Diabetes this includes annual reviews, screening and optimisation to ensure appropriate treatments target are met.

https://qof.digital.nhs.uk/

Improvement of the Eight Care Processes

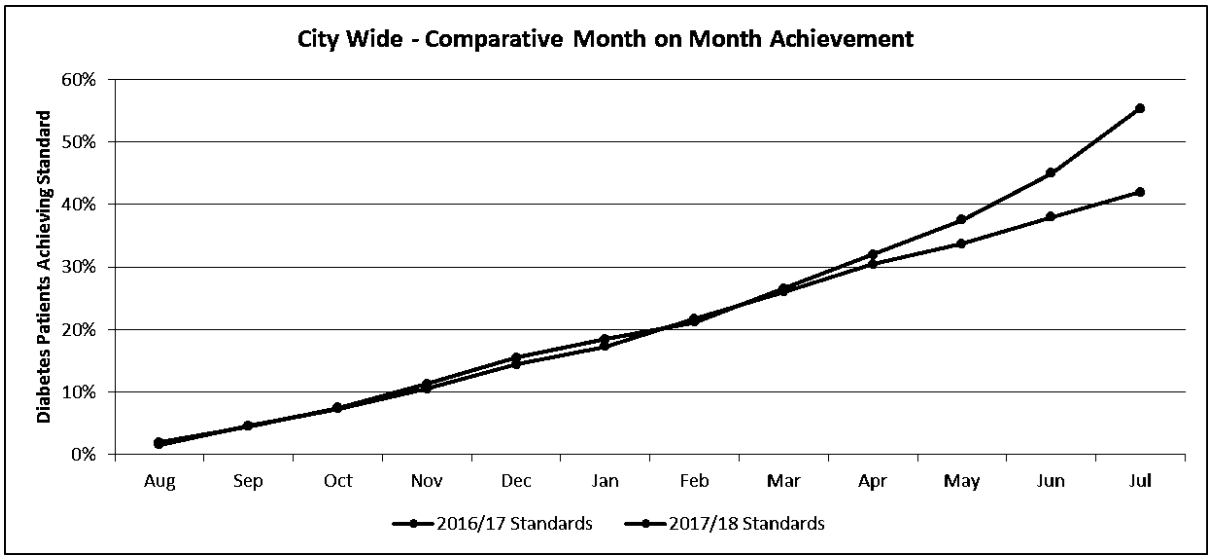
MHCC has been working to standardise care for patients regardless of which GP Practice they are registered with. One way of achieving this is through the Manchester Standards, which all practices have signed up to deliver (see Appendix 3). One of the areas for focus on is achievement of the eight care processes:

1. Blood Pressure measurement
2. Lipids measurement
3. HbA1c measurement
4. BMI measurement
5. eGFR/serum creatinine measurement
6. Urine microalbumin measurement
7. Documentation of foot examination
8. Record of smoking status

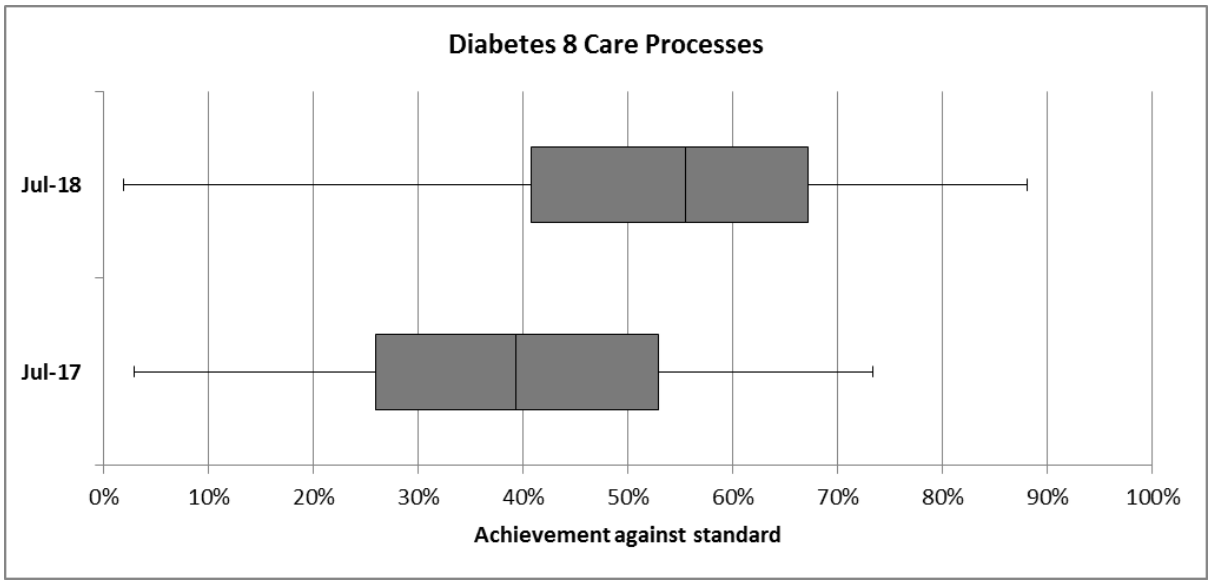
Practices are now formally benchmarked for their performance relating to the achievement of the above essential care processes in diabetes and unlike QOF data there is no scope for exception coding. In addition, key processes such as urine microalbuminuria measurement are included. This measurement was dropped from QOF in 2016 with a subsequent national deterioration in numbers obtaining a microalbumin sample which is often the first sign of any chronic kidney disease and a highly significant marker of long term detrimental outcomes in relation to cardiovascular morbidity and mortality.

To support the implementation of this standard, MHCC has been innovative in designing a standardised template for capture of this data which includes useful links for health care professionals and people living with diabetes. Diabetes UK Information Prescriptions which have been nationally and internationally recognised as gold standards for shared decision making, delivering consistent messages in care and signposting to further support are easily accessed, and there are hyperlinks to other useful advice around sick day guidance in reducing numbers of potential acute kidney injuries, remission information, injection technique guidance and pre-conception advice.

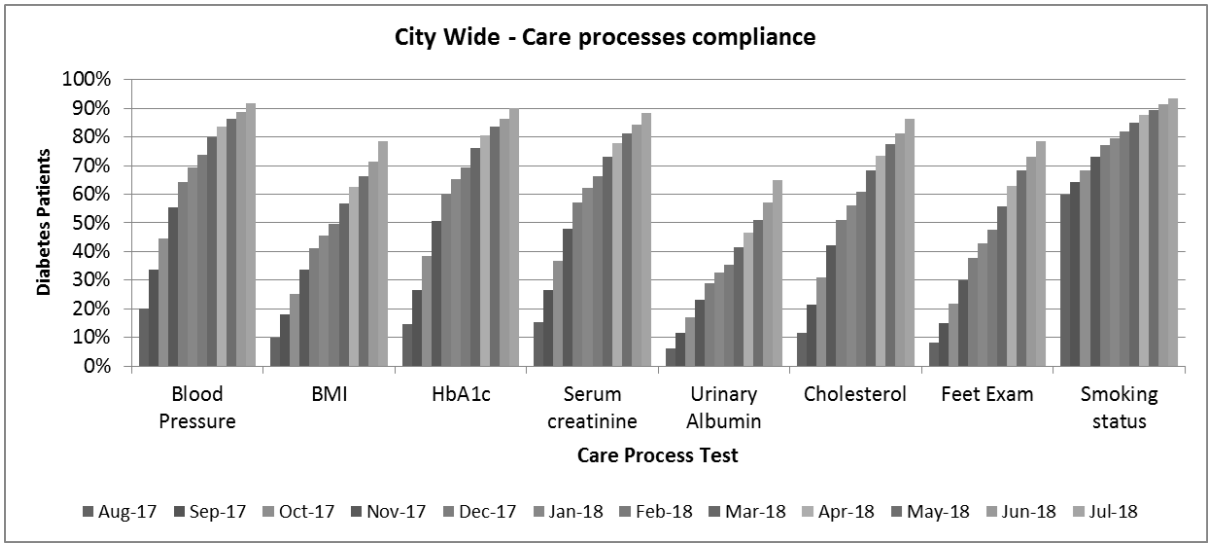
Data below illustrates the positive impacts thus far of the introduction of the standards in improving the numbers of those having received the eight care processes.



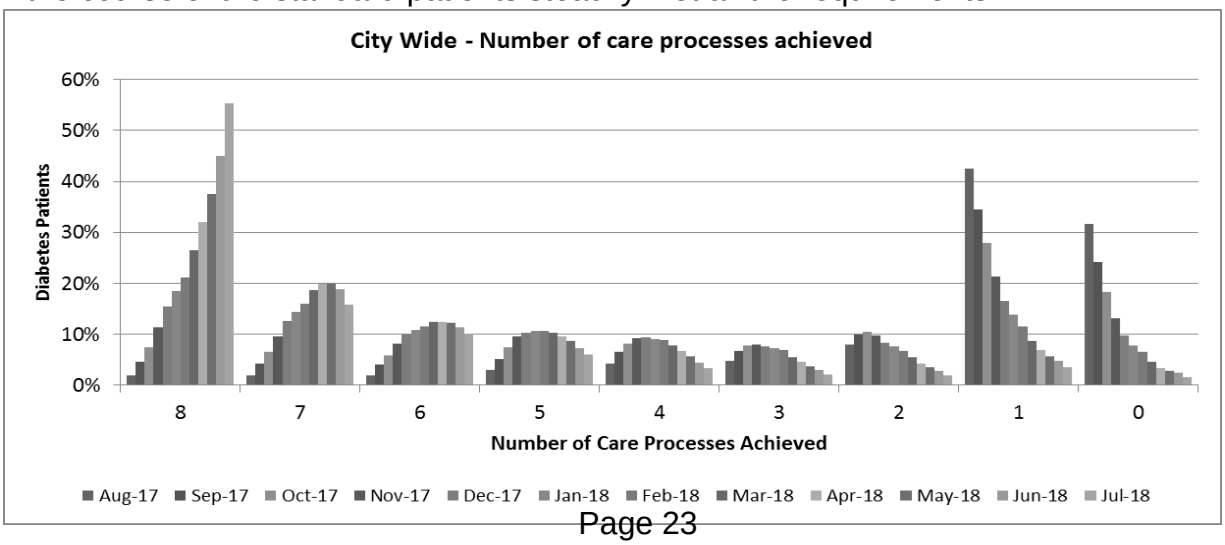
At the end of the 2016/17 standards, 41% of people with diabetes had received their eight-care process. This increased to 55% at the same point in 2017/18.



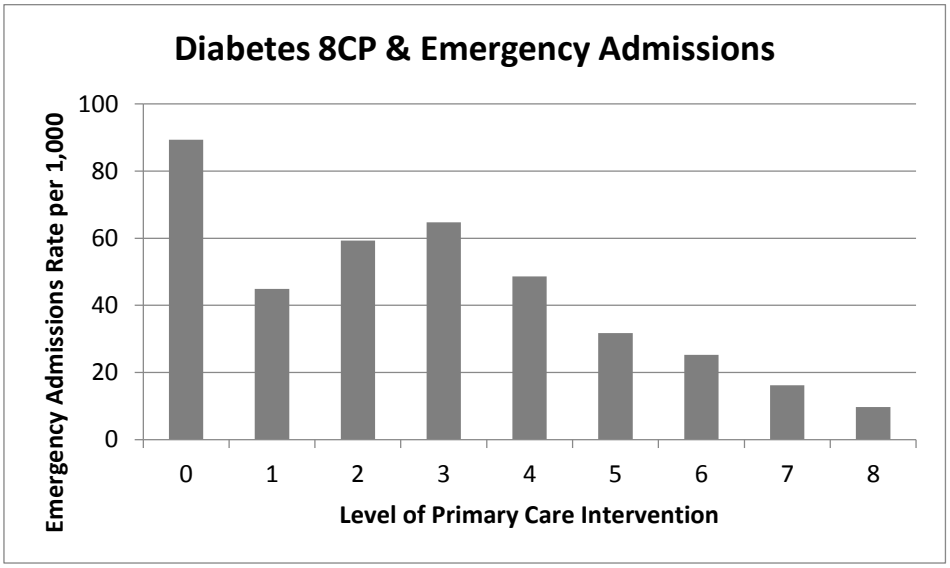
The below chart compares compliance against each of the 8 care processes, demonstrating Urinary Albumin, BMI and Foot Examinations were the least completed care processes.



This information can then be used to see how many patients were some way to achieving the standard, but did not meet all the requirements. This shows that over the course of the standard patients steadily met all the requirements.



Analysis of the 2017/18 standards demonstrates the completion of the 8 processes of care to directly impact emergency admissions activity. Overall, persons who receive more care processes have a significantly reduced rate of emergency admission (as demonstrated in the graph below). Furthermore, the number of care processes also correlates to the average number repeat admissions of a person over that year. Individuals with 0-1 care process completed had on average 3.1-3.4 admissions per individual whilst this significantly dropped to 1.8-1.9 admission per individual who had received 7-8 care process.



Closer analysis of the data identified that those with an increased number of care processes however, did not impact on the average length of stay and cost per admission. Thus, this suggests, patients being admitted with a higher number of care processes are of higher acuity, and require intensive specialist care at secondary care level.

Number of Care Processes	Emergency Admissions	Eligible Patients	Emergency Admission Rate (per 1,000)	Unique Patients	Admissions per patient	Cost per admission	Average Length of Stay
0	61	683	89.3	18	3.4	£1531	4.1
1	50	1,113	44.9	16	3.1	£1331	2.9
2	36	607	59.3	21	1.7	£1596	3.6
3	43	664	64.8	22	1.0	£1522	2.5
4	54	1,111	48.6	25	2.2	£870	2.2
5	66	2,080	31.7	32	2.1	£1900	8.5
6	88	3,481	25.3	49	1.8	£2225	8.0
7	117	7,241	16.1	65	1.8	£2170	5.2
8	133	1,3760	9.7	69	1.9	£1929	4.6

Indicative data analysis for a period before the Primary Care Standards demonstrates a diabetes admission rate of 32 per 1,000 patients, at a total cost of £1.7 million.

Analysis of secondary care data above shows that the diabetes admission rate has fallen to 21 per 1,000 patients, at a total cost of £1.1 million. Over these two periods the number of patients receiving the full diabetes 8 care processes increased by over 2,000.

Whilst we appreciate that there are multiple factors that affect this reduction in non-elective admissions and costs, the implementation of the Primary Care Standards and the subsequent improvement in pro-active, high quality primary care we feel is one of them.

In addition to the work on achieving the eight care processes, MHCC has been supporting educational events to facilitate health care professionals managing those whose measurements sit out with their individualised targets for the care processes. Legacy data pertaining to good outcomes for those with diabetes relate to early and appropriate interventions and helping individuals to meet key treatment targets especially in relation to blood pressure, lipids and HbA1c. Funding for backfill time has been made available by MHCC so that health care professionals can attend educational events to enhance their knowledge on diabetes care processes and management pathways.

National Diabetes Audit
All Practices now submit data to the National Diabetes Audit which is a significant shift in recent years as only 19% of Central Practices submitted in 2016.

https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit

Enhanced Primary Care Service
A service exists to allow for those who have the expertise and skills in injectable therapies initiation to deliver an enhanced service and be reimbursed to reflect the increased time this can often take rather than refer to secondary care services. The service also allows for inter- practice referrals. Seven practices are still actively signed up for this and an update education on insulin therapies in accordance with the enhanced service is planned for April 2019.

A review of the enhanced service for insulin initiation will be undertaken by MHCC Steering group in 2019 with scope to include not just insulin initiation but also insulin management which has proved successful in areas such as Bradford CCG.

The CoDES Team have an insulin choices guide and insulin titration guidance document which has just completed its consultation phase on GMMMG website and will hopefully go live in January 2019 and enhance confidence in primary care of managing those with T2D on insulin therapy.

Pre-Conception
Mothers with diabetes are at increased risk of their infants suffering major congenital malformations, which result in mortality and serious morbidity in infants, Also, still birth, pre-term delivery, surgical delivery and separation from new-born who may need neonatal intensive care. However, with appropriate education and care, such complications can be significantly reduced. Consequently, Manchester have been highly innovative to include this area of work within the Primary Care Standards. Practices will be expected to:

- Complete an accredited e-learning education module to support management of care. This is to ensure HCPs are aware of the importance, impact and management of this patient cohort. It is to be noted that this e-earning module sponsored by Welsh Assembly was co-authored by a practice nurse from MHCC as part of their role as a Committee Member of Primary Care Diabetes Society
- All women with diabetes and of a child bearing age (16-45 years) are to receive awareness, advice and guidance on complications in regards to diabetes related pregnancies (with mindfulness over sensitive areas e.g infertility, history of miscarriage)
- Ensure all women proactively trying to conceive are provided with comprehensive advice, care planning and management in line with NICE guidance.
- Diabetes UK Information Prescriptions relating to pre-conception and pregnancy in diabetes are to be switched on EMIS clinical systems.

As previously mentioned this is an innovative addition to the Primary Care Standards following collaborative work with Diabetes UK (DUK) who if successful may publish as an example of good practice to be adopted by other CCGs.

Community Diabetes Services

North and South Manchester localities have established community Diabetes services. In April 2018 Central Manchester began rolling out a community service pilot.

The three services have different working practices which are summarised below.

Locality	Overview	Coverage
North	The team sit within the community with supervision from consultant diabetoligist	Service works across all practices in North Manchester locality and deliver care to those with T1D and T2D
Central	Community team are employed by MFT. They work in GP practices providing education and mentorship and one day a week they work within	This is a new pilot service for those with T2D which was implemented in April 2018, and is currently working within 7 practices in Central Manchester.

	secondary care team to maintain specialism	
South	Team work within hospital and community to ensure specialism is maintained	The service covers all practices in South Manchester and T1D and T2D.

Community Diabetes Education and Support (CoDES) Team
MHCC funded a two-year community pilot scheme in the Central Manchester area which is ground breaking in that is looking to work with practices to meet their individual needs in relation to diabetes care rather than dictating what needs might be prevalent. The Community Diabetes Education and Support (CoDES) Team is primarily designed to facilitate awareness, enthusiasm, and increase knowledge in relation to diabetes, its prevention and management. It is hoped to increase the knowledge of those living with diabetes, their families and carers and increase healthcare professionals understanding of the optimal management of the condition. The team has so far worked with GPs, practice nurses, district nurses, pharmacists, health care assistants, active case managers and voluntary sectors in delivering education and mentorship alongside seeing people with diabetes who might have otherwise been referred to secondary care. Initial data shows that the average HbA1c of those seen by the team has dropped from 84mmol/mol to 74mmol/mol. The aim is for the pilot to illustrate best practice in facilitating effective, sustainable primary diabetes care so that is might be delivered to a wider population.

Secondary Care Services

People with Diabetes who live in Manchester have access to a number of Secondary Care services.

MFT currently looks after a large population of people with T1D. The Manchester Diabetes Centre specifically provides a clinical service to one of the largest national cohorts of patients using diabetes devices and technology (over 600 patients on insulin pumps and over 300 patients on real-time and flash glucose sensors). The T1D service at Manchester Diabetes Centre (MDC) is nationally and internationally recognised as being at the forefront of the field of diabetes technology. An important milestone was achieved when MDC was chosen as the first diabetes centre in Europe to use the artificial pancreas (automated insulin delivery/closed-loop) in clinical practice in adults with T1D. This and other technological expertise provided by the team has resulted in new patient referrals to the T1D service from other clinical services wishing to avail of specialist input.

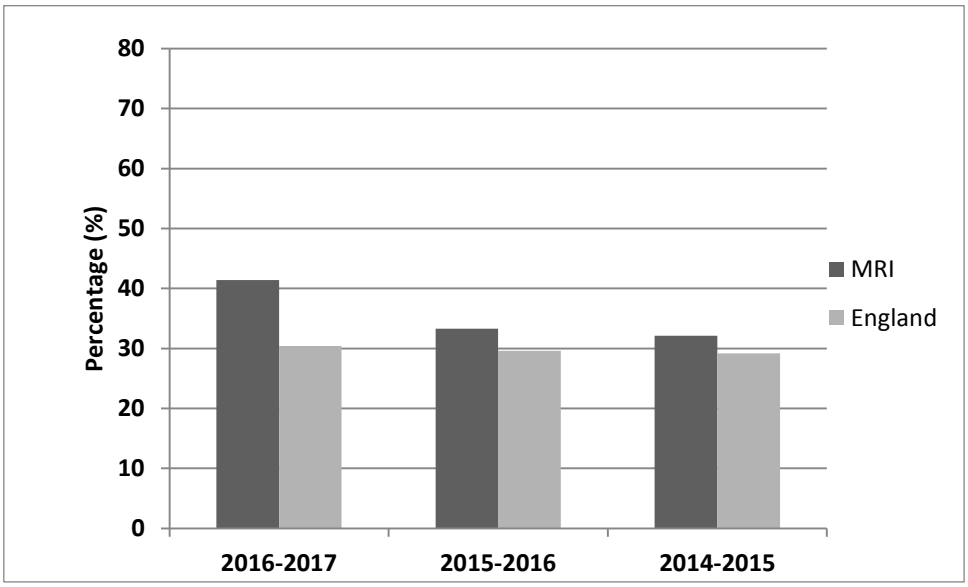
Another important strength is the collaborations with industrial and academic partners, who are attracted by the capabilities and technological interest of the T1D team at MDC. By being actively involved in innovative research, the T1D clinical and research team has collectively contributed over £800,000 to MFT and University of Manchester through research grants in the last 4 years. Ground-breaking research work has been published in high impact factor journals such as the BMJ, Lancet and New England Journal of Medicine.

National Audit data over the past years have reported that MDC has achieved one of the best national outcomes in T1D and pump service. There has been a clear increase in the percentage of people achieving HbA1c <7.5% at MDC, compared to the national data which has not improved (See table below).

This has been recognised by the Clinical Lead of the National Diabetes Audit: "MRI was among the top 15% for the proportion of patients achieving the glucose control target HbA1c<58mmmol/mol. We are keen to help reduce what is presently an almost 100% variation between services in this measure. It would be tremendously helpful if you could tell us in just a few words what factors you think might have contributed to your success."

This clinical milestone justifies the work and effort by the T1D on providing excellent service and support to people with T1D. It also provides a service template and model for other diabetes services across Greater Manchester and further afield.

Figure 1: Percentage of people with type 1 diabetes achieving HbA1c <58mmol/l (7.5%) at Manchester Diabetes Centre and England.



Islet Cell and pancreas Transplantation Service

MFT is one of seven UK centres providing an islet-cell transplantation service the people with type 1 diabetes and life-threatening hypoglycaemia that is not responding to optimal medical therapy. With the pump and sensor expertise available, the centre is able to provide seamless care for those with the most problematic hypoglycaemia.

In 2017, MFT was the first English centre to perform a simultaneous islet and kidney transplant – a new treatment for people with type 1 diabetes and end-stage renal disease. MFT now has 18 patients listed for the procedure. This is a major advance especially for those patients who are not physically fit enough to go through simultaneous pancreas and kidney (SPK) transplant.

Inpatient Support

All hospital inpatients teams are participating in the National Diabetes Inpatient Diabetes Audit (NDIA) and it is accepted that improvements in care and safety are of paramount importance. MFT has successfully put forward a business plan to increase DSN ratios and look at extended hours of practice based on NADIA findings. MHCC will continue to strive to look at ways of reducing unplanned admissions, excess length of hospital stay and medicines safety as a matter of high importance in alignment with GM Strategy Group and the recommendations of the diabetes steering group.

Transition to Adult Services

Diabetes transition and young adult care has been prioritised by both the Department of Health and NHS England and whilst effort has been made to generate improved outcomes nationally with the publication of the document "You're Welcome Pilot 2017. Refreshed Standards for Piloting". Despite this transition and young adult services nationally remain varied according to local resources, patient mix and clinical expertise. MFT has been working on transition services Evaluation is expected over the next twelve months.

Health Care Professional Education

Various health care professional education events have taken place in MHCC over the last twelve months to include:

- ✓ The pre-insulin and insulin merit courses in South Manchester
- ✓ Topical Diabetes Study Days (x3) over 30 attendees
- ✓ Primary Care Nurse Event

Moving forwards, MHCC will work in partnership with GM Stratergy Group to formally evaluate programmes of diabetes education and work to put a catalogue of accredited and appropriate learning courses together for HCP in Manchester. Discussions are in progress around EDEN Diabetes Course run from Leicester University (https://www.edendiabetes.com/) to commence in Manchester for Spring/Summer 2019. This may include a specific diabetes education course in collaboration with Trafford Commissioners for health care assistants in that we are looking at optimal ways of using the workforce and forward workforce planning.

The Diabetes UK Annual Professional Conference will take place in Liverpool in March 2019 and see a nurse from Manchester as its first 'practice nurse' chair. The CoDES Team has secured 25 fully funded places for its Primary Care Day on 8th March for Manchester HCP to attend.

The CoDES team have pulled together a resource pack for all health care professionals and includes for example, pathways on the management and treatment of hypertension, raised lipids in diabetes, pharmacological treatment of diabetes, chronic kidney disease management guidelines, foot pathways, erectile dysfunction guidance, and weight management and smoking cessation signposting.

The first specific dedicated diabetes education took place on 6th November at The Primary Care Nurse Event with around 70 nurses in attendance. Further monthly

events are planned with diabetes weaving into this. A Preceptorship Group for newly appointed practice nurses is also being established by MHCC with the first group meeting in January 2019 and again diabetes and the Manchester Diabetes Standards is planned as an educational session. Other sessions are being delivered to GP registrar trainees in February 2019.

Implementation of the Manchester CardioMetabolic Pathway
Key stakeholders from Manchester and ABPI have collaborated in implementing emerging cardiovascular outcome data in relation to treatment pathways for those with co-existing T2D and cardiovascular disease. This is very reflective of the new ADA/EASD diabetes management guidelines and is currently sitting with GMMMG after completing its initial consultation period. The document is expected go live in January 2019 and Manchester will be the first area in the UK to have implemented such guidance.

NHS England are interested in the pathway, the collaborative approach taken with ABPI and are looking to use this as an example of best practice. This will be rolled out in other CCG's.

Structured Education for People with Diabetes

Current practice shows variation in education offered to those living with diabetes across MHCC based on the previous three areas of service delivery, ie North, South and Central Manchester. There are three different offerings for T2D but all three areas provide DAFNE Education for T1D.

Locality	Course offered
North	Desmond
Central	Locally developed
South	X-Pert

Attendance figures are poor but this is perhaps reflective of national difficulties of read coding when someone has attended for education and MHCC are not alone in looking at ways to improved such data capture in practices.

		Locality			
		North	Central	South	England
Type 1	Offered	52.4%	33.3%	39.3%	35.8%
	Attended	No data			4.2%
Type 2	Offered	85.2%	80.35%	81.9%	80.6%
	Attended	3.8%	0.7%	1.0%	7.6%

A priority for MHCC is to re-design the Diabetes Structured Education Programme for T2D to include for those newly diagnosed and those with longstanding T2D especially those who are struggling to meet appropriate targets. Desired outcomes include improved uptake of diabetes education.

- Focus on the delivery of a consistent approach across the city- potentially through the development of DESMOND diabetes structured education for persons with T2D (T1D currently a consistent offer)
- Seek support from community and voluntary sector to increase participant engagement and hard to reach groups, particularly the BME community and deliver education to include novel initiatives such as Bolton CCG's Community Champions Scheme.
- Review and develop education for people from BME groups and those with low literacy ages.
- Provide sessions online through pre-recorded sessions to allow increased benefit
- Develop refresher education courses which looks at a whole person approach
- All providers to work together to share limited resource
- Work in a smart way that utilises existing geographical enablers.

MHCC is currently working collaboratively with the GM Diabetes Strategy Group with widespread representation on its task and finish group for structured education and work from this will directly link to MHCC design. The next meeting is planned for January 2019.

Digital Education

'GM MY DIABETES MY WAY' is a digital application and has received just under £1million in a test bed funding application. The project collaborative was set up, and led by the Greater Manchester & Eastern Cheshire Strategic Clinical Networks (SCN) heavily supported by a diabetologist and GP in Manchester. The aim is to support people with T2D. The app provides a one-stop digital platform designed to help people self-manage their condition more effectively and to provide education on how to do this.

The system is designed to improve outcomes and experience of people with T2D. It will provide them with a single care record which is shared with their clinician(s); thus giving people increased access and control of their own data. The system will allow clinicians to access patient recorded information, with patients' permission, provide them support for clinical decision making, care planning and self-management advice. As well as the one-stop platform, this project will offer a range of other supporting services and materials. In particular, it will combine online interactive support with education, nutrition/dietary advice, reducing depression/anxiety and remote (video) consultations with clinical staff. Also included will be the opportunity to access coaching and dietician advice from health care professionals to ensure tailored individual care. Many people with diabetes do not currently access healthcare support to be able to manage their condition, so this project will aim to engage with hard-to-reach people and investigate the potential to financially incentivise people with diabetes to attend care services.

The project is expected to go live in April 2019 and will be evaluated by the University of Manchester with the intention if successful, to be rolled out across other CCGs in England. MHCC and Primary Care will be key stakeholders in promoting uptake and usage of the digital platform. The all GP Practice event in January 2019 will begin the raising awareness process so that roll out can begin from April 2019.

Medicines Optimisation

Prescribing in Manchester is high, with a significant spend dedicated to diabetes prescribing. Data has identified the number of admissions versus prescribing for diabetes to be inefficient. Compared to GM, Manchester has been identified to have very high prescribing costs, whilst admissions are high.

Work has already taken place to support improvements. This includes:

- Rationalisation of citywide blood glucose testing meters and strip choices to the most cost effective, ISO compliant for testing, accompanied by promotion of appropriate testing frequencies in accordance with GMMMG guidance
- Review of DPP-4 inhibitor prescribing to ensure compliance with the Greater Manchester Medicines Management Group (GMMMG) formulary including a review of renal function.
- Education & training sessions delivered within the medicines management team to support positive outcomes.
- GMMMG one of the first health economies to provide a guidance document on access to flash technology.

In addition, the team have developed a targeted work programme aimed at improving prescribing efficiencies and outcomes across the city to address inequality within Manchester. A five-year work plan has been developed to ensure optimised medicines prescribing is in line with the Greater Manchester Medicines Management Group formulary. Work will take place in a targeted approach within each of the twelve localities based on population need.

To improve outcomes, the medicines optimisation team have linked with the existing neighbourhood specialist teams to develop and deliver the work streams. This includes the:

- Review of HbA1C for patients prescribed oral antidiabetes agents to ensure ongoing benefit gained from the treatment
- Working with practices around GMMMG formulary choices to promote the most cost effective evidence based medicines
- Working with specialist and established neighbourhood teams to align: work plans, reviews, management and education and training across the city.

Amputation Reduction

New lower limb guidelines have been produced proposing a co-ordinated GM-wide lower limb pathway for the assessment, diagnosis and management of patients aged 18 and over who are at risk of lower limb amputation. Implementation will provide comprehensive coverage of lower limb service provision which would greatly reduce lower limb amputations. This sits in alignment with one of NHS England's key priorities to reduce lower limb amputation rates, and links with national initiatives such as the Vascular All Party Parliamentary Group. Although not all lower limb treatment relates to diabetes, and vice versa, there is a huge overlap between the two. This work stream involves joint working to deliver better patient outcomes and aims to link with other initiatives such as MARS (the Manchester Amputation

Reduction Strategy) and StAMP (Stamping Out Amputation One Limb at a Time).

The Manchester Diabetes Steering Group is working collaboratively with The GM Strategy Group and The Manchester Amputation Reduction Team in having devised and now promoting work around appropriate foot pathways. All inpatient and outpatient teams are inputting into the National Diabetes Foot Audit data in trying to ensure that persons with diabetes have an assessment for foot ulceration within 24 hours of admission and appropriate and timely referral to the multi-disciplinary diabetes foot team (MDDFT) and best practice care of any foot disease in accordance with national guidelines.

https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-foot-care-audit#what-does-it-measure

National Work

Primary Care Diabetes Society

Manchester sees representation of a GP (Naresh Kanumilli) and Community DSN (Nicola Milne) on The Primary Care Diabetes Society Committee. The aim of the Primary Care Diabetes Society is to support primary care professionals to deliver high quality clinically effective care to improve the lives of people living with diabetes

The society represents all healthcare professionals involved with primary care diabetes to include not only general practitioners and practice nurses but also GPSIs, pharmacists, clinical assistants and other allied professionals.

Sharing best practice, promoting and participating in high quality research and audit the Primary Care Diabetes Society delivers high quality contemporaneous education. Affording leadership at local, national and international levels and collaborating with all organisations promoting high quality diabetes care it provides a unique voice for optimal primary care diabetes care.

Diabetes UK

Nicola Milne (Practice Nurse/community DSN) is the current chair of the Diabetes UK Professional Conference Organising Committee for 2019. In 2019 Martin Rutter, diabetolgist from Manchester will take up the role as Vice Chair. Nicola is also a Member of The Diabetes UK Council of Healthcare Professionals which advise DUK on clinical matters and national policies. Naresh Kanumilli is a Diabetes UK Clinical Champion and worked on ensuring full participation in South Manchester in the National Diabetes Audit. His work and enthusiasm on this lead to improvements in audit participation in Central and North Manchester. Naresh has spoken nationally and most recently internationally in USA sharing the good work of GM Strategy Group in improving diabetes care.

Recommendation

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

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Tackling Diabetes Together

Greater Manchester Health and Social Care Partnership

The Greater Manchester Health & Social Care Partnership

Diabetes Clinical
Best Practice Strategy
2018-2023

April 2018

CONTENTS

Foreword

A great number of people including clinicians, commissioners, improvement teams and patients have contributed to the development of this *Diabetes Clinical Best Practice Strategy*. This is a clinically led document which articulates a vision of best practice for diabetes care in Greater Manchester and proposes actions and interventions aimed at achieving that vision. While clinical consensus is key to improving standards, this strategy also aims to reflect the need for a partnership approach. It recognises that best practice cannot be achieved overnight and that a great deal of work, and indeed investment, will be required to meet our goals. In the strategy we have adopted a positive 'we will' approach to tackling the challenges that lie ahead but we are under no illusions that this will necessitate a continuous and iterative approach to implementing improvements over time as local and GM budgets and priorities allow. As a Diabetes Network, we expect to support commissioners and providers where appropriate in benchmarking and costing services to help identify how and where improvements should be implemented. We do believe, however, that it is vital that we set out our goals in a document such as this to guide our long term direction. We also recognise that clinical and technical innovation will continue and that we will need to revise our plans and expectations accordingly as these evolve.

I commend this strategy to you and call for your support in realising what we believe is a bold vision for delivering outstanding diabetes care to the people of Greater Manchester.

Naresh Kanumilli
Clinical lead for diabetes
GMEC Strategic Clinical Networks
Greater Manchester Health & Social Care Partnership

1. Introduction

1.1 Introduction

The number of people diagnosed with diabetes in England is increasing. The prevalence has doubled over the last 20 years. It is expected that over 25% of people living in Greater Manchester will develop the condition in their lifetime.

Insulin manages the way glucose is used and stored in the body leaving an appropriate level of glucose in the blood. There are two main types of diabetes. Type 1 diabetes (T1D) is an autoimmune disease that leads to little or no insulin being available to the body. Type 2 diabetes (T2D) tends to occur later in life, as the ability to produce insulin declines at a time when the body becomes resistant to the effects of insulin, resulting in reduced glycaemic control. An international clinical consensus has created thresholds that categorise the reductions in glycaemic control during this process as non-diabetic hyperglycaemia or T2D.

The Greater Manchester Strategic Clinical Network (SCN) is part of the quality improvement architecture in the Greater Manchester Health & Social Care Partnership (GMHSCP). The Partnership was born out of recognition that health can only be improved by all agencies working together and in partnership with the third sector and the community. The Partnership has identified a number of priorities which include diabetes. This principle is central to the production of this Greater Manchester (GM) strategy for tackling diabetes which has been devised within the context of the GM Population Health Plan, its focus on lifestyle approaches to health and its aims to improve the utilisation of personal health budgets and social prescribing.

The overall aim of the diabetes programme and the strategy is to improve the quality and consistency of services in line with both local and national standards and funding programmes. A *GM Diabetes Strategy* is required in order to facilitate a collective approach to achieving this aim. The GMHSCP's vision is to improve the lives of all people across GM affected by diabetes and at risk of developing it. Much of this strategy will be relevant to children but issues specific to children will be addressed at by the Childrens' Strategic Clinical Network.

1.2 Diabetes prevention and care at a population health level

Prevention is key to improving patient outcomes and reducing treatment costs. GMHSCP, through the SCN, are already responsible for co-ordinating roll-out of the National Diabetes Prevention Programme (NDPP) as noted in section 1.5 of this strategy. The GM Population Health Plan (2017-21),however, also recognises that "*Our population continues to suffer higher than national instances of heart disease, diabetes and other lifestyle related illnesses.*", and this is a key reason for developing this strategy, which is designed to support CCGs to tackle this issue both locally and jointly at a GM level. The population health plan also highlights the importance of obesity and lack of exercise as modifiable risk factors for diabetes and the fact that, in both cases, the GM population figures are worse than national averages. By

developing a vision for clinical best practice and a Diabetes Network to help identify and reduce variation, we aim to contribute to the achievement of the population health plan objectives.

1.3 Diabetes care services in GM

The development of diabetes care in GM over the period 2018 to 2023 will comprise of:

1. What is already being delivered in localities (business as usual)
2. New activity proposed by CCGs (in 2017 locality transformation fund bids)
3. GM-wide collective transformation work (which would be difficult for CCGs to undertake individually)
4. Delivery of national programmes at a local level (which are separately funded)

The above elements need to be combined to generate improvements which can be embedded in the system and address unwarranted variation. Variation occurs on a local basis (eg in delivery of primary care) and on a GM basis (in different approaches and outcomes across different CCGs). A *GM Diabetes Strategy* is required in order to take a collective approach to understanding variation at different levels and addressing it to embed improvement. It needs to ensure that the organisation of services in GM is focussed on the prevention of diabetes, the control of diabetes and complications of the disease. Some examples of the recommendations are:

Prevention of diabetes: Preventing the onset of T2D requires effective policies for children and young people as well as adults. The GM Diabetes Strategy supports the GM Population Health Plan commitments in relation to improved nutrition and physical activity for young people. It will also complement the plan to revamp NHS Health Checks in GM meaning more people at risk will be identified earlier. SCN focus on transition from childrens' to adult services will include diabetes, leading to improved transition.

Control of diabetes: In T1D, control of diabetes depends upon balancing diet, physical activity and the use of exogenous insulin whilst accepting that diabetes will be ever present. In T2D, lifestyle changes and/or clinical interventions will improve glycaemic control – indeed, in some people, glucose levels may become normalised. The commissioning of more structured education will be an important element in achieving this.

The requirement for high quality information to be embedded into GP standards and other clinical specifications will improve the fight against the progression of T2D and the development of complications. In all diabetes care there will be improved quality of information provided to people with diabetes with the assistance of novel use of new technology, and improving the electronic communication between primary and secondary care. Flash glucose monitoring, for persons reliant on insulin, will improve self-managed care and this will be further supported by personalised care planning. More proactive discussion around bariatric surgery, for people with T2D satisfying the NICE criteria, will help to ensure that an increased number of these people will

be able to access the benefits of this cost-effective intervention. A GM-wide strategy for tackling diabetes will mean that an increased number of persons will receive all designated care services and the inclusion of additional processes over and above those already agreed nationally.

Prevention of complications: The introduction of an inpatient care bundle and a commitment to ensuring one nurse with specific diabetes knowledge to every 250 inpatient beds will help to reduce complications and improve patient care and experience. Improved management of cardiovascular disease and risk factors and rapid access to lower limb care will help to reduce cardiovascular complications including amputations. Older people with diabetes will be screened for atrial fibrillation and, because they have diabetes, their CH_2DS_2-VASc score will be at least 2 which means they should be prescribed anticoagulation.

1.4 Key work areas

Within the context of the above framework, there is significant potential to improve services in both traditional and innovate ways and contribute to national targets in areas such as:

- Structured education
- Lower limb care
- Treatment targets
- Diabetes nursing levels

Localities will be supported to work together to build on the existing baseline measures on the quality and uptake of structured education and agree targets for improving both. A co-ordinated approach is required in order to facilitate an integrated lower limb pathway (including with non-diabetes care services) in order to build rapid access coverage across GM. Information sharing and mutual support will help all areas meet treatment targets. A joint initiative by localities to increase nursing provision is required to improve patient care. A *GM Diabetes Strategy* will provide a platform to support a conversation between localities and with the GMHSCP on increased joint working. The GM Diabetes Strategy provides a framework for the development of a comprehensive service specification supported by agreed pathways and processes which will help people with diabetes across GM to experience the same high level of care.

1.5 The National Diabetes Prevention Programme

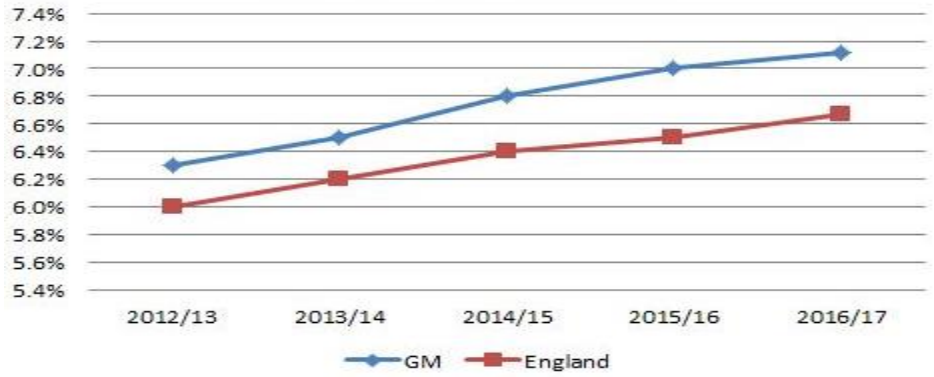
The GMHSCP has agreed a memorandum of understanding with the National Diabetes Prevention Programme (NDPP) to facilitate direct funding to CCGs for implementation of the 'Healthier You' programme in all areas of GM not covered by the early rounds of funding. The SCN is funded by NHS England to co-ordinate the Wave 2 roll-out of the NDPP in GM.

2 Background

2.1 Background

In recent years the number of people diagnosed with diabetes in England has risen (see Fig 1) with the prevalence expected to rise to near 10% by 2025:

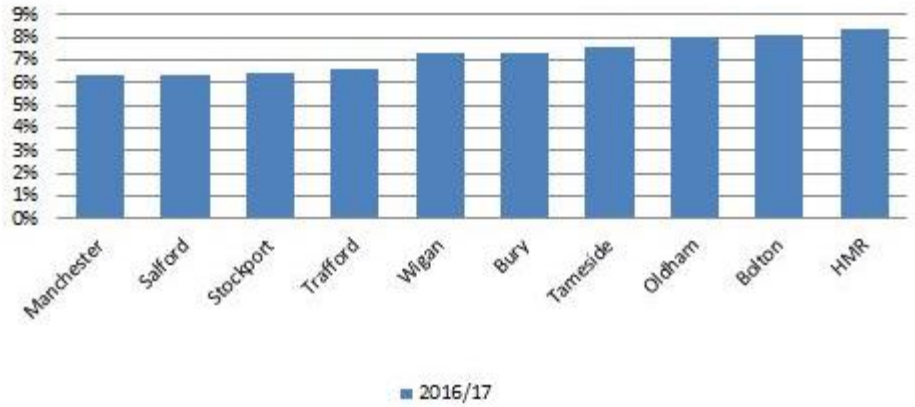
Figure 1: GM Diabetes prevalence (17+ yrs)



2.2 The GM context

Over a quarter of people living in GM will develop diabetes in their lifetime. In GM, there are approximately 160,000 people presently living with diabetes. Most have T2D but about 11,000 have T1D. An equivalent number are also thought to be at risk. There is some variation in the prevalence of diabetes across GM (see Fig 2).

Figure 2: Diabetes Prevalence (+17yrs) 2015/16



Diabetes causes over 1,000 premature deaths in GM each year. Complications will vary by type of diabetes, its severity and the age of the patient. Compared to the general population, people with diabetes have a 55% higher chance of having a myocardial infarction; a 34% increased risk of having a stroke; a 164% increased risk of having renal replacement therapy; a 221% increased risk of having major amputation above the ankle and a 337% increased risk of having a minor amputation. Sight loss is common with diabetic retinopathy affecting a third of

people. Depression and anxiety is at least twice as common in people with diabetes than in the general population. Babies born to women with diabetes have a high risk of congenital abnormalities, prematurity and experience a high rate of complications during childbirth with the risk of needing admission to a neonatal intensive care unit.

Direct medical costs are high and include both the costs of treating diabetes, such as medication, testing supplies, GP visits and the costs of treating its complications. One study estimated the approximate cost of a person diagnosed with T2D aged between 25 and 44 to be over £80,000 over their lifetime.

Standards of diabetes care have shown a steady improvement but there is still much to do to improve our overall response and to reduce variations in outcomes and quality of services. This GM diabetes strategy will lay out how we intend to reduce the incidence of diabetes and the complications of diabetes. It will pave the way to the development of standards and service specifications to improve our services.

3 Vision, mission and goals

3.1 Our Vision

To improve the lives of all people across Greater Manchester affected by diabetes or at risk of developing diabetes.

3.2 Our Mission

To empower people to manage effectively their diabetes or their diabetes risk, by making them aware, educated, and able to access high quality and equitable care.

3.3 Overarching Goals

To achieve our vision we should aim to prevent the onset of diabetes; improve the management of diabetes and prevent its complications. To achieve our mission we should support health care professionals and those with or at risk of diabetes to:

1. Improve blood glucose control
2. Reduce cardiovascular risks and cardiovascular complications
3. Reduce other complications
4. Improve safety
5. Improve experience of diabetes services for those living with the condition

3.4 How do we achieve it?

The GMHSCP, commissioners, providers and other key stakeholders will need to work together to realise the vision. This strategy outlines key actions for consideration and implementation locally and at GM level to enable the overarching goals to be achieved. It is supported by more detailed resources including a technical reference document and a GM draft diabetes service specification. We recognise the diverse nature of the population in GM and will proactively seek to engage in different ways, through different formats and with different sectors.

4 Prevention of Diabetes

4.1 Health in children and young adults

There has been an alarming rise in the prevalence of both T1D and T2D. Part of this is due to increasing life expectancy as the overall prevalence of T2D increases with age. However there are also preventable causes for the rise. Whereas the reasons for the rise in T1D are less clear, it is changes in lifestyle, driven by an obesogenic environment, that have caused the surge in T2D. Reversing this trend will potentially have the greatest impact in tackling diabetes.

Even small shifts in lifestyle behaviours, in particular a reduction in refined carbohydrates, an increase in dietary fibre and an increase in physical activity, will have an effect on reducing the incidence of diabetes.

This diabetes strategy will complement the Greater Manchester Population Health Plan 2017-21 (www.gmhsc.org.uk/assets/GM-Population-Health-Plan-Full-Plan.pdf). The Plan contains commitments to the production of a comprehensive physical activity plan and a comprehensive plan for better nutrition and healthy weight. These plans will include the role of schools and colleges in encouraging children to develop healthy lifestyles; the move to a more leptogenic environment, that is an environment that is more conducive to people maintaining a healthy weight; and innovations such as the Oldham proposal to give business rate relief to takeaways offering healthy options. The successful implementation of the Plan is vital in reducing the burden of diabetes.

4.2 Identification of those at risk and behavioural interventions

There is an increasing identification of people at the early stages of declining glycaemic control both systematically (eg through the NHS Health Check) and opportunistically (eg when people present with obesity, hypertension or periodontal disease). People with elevated glucose levels who are identified as having non-diabetic hyperglycaemia are not only at an increased risk of developing diabetes but also have an increased risk of cardiovascular disease even if they do not develop diabetes.

The NHS Health Check in GM will be revamped. It will include using existing data within the primary care electronic records to identify people, not previously diagnosed with diabetes, who have risk factors which are likely to satisfy the diabetic filter so that they can be invited for screening for diabetes. Presently whether a person is invited to an NHS Health Check is dependent on the practice where the patient is registered. In future, all people who have a QDiabetes score (a measure of the risk of developing diabetes) >4%, who have not previously been diagnosed with diabetes, will be invited for a Health Check at least every five years.

About half of all new cases of T1D are in adults. About one in ten adults with T1D are misdiagnosed as T2D. Clinicians need to have a lower index of suspicion for T1D, even in persons who are overweight, and be more ready to test for urinary

ketones. If they are still uncertain about the diagnosis, they should seek urgent specialist advice.

There will continue to be active support for the developing cross-disciplinary work which includes the identification not only those at risk of diabetes but also those with undiagnosed diabetes. Whereas some signs occur even at the earliest stages of hyperglycaemia (eg periodontal disease), other signs are indicative of more advanced disease which may not yet have been identified (e.g. pathological changes in the eye).

If a person has an HbA1c indicating non-diabetic hyperglycaemia (HbA1c 42-47 mmol/mol) it is important that there is follow-up. People with non-diabetic hyperglycaemia are at increased risk of developing diabetes and will need further HbA1c testing. Guidance will be developed on the recommended frequency of such testing.

People with non-diabetic hyperglycaemia already have a raised cardiovascular risk and are at high risk of further declines in glycaemic control. Lifestyle intervention programmes similar to that offered to people with diabetes have benefits that include increased physical activity, weight loss and lower glucose levels. One systematic review concluded a 26% reduced incidence rate of diabetes in those that undertook the intervention.

By early 2019, the national non-diabetic hyperglycaemia lifestyle intervention programme ('Healthier You') will be fully rolled out in GM with up to 14,000 people a year being offered intervention (with 30% expected to take up the offer). This follows the initial pioneering work of the Salford demonstrator site and the phase 1 roll-out in Oldham, Rochdale and Bury. Localities throughout GM are co-operating in designing measures to improve uptake. The evidence indicates that the effect of these programmes wears off over time with little effect at three years if there is no longer-term follow-up. So the initial programme will be complemented with shorter annual refresher sessions to sustain improvements.

4.3 Planning for pregnancy

There needs to be measures taken to reduce the incidence of gestational diabetes, which is associated with an increased risk of adverse outcomes. Some services have provided interventions for women at high risk preconceptually whilst others have done so for women in early pregnancy. We will develop a clinical consensus to decide which women are at high-risk (eg those with a history of gestational diabetes) to warrant such support.

Additional work will be undertaken to improve preconceptual care for women with established T1D or T2D (see below).

4.4 Health incentives

Incentives can work to improve health behaviours such as losing weight and quitting smoking but the challenge is maintaining those behaviours when the incentives stop.

Incentives are already used in GM (eg reduced cost of membership to weight loss classes, taster sessions for dance classes, and exercise on prescription to encourage positive changes in lifestyle). The Greater Manchester Population Health Plan 2017–2021 intends to develop and test an innovative incentives-based digital platform to support lifestyle behaviour change. There are particular challenges for people losing weight for which incentives may help. Some of these incentives can be provided by health services such as the promise to perform abdominoplasty for excessive loose skin if a person maintains weight loss for an agreed period whilst other incentives would require co-operation with the private sector such as reduced cost of clothing as a person's size declines.

Key actions to prevent the onset of diabetes:

- Support implementation of the Greater Manchester Population Health Plan and align with its wider strategic aim to embed a more proactive approach to person centred prevention and early intervention practice.
- Complement programmes like 'Healthier You' with refresher sessions to embed behavioural change.
- Encourage the use of existing patient apps to support education & care planning and develop additional app(s) as required.
- Contribute to the development of a clinical consensus to identify women of child bearing age at sufficiently high risk of developing diabetes to warrant additional support.
- Seek ways to incentivise healthy behaviours espoused in the GM population Health Plan such as exercise and weight loss.

5 Control of diabetes

5.1 Measuring quality of care

Both good glycaemic control and reduction in blood pressure substantially reduce macrovascular and microvascular complications and reducing cholesterol reduces macrovascular complications. The National Diabetes Audit (NDA) uses the proportion of people achieving levels set out in Figure 3 to measure quality of care.

Figure 3: Levels used to measure quality of care

HbA1c	<=58mmol/mol
Blood Pressure	<=140/80
Cholesterol	<5mmol/L

However, NICE recognises that many people with diabetes should try to achieve lower levels than those used by the NDA, for those with T2D, that can sometimes be achieved by changes in lifestyle and use of metformin therapy. At present for other people with T2D, unless there is a contraindication to metformin, intensification of medication should only be recommended for those with HbA1c >58mmol/mol. For people with T1D, some achieve very good control much below 58mmol/mol which is desirable if hypoglycaemic attacks can be avoided. This led to NICE recommending that "*Diabetes services should document the proportion of adults with type 1 diabetes in a service who achieve an HbA1c level of 53 mmol/mol (7%) or lower.*"

The Greater Manchester Medicines Management Group (GMMMG) will be responsible for developing local guidelines for the intensification of medication for the control of diabetes. They will also monitor and report against these guidelines with the aim of reducing unwarranted variation.

5.2 Information and structured education

There should be a personalised approach for each person with diabetes. Lifestyle advice and other education relevant to diabetes should be part of the therapeutic plan from the time of diagnosis and at every stage thereafter.

There will be consistent, high quality information provided to all persons with diabetes at diagnosis and other appropriate times both verbally by clinicians and through written information. It will be available in a variety of formats and languages to meet the needs of people with sensory impairment, with learning disability or whose first language is not English. This giving of information and discussion is enhanced by attendance at structured education.

Structured education improves diabetes management and is likely to reduce diabetes complications. It leads to lifestyle changes conducive to good health, such as better nutrition and increased physical activity as well as improved compliance with medication and care processes. Structured education should be available to those newly diagnosed and existing people who have not previously attended it.

Only about one in eight of people diagnosed with T1D are reported presently to attend structured education and fewer than one in ten with T2D attend. To improve attendance, we will move towards an opt out system rather than opt in with structured education being seen as an integral part of management. Commissioners will embed this as part of the GP standards and an agreed education cycle will be shared through GP networks via tools currently available or being developed.

The time before starting structured education should be reduced so that those who feel able to do so can start structured education as soon as possible after diagnosis, or after the education programme to manage insulin treatment. Carers and people living with those with diabetes will be encouraged to attend the structured education so that they are in a better position to offer support.

The evidence indicates that lifestyle changes are not sustainable and compliance with treatment is sub-optimal without refresher courses. So, as with the non-diabetic hyperglycaemia lifestyle intervention programmes shorter annual refresher courses to follow up structured education will be an integral part of the management of diabetes.

The management of non-diabetic hyperglycaemia and T2D not requiring insulin is similar, so the same programme can be offered to both groups. For people with T2D requiring insulin, there should be a structured programme for managing insulin but other aspects of education required will be similar to that required by other people with T2D. In the longer-term, we will aim to have a combined programme for people with non-diabetic hyperglycaemia and T2D. This will increase the ability to give people a choice of time and place when selecting which course to attend. Some areas, such as Bolton, have expanded structured education to include the care processes to encourage increased attendance. Such programmes may need to be organised so that there are one or two sessions aimed at people with T2D. People with non-diabetic hyperglycaemia may decide not to attend these sessions.

There are national trials offering electronic structured education with Salford being one of the participating sites. If shown to be effective, electronic structured education will be offered to all those with diabetes but whether clinicians should still recommend face to face group structured education will depend on the relative effectiveness.

For people with T1D, there will be an education programme for initiating insulin immediately on diagnosis and managing insulin or insulin pump therapy. Good results within the SCN footprint for achieving HbA1c targets in people newly diagnosed T1D have been achieved in Cheshire. They feel their results are due to the intensity of the intervention and aiming for a slow, but steady, reduction in blood glucose. We will consider whether the adoption of the Cheshire model in other areas will improve attendance and results and, if adopted, we will audit results to ascertain whether the Cheshire results are replicated

5.3 Continued care planning and person centred care

Increasingly, patients and clinicians in both primary and secondary care will work together in partnership to improve compliance with agreed plans and optimise outcomes through a process of Shared Decision Making (SDM). This requires sufficient time for

- Fully explaining treatment options and possible effects
- Offering choice
- Providing people with the opportunity to be involved in making decisions about their care

There will be an initial assessment and personalised care planning with a member of the care team which will include arranging follow-up appointments. Although, for most people, their care should be largely based within general practice, community diabetes nurses, working in partnership with general practice, will enhance the care of people with diabetes. The care plan will be renewed at least annually. Assessments of people's needs should be holistic and person centred. Approaches that are person and community centred include a very broad range of practice, ranging from 'more than medicine' support that complements and enhances clinical care for people with long-term conditions (such as peer support) to everyday community activities that enable people to improve their health and wellbeing (such as a local football team or gardening club).

People on insulin benefit from self-monitoring. This can now be done less invasively using a flash glucose monitoring system which costs about £1K per year. People using insulin will be offered such a system for a trial period before reviewing its use and providing it in the longer term to people who seem likely to benefit. This offer will be integrated with the insulin education programme. When the flash glucose monitoring system needs to be phased in, for affordability reasons, the SCN will build a clinical consensus about who should have priority. This may be people who have experienced a hypoglycaemia, those newly diagnosed with T1D and pregnant women.

Information technology (IT) can facilitate peoples' involvement in the management of their own care. Personalised care planning will enable people to use the patient access facility of the general practice system so that they have easy access to their records. This will be complemented by supporting people with access to interactive diabetes websites that not only give up-to-date clinic results but also provides other material which supports people to manage their own diabetes. There are widely used websites such as www.mydiabetesmyway.scot.nhs.uk/ or more locally developed websites such as Salford's www.patientview.org. There will be evaluation of systems available and a decision made about which system(s) is appropriate across GM. Whichever system(s) is used, there will be some dedicated resources to keep local information up to date such as contact details of services, news, events and patient stories

Peer support programmes assist people with diabetes in daily management to enhance social and emotional support. Diabetes UK's Peer Support Programme

runs groups led by trained volunteer facilitators and has the potential for members to buddy up. Considering participation in peer support will be part of the care planning process.

5.4 Reversing type 2 diabetes

A major clinical trial reported in Dec 2017 showed that almost half of people who agree to a nutrient-complete, liquid low-calorie diet for 3 to 5 months followed by foods being reintroduced along with long-term support to maintain weight loss, have a reversal of their T2D at 12 months, although we are awaiting results of longer term follow up. This intervention was delivered through GP practices, with nurses and dietitians.

Bariatric surgery leads to improvement in glycaemic control within hours of surgery. In trials of surgery, over half of patients stop medication prescribed for their diabetes as they no longer meet the criteria for a diagnosis of diabetes. Bariatric surgery is highly cost-effective (especially when undertaken early in the course of diabetes) partly as a result of reduction in medication costs. This evidence led to NICE producing new guidance in 2014 (CG189) that increased the number of people with diabetes who are eligible for bariatric surgery as long as they are also receiving or will receive assessment in a local weight management multi-disciplinary service (or equivalent).

All people with a BMI over 25 should be offered dietary intervention that has the potential to reverse diabetes. The design of such dietary intervention may need to be modified as it is a rapidly moving area of research. People who fulfil NICE criteria should also be offered the option of bariatric surgery.

GM clinical commissioning groups have not felt able to implement CG189, because of affordability of bariatric surgery and insufficient capacity in weight management multi-disciplinary services, and have based their policy on the previous NICE guidance (43). This potentially raises conflicts for people with diabetes as the NHS Health Choices website informs them that the NHS offers surgery in accordance with CG189.

GM will comply with NICE guidance when it is considered possible to do so. This will allow clinicians to offer all people with a BMI of 35 or over who have recent-onset T2D an expedited assessment for bariatric surgery and consider an assessment for bariatric surgery for people with a BMI of 30–34.9, or lower if of South Asian family origin, who have recent-onset T2D. Presently, even those who would be eligible for bariatric surgery in accordance with CG43 have to raise the possibility of the surgery themselves. Part of the implementation of CG189 will involve clinicians proactively discussing the offer of bariatric surgery enabling people to make an informed choice. As different types of bariatric surgery have different levels of effectiveness, especially in the long term, this choice will entail making an informed decision regarding the type of bariatric surgery to be undertaken. We will proactively seek to

develop local guidelines for bariatric surgery to facilitate access to surgery in line with national guidance.

There is good guidance about advice on diet immediately prior to bariatric surgery and after the operation although the evidence on the effect of this advice is not robust. However, it will be sensible to build such advice into any service for bariatric surgery.

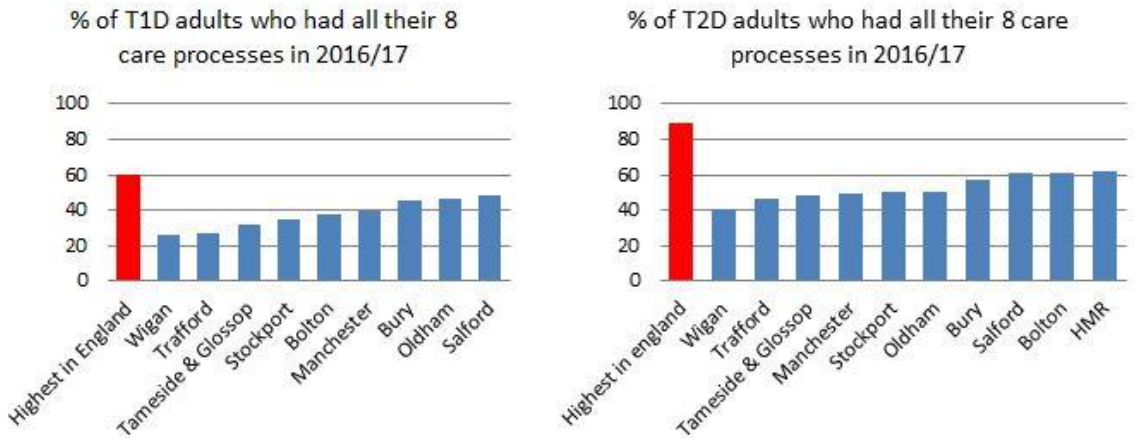
5.5 Care processes

People with diabetes will continue to be offered a number of healthcare tests as part of their ongoing care in accordance with NICE guidance. Historically these have been referred to as the diabetes care processes. Adults should receive HbA1c, cholesterol and blood pressure measurements, in addition to having blood and urine estimation of kidney function, their eyes screened, their body mass index calculated and their feet checked. Smokers will also be offered support to quit. All these processes will happen at least annually, although it is recommended glycaemic control is checked a minimum of twice a year.

Just like adults, children should expect HbA1c testing a minimum of four times a year. They should also expect screening for coeliac and thyroid disease, their body mass index calculated and an offer of psychological support. In those over twelve years, there should be tests of kidney function, eye screening, measurement of blood pressure and a check on their feet.

Relatively very few people with diabetes have all the care processes carried out annually (Fig 4). In most cases fewer than half of adults with diabetes have the eight care processes (excluding eye screening) carried out and there appears to be a particular challenge with kidney function tests in both types of diabetes and foot surveillance in T1D.

Figure 4: Proportion of people who have care processes carried out



In GM, work will be done to improve the proportion of people receiving all care processes. We will build on the integrated approach, used for many people with diabetes in GM, of joint working across health sectors and disciplines which clearly allocates responsibilities for carrying out each of the care processes. This will

improve uptake and appropriate follow-up. We will enable people with diabetes to provide the data to the clinician, possibly electronically, to give more control to the patient and reduce clinician time (eg home blood pressure measurements and urinalysis). Other measures could include improving the correspondence to people inviting them to attend; minimising the number of visits people have to make, sometimes to different venues; increasing choice of times to attend; and virtual clinics using telephone or skype.

It is important that action is taken following the identification of issues as a result of undertaking the care processes. For example, smokers will be encouraged to access specialist services to quit which will be available throughout GM as laid out in the GM Tobacco Strategy (*http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf*). This strategy also states that e-cigarettes can provide a route out of smoking. So we will explore the potential of providing starter kits for e-cigarettes for those who prefer to quit smoking by switching to vaping as well as the stop smoking aids already available.

5.6 Additions to nationally agreed care processes

Diabetes-specific emotional distress, depression and anxiety are all common in people with diabetes. Brief screening for these conditions should be an additional process undertaken annually.

Diabetic retinopathy is a leading cause of blindness in the UK and we will continue to take measures to improve attendance at National Diabetic Eye Screening Programme. People with diabetes have an increased risk of glaucoma. For the routine eye examination at an optometrist, guidance from the College of Optometrists state that risk factors for glaucoma include being “over the age of 40”. The risk increases with every decade of life thereafter”. The guidance continues that “*When examining a patient who is in the at risk groups for glaucoma you must carry out relevant tests*” and these include measuring intraocular pressure and assessing visual fields. It is inappropriate that people with diabetes over the age of 40 are considered in need of screening for glaucoma only if they visit an optometrist. Raised intraocular pressure is a modifiable risk factor for glaucoma and will be part of the diabetic eye screening. However, it has poor sensitivity and specificity for the diagnosis of glaucoma. So relevant pathways will be put in place to ensure people with identified raised IOP at diabetic eye screening have additional assessment to investigate potential glaucoma (including assessment of optic nerve, visual field and contact tonometry) and should be assessed for treatment to reduce IOP even in the absence of glaucomatous pathology.

In addition to the children’s programme for flu and pneumococcus, adults will benefit from having flu immunisation each year and the pneumococcal vaccine according to national guidance. However coverage could be improved with only about two-thirds of people with diabetes having the flu immunisation each year. As well as inviting people for their immunisation, advising about immunisation should be part of the discussion that takes place when undertaking other care processes.

Erectile dysfunction has an increased prevalence in men with diabetes. Even when men are affected by erectile dysfunction, they are often reluctant to mention it to the clinician. As part of undertaking the care processes, clinicians will proactively ask about erectile dysfunction.

There is a clear association between periodontal health and glycaemic control although the direction of that association is not clear. However, during consultations with patients for the care processes is an opportunity to encourage people to visit the dentist for an oral examination and dentists can encourage people with periodontal disease to be checked for diabetes.

5.7 Transition

Most people transition between the ages of sixteen and nineteen years. However, blood glucose control often deteriorates considerably in the years that follow transition with HbA1c treatment target being less likely to be reached during this period.

While the path to adulthood is a continuous one, the path through clinical services may not be so smooth. It is appropriate that children and adolescents take increasing responsibility for their condition as they grow up. It is important that this assumption of greater responsibility starts early. For example, the 'Ready, Steady, Go' programme prepares children with diabetes for transition starting at 11 years of age. There also needs to be a good handover of care from paediatric to adult physicians. All services for children with diabetes will adopt a systematic approach to transition in line with the GM Childrens and Young Adults Strategy.

Key actions to improve the management of diabetes:

Structured education

- Ensure consistent high quality information is provided to all at appropriate times in a variety of formats.
- Adopt an 'opt out' rather than an 'opt in' approach to structured education and embed this is GP standards.
- Invite carers, and people living with those with diabetes, to attend structured education.
- Ensure refresher courses are available.
- Implement new structured education opportunities through a patient diabetes app for use remotely on mobile devices.
- Offer an education programme for initiating insulin to those with T2D requiring insulin.
- Investigate the potential for the electronic delivery of structured education through mobile devices.

Person-centred care

- Review person centred care plans, incorporating the 'more than medicine' approach, at least annually.
- Offer appropriate persons on insulin the opportunity to trial flash glucose

monitoring.
- Contribute to and participate in the development of online patient access to personalised information.

Bariatric surgery
- Ensure clinicians proactively offer people who have diabetes with a BMI over 35 or over with recent onset diabetes the option to discuss bariatric surgery.

Care Processes
- Improve joint working and increase integrated care.
- Improve opportunities for people with diabetes to provide data to clinicians, including electronically.
- Provide additional support to stop smoking, including e-cigarette starter kits.

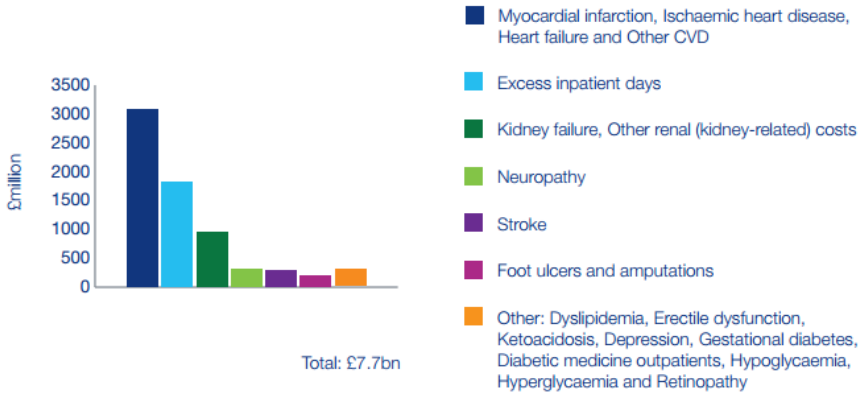
Additional care processes
- Include screening for diabetes-specific emotional distress, depression and anxiety.
- Include measurement of intra-ocular pressure and optic nerve damage inspection during as part of eye-screening.
- Ensure that both children and adults are advised to take up pneumococcal and annual flu immunisation.
- Ensure clinicians proactively ask men about erectile dysfunction.
- Ensure people undergoing the diabetes care processes will also be encouraged to have regular dental check-ups.

6 Prevention of complications

6.1 Impact

Complications as a result of diabetes have a profound impact on those living with them, as well as their families and their carers. Complications such as cardiovascular events, renal failure, visual impairment, erectile dysfunction, gum disease or a wound resulting in amputation can be life changing and people may require considerable support from all involved in their care. In some cases, it will be appropriate that people are offered assessment for a personalised health budget and we will proactively seek to ensure that these discussions take place.

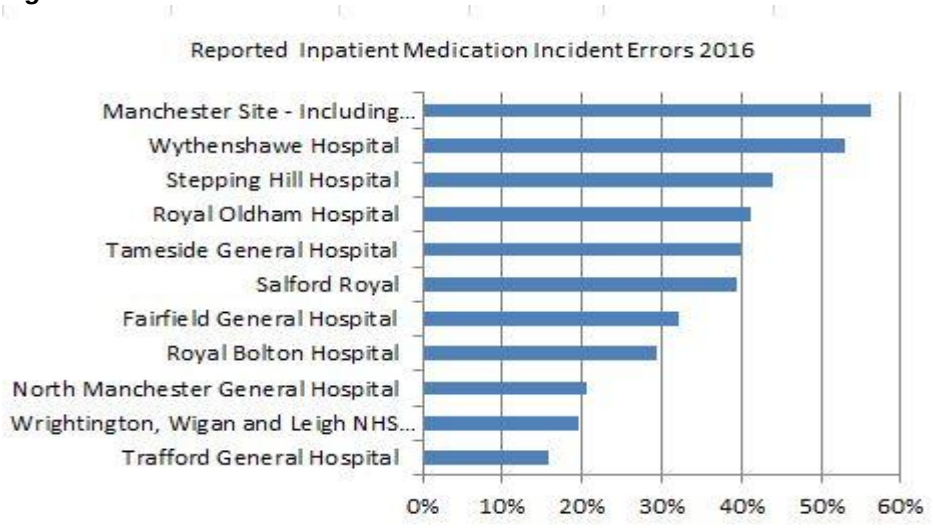
Figure 5: Costs of diabetes complications



Source:
Cost of Diabetes Report v2 (2014)

Based on an analysis of diabetes costs in 2010/11, around £400 million is spent each year on treating complications in GM (Fig 5). Inpatients with diabetes often exceed the NHS tariff paid to hospitals by up to 8.5% due to longer length of stay. Readmission rates are high (59% higher than in age matched populations without diabetes and there are thousands of emergency call outs for ambulance staff and presentations in accident and emergency departments). Presently a high proportion of inpatients with diabetes have medication errors during their stay in hospital (Fig 6).

Figure 6: Medication errors in GM.



Source: SUS data and the National Diabetes Inpatient Audit

We will pilot the introduction of an inpatient bundle of care to reduce harm (see box), prevent inpatient medication errors and reduce inpatient length of stay. Many people treated with insulin have greater knowledge and experience of insulin adjustment than the medical and nursing staff responsible for their care. They routinely monitor their capillary glucose and adjust the insulin dose depending on the result. Self-management of diabetes by people who are willing and able improves the safety of insulin use in hospital. Hospitals will have a policy for diabetes self-management. Self-management will be the default position for all inpatients who are willing and able to manage their condition. We will explore the option of introducing clinical decision support systems and information prescriptions to enable clinicians to respond appropriately to abnormal test results.

The inpatient bundle of care comprises components relating to:

- Ambulatory care model
- Link to nurses
- Purple lanyards for DT
- Incident reporting response
- Timely access to nutrition
- Purple food trays
- Nutritional information
- Electronic patient tracking
- 'Think glucose' icon patient identifier
- MDT 7 days per week
- Safe medication management

Full details are contained in the draft diabetes service specification

Diabetes nurses provide management plans, treatment advice, and support for adults with diabetes and their carers. They are also a clinical and educational resource for other health professionals. They improve patient care, including reducing medication errors, and reduce length of stay. We will aim to ensure that these nurses are employed in line with the national recommendation of one nurse per 250 inpatient beds during the lifetime of the strategy.

6.2 Cardiovascular complications

Cardiovascular disease accounts for over half of all deaths in people with diabetes. People with diabetes are about twice as likely to die prematurely from cardiovascular disease than those without diabetes. The death rate can be halved by managing cardiovascular risk factors more effectively. This will be done through the personalised care plan which will include measures such as healthy lifestyle advice, control of blood pressure and the use of statins. Measures will be taken to improve the proportion of people offered the appropriate intervention and compliance with those interventions.

Major amputation rates vary, with parts of GM up to 81% higher than the national average. When clinicians, on examining the lower limb, suspect acute limb ischemia, they will send people directly to those A & E departments which have rapid access to a vascular opinion. As the majority of amputations are preceded by ulcerations, which account for over half of hospital admissions for foot disease, any person with

wounds or ulcers to their foot will be offered an appointment with a community podiatrist within 24 hours whether during the week or at weekends. Other people with suspected peripheral arterial disease will have a specialist assessment within 28 days unless there is infection when this assessment should be done within 24 hours. A unified GM foot pathway will be developed.

The risk of developing a foot ulcer is significantly increased when a person has a callus. The main reason for people with diabetes developing a callus is peripheral neuropathy which predisposes to abnormal pressure on the foot. The skin reacts to this pressure by increasing keratinization and leading to a callus which increases the risk of ulcers. The potential reduction of ulcers if we treated calluses assertively is large but, as yet, there is a lack of robust evidence that this is effective. GM will support the recruitment of people with diabetes for suitable trials that will inform whether treating calluses assertively will reduce ulcers.

The inclusion of diabetes in the CHA_2DS_2-VASc score (used to decide which people with atrial fibrillation should be anti-coagulated) is a reflection of the increased risk of stroke faced by people with diabetes when they have atrial fibrillation. The most recent Health Technology Assessment, commissioned by National Institute for Health Research (NIHR), concludes that opportunistic screening, for the general population, is the most cost-effective approach using pulse palpation or modified blood pressure monitors. The undertaking of care processes is a suitable opportunistic encounter with people with diabetes to screen for atrial fibrillation. All people with diabetes over the age of 65 will be screened for atrial fibrillation when the care processes are being undertaken. As all people over 65 with diabetes will have a CH_2DS_2-VASc score of at least 2, they will be prescribed anticoagulation in accordance with NICE guidance.

6.3 Renal complications

About 40% of people with diabetes will develop diabetic nephropathy. This can be reduced by good glycaemic control, blood pressure control and, for those with a diagnosis of nephropathy or microalbuminuria, treatment with ACE-I or ARB drugs. These are measured by QOF but exceptions and a top threshold well below 100% gives insufficient incentive for optimal clinical practice. There will be discussions with primary care about removing exceptions and increasing the top thresholds in exchange for increased financial incentives.

About one in eight adults have masked hypertension. This is a risk factor that is often missed. People with diabetes who are normotensive when their blood pressure is measured by a clinician will have 24 hour ambulatory blood pressure monitoring or home self-monitoring every five years.

Diabetic and renal services should work together to manage people ‘at risk’ early with the aim of preventing progression to end stage renal disease. People with diabetes and declining renal function, who may be suitable for transplantation, will be referred sufficiently early so that they can be considered for pre-emptive renal transplantation.

6.4 Microvascular complications

Eye disease, erectile dysfunction and periodontal disease may be identified as part of the care processes. When they are detected, they will lead to appropriate management or referral.

6.5 Mental health

There are interventions to tackle complications that will improve the mental health of people with diabetes with GM, such as the integrated IAPT (Improved Access to Psychological Therapies) service. People with diabetes can also suffer with eating disorders with diabulimia being especially dangerous. People with eating disorders will often require referral to specialist mental health services.

6.6 Pregnancy

NICE have produced clear guidance on good preconceptual care for women with diabetes. Some of this guidance needs to be read in conjunction with other NICE guidance. For example, the guidance on preconceptual care that advocates the "*use of contraception until good blood glucose control*" has to be read in conjunction with NICE generic advice on contraception that states that "*women …* (should be) *… offered a choice of, all methods including long-acting reversible contraception (LARC)*" and that long-acting contraception is suitable for women with diabetes.

General Practices should identify all women with diabetes who may become pregnant as a part of the annual care planning and support them to develop a plan for either safe, effective contraception or for pregnancy preparation as part of routine care. Once a woman with diabetes has her pregnancy confirmed there should be early referral to a dedicated multi-disciplinary team (MDT) ante-natal clinic.

Key actions to prevent complications arising from diabetes:

Impact

- Introduce the inpatient care bundle.
- Hospitals have a policy of diabetes patient self-management.
- Ensure the numbers of nurses employed with specific diabetes knowledge or experience are in line with national guidelines.
- Ensure patients are able to access assessment for personalised health budgets where appropriate.

Cardiovascular complications

- Send people with suspected acute limb ischaemia directly to A&E departments with rapid access to vascular opinion.
- Offer people with wounds or ulcers a community podiatrist appointment within 24 hours.
- Offer people with suspected peripheral arterial disease a specialist podiatrist assessment within 24 hours (if wound present) or 28 days (if no wound

present).
- Support the recruitment of people with calluses for suitable trials to assess whether assertive treatment will reduce ulcers.
- Screen people with diabetes, who are not diagnosed with hypertension, for masked hypertension every five years.
- Include measures such as healthy lifestyle, control of blood pressure and the use of statins in personalised care plans.
- Screen people with diabetes over 65 for atrial fibrillation during the care processes.

Renal complications
- Hold discussions with primary care about removing exceptions and raising upper thresholds.
- Offer normotensive people 24hr blood ambulatory pressure monitoring or home self-monitoring every 5 years.
- Refer suitable people with diabetes with declining renal function for pre-emptive transplantation.

Pregnancy
- Ensure preconception care is integral to care planning.
- Offer women a choice of all contraceptive methods, including long-acting reversible contraception, until good blood glucose control is achieved.

7 Additional issues for consideration

7.1 High risk groups

Certain cohorts of people run a higher risk of diabetes progression and subsequent complications because they are not engaged as effectively as others. They include those with mental health problems, people from black and minority ethnic backgrounds, the lesbian, gay, bisexual or transgender community, people with sensory or physical impairments, people with learning difficulties and homeless people. Reasons for suboptimal engagement can vary within these groups from not understanding the seriousness of their condition to not having provision appropriate to their needs. The third sector will be especially important in the engagement of hard to reach groups.

Particular attention should be paid to the communities with South Asian and Afro-Caribbean origin and other high-risk groups as they have especially high prevalence of diabetes. Engaging with these communities and recruiting peer supporters from within these communities will be a priority.

The present QOF enables primary care to make exceptions and exclude people from the denominator when measuring the quality of care. One of the reasons for making exceptions is when patients do not respond to repeated invitations and these people can be some of the most vulnerable. Measurements of the quality of care provided by the National Diabetic Audit (NDA) does include people who are excepted from QOF. This data is available by practice and is a more useful measure of quality than QOF.

Over the lifetime of this strategy, we will work to make services more equitable and accessible. We will expand the information and education provided in multiple languages and formats in discussion with these communities. We will engage those at high risk of progression and complications using care calls, messaging and other methods such as health apps to check how they are managing their diabetes and to offer advice and support to reduce diabetes progression.

People with mental ill-health are at high-risk of diabetes especially people with psychosis. Efforts have begun to achieve parity of esteem so that people with poor mental health with diabetes are detected early and treated appropriately. The choice of anti-psychotic medication can increase the risk of diabetes. Further work will be done to consider diabetes when the choice of anti-psychotic is made and, if an anti-psychotic that increases the risk of diabetes is used, to minimise the dose if that is possible.

Diabetes is common in residential and nursing homes. We will work with these homes to help ensure good care of their residents eg there are clear policies on self-medication and on dealing with hypoglycaemic events.

Some people find it very difficult to control their diabetes. People with T1D diabetes that meet the guidelines will have access to insulin pumps as approved by NICE.

7.2 Unwarranted variations

Some variation in healthcare is unavoidable because of its complexity and the difficulties in controlling all the variables that contribute to it. Variation can sometimes be explained by the characteristics of the local population, individuals or by differences in the capability of healthcare professionals. Often differences occur when innovations are made but innovation is essential to drive up standards. . The important thing for us to understand is whether the variation is warranted.

The term 'unwarranted clinical variation' has been described as 'care that is not consistent with a patient's preference or related to [their] underlying illness.' This can relate to substandard care around access to services and outcomes. To limit unwarranted variation in diabetes care, we have to outline a set of minimum standards people should expect from our services.

In GM we plan to outline a set of minimum standards by:

- Developing a GM diabetes services specification covering all elements of care and;
- Supporting the service specification with agreed pathways and processes

The service specification will incorporate the NHS RightCare Diabetes pathway to facilitate a reduction in unwarranted variation. The RightCare programme can then be used to improve standards as is presently being done for blood pressure control and the management of atrial fibrillation.

The service specification will define the minimum components of quality diabetes care and should not limit local innovation. The pathways and processes aim to incorporate all necessary components of care and recommendations in this strategy, but not limit the local service models to deliver them. Combined these deliverables will support commissioners and local care organisations to review service provision and support the provision of quality diabetes care that is sustainable.

The service specification will include the agreed standards which can be audited. Clear presentation of data which shows how well services are meeting the standards and giving comparison between providers will act as a spur to improvements and help to reduce variations.

At the same time we should improve the way we evaluate diabetes health outcomes so we have a greater understanding pertaining to what is optimum, the reasons behind local variation, and what markers truly indicate a move in the right direction. Data recorded and collected should be consistent, up-to-date and enable commissioners to assist local services in need of support.

7.3 Continued learning for clinicians that support those with or at risk of diabetes

As well as educating people with or at risk of diabetes, we will ensure clinicians have the necessary competencies and skills to be able to offer effective support.

There is often an assumption that health care professionals already have these skills. However, in 2016 as part of stakeholder engagement, clinicians in GM highlighted the need to have more accessible and targeted healthcare professional training. One of the main reasons being clinical inertia; a concern highlighted in a number of diabetes studies. Clinical inertia often results in delays to treatment intensification where there is sub-optimal glucose control. This can accelerate the progression of diabetes and cause avoidable complications. Some clinicians do not feel confident or supported with complex cases and others believe the training they receive is often pitched at the wrong level and more appropriate training and mentorship would not only educate them, but help them achieve better clinical outcomes.

We will define the responsibilities of clinicians involved in diabetes care using agreed care pathways and a service specification. Those that lead the care will relay important health messages in a sensitive manner; have skills to tease out what is important to the individual; agree with the person the positive changes to be made; and signpost them to supportive tools that may help. To reduce clinical inertia, health care professionals will be offered training suitable to their needs and be supported by an infrastructure that features mentoring and partnership working with other specialists.

We will explore the potential for complementing traditional training with web-based and mobile educational programme. Such a programme for cancer (Gateway-C) has proved popular amongst primary care with over 70% of GP practices now having registered users. When appropriate, support will include involvement of community diabetes nurses working between primary and secondary care.

7.4 Improving research and innovation

Continued research and innovation is crucial to improve diabetes care especially when focussed on strengthening evidence based practice for the prevention of diabetes and its complications. Whether it is findings from clinical trials or identifying best practice locally, the information needs to be shared with peers to support continued improvement.

In GM we will continue to work with our clinical research network to improve information management when it comes to disseminating research and innovation locally. Audit data relating to clinically relevant diabetes outcomes such as CVD risk factors will be provided in a timely fashion in ways that will help improve clinical performance across the diabetes care pathway.

We will explore new ways of promoting and disseminating research and innovation not just to local academics and clinicians but commissioners, managers and people

with or at risk of diabetes. Such an approach will also aid further collaborative working and avoid repetition when it comes to service improvement.

7.5 Future planning

As new evidence emerges there will be a need to revise this strategy. Within the strategy it will be important that service redesign and implementation is a continuing process. It is vital that any future strategy development and implementation has the full involvement of service users.

Key actions to minimise the impact of additional diabetes risk factors:

High risk groups

- Maximise engagement with the third sector to ensure that every effort is made to access and support hard to reach groups of individuals.
- Expand the extent to which information and education is available in multiple languages and formats.
- Explore the options for engaging with those with diabetes in new ways (including electronically) and use these to provide new opportunities for self-managed care.
- Ensure diabetes is considered during the choice of anti-psychotic medication.

Unwarranted variation

- Introduce a GM diabetes service specification and comply with minimum standards and agreed pathways contained in it.

Continued learning

- Ensure clinicians have the necessary competencies to offer effective support on an ongoing basis.
- Define the responsibilities of clinicians in diabetes care.
- Offer new web-based learning opportunities for clinicians.

Research & innovation

- Provide diabetes audit data in a timely fashion and an accessible manner.
- Explore innovative approaches that have been delivered in other areas and replicate locally where applicable. This may be especially important in areas of high need.
- Explore new ways of disseminating research information throughout the GM diabetes care system.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Population Health Plan

2017-2021

summary

Greater Manchester

Health and Social Care Partnership

Greater Manchester's Population Health Plan

This is a summary of Greater Manchester Health and Social Care Partnership's new and ambitious plan to improve population health.

Contents

What is population health?

Nearly three million people live in Greater Manchester. Population health means making things better for all of them, throughout their lives. It means tackling what causes poor health and providing the right help at the right time to stop health problems developing. It focuses on key points in people's lives when there is an opportunity to make a big difference to their mental and physical health.

Population health uses what every community has to offer, like networks, skills and voluntary groups. We want people to be more in control of their own health and able to make the most of local opportunities to live better.

Our plan aims to make the top-level goals in Taking Charge of our Health and Social Care (our overall five-year strategy) – 'a reality for everyone'.

Our plan is about the population health of all 10 areas of Greater Manchester (Manchester, Stockport, Tameside and Glossop, Oldham, Rochdale, Bury, Trafford, Salford, Bolton, and Wigan) and will build on what's already going on in these communities.

We want to seize the opportunity devolution has given us to do things differently across the region – testing new ideas locally then applying them in a consistent and cost-effective way to the rest of Greater Manchester.

So our plan includes overall aims linked to existing and future work. Some of these are the result of national policy ideas to test new ways of providing preventative health care. Others expand on good practice that's already happening locally. Some of the work will have an immediate impact ('quick wins'), others will take time and lead to benefits in the future.

But what they all have in common is a strong evidence base – we know they can work. And they all involve different parts of Greater Manchester, and organisations of all shapes and sizes, pulling together for the benefit of us all.

This 'whole system' approach lies at the heart of population health. It means we won't do things in isolation. We'll break down the divides between different parts of our health and care services and work together to have the best and widest impact possible.

Population health in action: People power in Stockport

Stockport Together is about breaking down boundaries between organisations, working together, and encouraging communities to use their skills and knowledge to get involved in local health and care. People are helping to design services that meet local demand and creating support networks. Future plans focus on helping employers to offer healthier workplaces, diagnosing more health conditions without people having to go to hospital, building core health and care teams for each of the area's eight neighbourhoods, and more responsive community services so people spend as little time in hospital as possible.

Why is it important to Greater Manchester?

Our future success depends on the health of our population. But we lag behind other places and there are too many health inequalities within and between Greater Manchester communities that stop people getting the same opportunities to live well and healthily.

Poor health affects individuals and our economy. It costs the NHS and local authorities (and tax payers) more when people need urgent or long-term care for problems that could have been identified earlier, managed better, or prevented altogether.

We need to do things differently for lots of reasons. We want to adopt 'person and community-centred' approaches. The idea behind this is to get people in a specific area much more involved in their own health and care. We know this can have real benefits for individuals and their local area. This kind of approach reduces demand for hospital and other care services and contributes to better health and wider benefits for both children and adults. For instance, focusing on young children early in their lives means we can help them develop socially and emotionally so they're ready for school, improve their school attendance when they get there, and ultimately give them better chances of having a good job when they leave.

Facts and figures

Greater Manchester may be a great place to live and work for many, but people here die younger than in other parts of England, and we face a range of health challenges affecting everyone.

We have an ageing population. Too many older people end up in care homes because there aren't enough alternatives.

Tooth decay affects a third of five-year-olds in Greater Manchester.

Nearly one in five children is obese by the time they leave school.

Around one in three children does not reach a good level of development at age five years.

Among our adult population, 7.4% (more than 200,000 people) have a long-term health problem or disability that seriously limits their everyday life and this number is growing. These conditions account for half of all GP appointments and 70% of the time patients spend in hospital.

A big proportion of unemployment is linked to health and disability. Approximately 225,000 people in Greater Manchester claim out-of-work benefits, over half of these are due to a health condition.

However, less than a third of the problems people see their GP about actually require medical treatment. Most are related to wider issues, particularly in more deprived communities.

One in five people in Greater Manchester live in 10% of the country's most disadvantaged areas.

An estimated 200,000 low-income families rely on Working Tax Credit to keep out of poverty. We have one of the largest populations of asylum seekers and refugees. Homelessness is increasing, including rough sleeping.

Many people in Greater Manchester have unhealthy lifestyles:

- One in five adults smoke, including many under-20s and young mothers
- Almost a quarter regularly 'binge drink'
- Around a third do less than 30 minutes of physical activity a week
- Six out of 10 adults are overweight or obese

As well as harming individuals, these behaviours have a massive knock-on effect on families, communities, the wider economy and society as a whole.

- Smoking is estimated to cost £785 million on things like health and care treatment and lost productivity
- Harm resulting from alcohol, including crime and worklessness, costs approximately £1.2 billion. Hospital admissions for alcohol-related conditions in all 10 boroughs and cities of Greater Manchester are above the national average (which has doubled in the past decade and is continuing to rise)
- Having a higher than average inactive population costs local health services £26.7 million a year because long term conditions, like heart disease and diabetes, could be prevented by people becoming more active and making other lifestyle changes

What do we want to happen?

Devolution gives us an opportunity to improve health right across Greater Manchester, something we've never managed before. We can do things differently based on real evidence of what works and rethink our way of doing things so everyone benefits.

We want to take an 'asset-based' or 'strength-based' approach, by helping people and communities come together to achieve positive change using their own knowledge, skills and 'lived experience' of the issues they encounter in their own lives. This is completely different to the traditional starting point for planning health and care services. So we asked what helps or stops us taking charge of our own health and what are the solutions, and do something about that. We don't just focus on people's problems, but what they have to offer, including local knowledge to find solutions.

We want to allow everyone to have more of a say over their health and care. We aim to make the most of carers, volunteers and people willing to work with us to design, test and deliver services, and support efforts to change behaviours and attitudes that are started by local residents and communities themselves. We want every individual to be more self-reliant and have stronger, more proactive relationships with their local community and health and care professionals, through things like support groups and health coaching.

The intention is to make everything more joined up. Our aims have been agreed by the 37 organisations that make up Greater Manchester Health and Social Care Partnership. They link in to other Greater Manchester strategies, around transport and the environment for instance, which will also affect people's health.

Our priorities for the whole population support the local plans being developed by each of the 10 Greater Manchester areas. We can avoid duplicating efforts and instead add value by working hand in hand and using local knowledge and expertise to develop and test new ways of doing things.

We want to make the best possible use of different types of service in a more joined-up way, to make it easier for people to get health and care closer to home. There are things going on nationally that will help our population change for the better. The Healthy Living Framework, for instance, means neighbourhood services like pharmacies and opticians will give individual advice to their customers. Making Every Contact Count encourages health professionals to seize any opportunity to talk to people about improving their health.

Population health in action: Cancer champions

We've launched a campaign to sign up 20,000 volunteer 'cancer champions' so people who've been touched by the disease can share advice and support. This network is part of our pilot Health as a Social Movement programme, and will use digital communication opportunities to encourage mass citizen-led change.

What do people want?

Before we wrote our Population Health Plan, we asked 6,000 people from across Greater Manchester, and from all walks of life, what mattered when it came to health. This is what they told us:

- It's about the wider environment of how and where people live, things like transport, housing, education, crime and pollution.
- It's about connecting with other people who can offer support, motivation and role models, and stop harmful social isolation.
- It's about making mental health as important as physical health, especially giving people the confidence to make positive changes in their life.
- It's vital to consider (and value) the diversity of our population but at the same time tackle health inequalities.
- It's about everyone – including younger people and health professionals – being easily able to get the information they need, whether that's about services, lifestyle, local communities or anything else that affects health and wellbeing.

And nine out of 10 people told us they want a healthier lifestyle.

The plan reflects what local people say is important and focuses on what we believe can make most difference across our population during the three 'life course' stages – childhood (Start Well), adulthood (Live Well) and growing older (Age Well).

Starting well

Helping every child get the best possible start is not just good for them, it's good for everyone. People who have problematic childhoods achieve less educationally, earn less and are less healthy. So the cycle of health inequalities may be repeated, passed down to their own children.

Putting right harm done to young children's health and wellbeing (and the effect it has on them later in life) is harder – and costs more – than preventing it in the first place.

So our plan focuses on investing in 'Early Years' opportunities from before birth to the age of five to build firm foundations for life, including mental and physical health, social and communication skills and behaviour.

One of the main ambitions of our population health plan is to enable children – especially those from deprived and vulnerable groups – to reach a good level of development, physically, mentally, emotionally and socially.

We need to make sure we identify and tackle abuse, neglect, delayed development and special educational needs and/or disabilities as early as we can so a child gets the right support quickly.

Devolution makes it easier for Greater Manchester to join up all the services that can affect a child's start in life, including support for parents who face challenges like mental health problems, worklessness and poverty.

Our plan builds on the Greater Manchester Start Well Early Years strategy approved in summer 2016 and aims to make improvements in areas where Greater Manchester lags behind the rest of England.

We want to see:

- fewer babies with a low birth weight
- more breastfeeding
- fewer women and their partners smoking in pregnancy
- fewer overweight or obese young children
- reduce the number of decayed, missing and filled teeth
- fewer visits needed to A&E
- more children being vaccinated
- more children accessing good and outstanding early education
- improved parental mental health
- fewer children in care.

Our new approach is to more actively reach out to communities and start working with the families of young children as early as we can. When we identify a need for support, we'll do things quickly to stop the situation getting worse. Different organisations and professionals will work together to offer families the help that's right for them.

Our Early Years plan will track the development of young children and their families at eight key stages, from pregnancy to school.

The new way of working includes a range of locally available universal services available to all families and more specialist and targeted services linked to need. Whilst there is a Greater Manchester framework the response should be locally determined and be proportionate to need and the requirements of local residents.

Priority areas:

Parents who smoke

Smoking poses the biggest risk to the health of babies and young children. An organised, joint effort to reduce the number of women and their partners who smoke in pregnancy will save babies' lives and improve how children develop.

If parents quit before a baby is born, there's a higher chance they won't start smoking again and their children will grow up in a smoke-free home and that means they're less likely to start smoking themselves. Our plan is to identify pregnant women who smoke at their first antenatal visit, so they get the right support to give up as early as possible.

Poor oral health

Treating tooth decay in children costs Greater Manchester £19 million a year. Having bad teeth removed is the most common reason young children are admitted to hospital. Many go to A&E because of the pain. Tooth problems can cause discomfort and infection, and damage a child's confidence, so they may find it harder to sleep, talk, make friends, and go to school. This harms their ability to learn and develop.

There's a strong link between tooth decay and poverty, with poor diet increasing the risk of oral health problems. Oldham, Salford, Rochdale and Bolton are four of the country's 13 'priority areas' for child oral health.

Population health in action: Help for all parents

Health Visiting is a truly universal service available to all families regardless of perceived need. Investment in this service over recent years has seen a more than 50% increase in the Greater Manchester Health Visiting workforce. This means that more families than ever are receiving high quality, evidence-based assessments, support and guidance. The Start Well objectives seek to ensure that each child has a joined-up team working to support them.

Our plan is to raise awareness of the importance of oral health and help Early Years and dental services to work more closely together. This will be helped by better communication, training, data and information, along with evidence of what works so we do the right things to stop young children developing problems.

Key Start Well objectives

- Use information management technology (IMT) better to track children's development and take action when necessary
- Develop and carry out consistent activities across all parts of Greater Manchester to help pregnant women stop smoking
- Introduce oral health projects throughout the region like health visitors and school nurses giving out toothbrushes when they routinely check on under-fives
- Work with the review being led by directors of children's services in Greater Manchester to develop a clear 'early help' offer for all children aged 5-19

Living well

We want all adults in Greater Manchester to be healthier, more able to cope with difficulties they face and to feel more in control. We want to help people make the most of local opportunities created by economic growth and encourage them to change their lifestyles so we can stop the rise in long term conditions. We want to reduce health inequalities so every adult has the same chance of a healthy life.

To do this we must continue to move away from the complicated and fragmented ways we've done things in the past and work with all sorts of organisations to make a real difference to people's lives. For example, we're already joining forces with national bodies like Sport England and Greater Sport (Greater Manchester Sports Partnership) to tackle high levels of physical inactivity locally, and with charities to help those adults who need it most.

There is already plenty going on as part of other Greater Manchester strategies linked to what we've got planned, like improvements to sexual health services and alcohol awareness campaigns.

We want to do more to meet the health needs of especially vulnerable groups, like Traveller communities, homeless people, offenders, asylum seekers and refugees. Working together more closely and cutting across local boundaries will help us to do this.

The big issues in adult health

Getting into work and staying in work

There's strong evidence that people in work live longer, healthier lives. Being without a job can lead to people having poor physical and mental health, not living for so long and needing more medical help. This obviously affects not just the person who's unemployed but their partner and family. And it can have a long-lasting impact on young people's health and ability to do well in their career when they do get a job. Returning to work after illness or injury is important to overall health and

Population health in action: Care of offenders

As part of our plans to tackle physical and mental health issues at every point in the criminal justice process, the local NHS and Greater Manchester's police and crime commissioner have together developed a way to make sure people get quick mental health support in police custody. We're the first area in the country to do this.

wellbeing too, as is ensuring that workplace conditions support good health.

In Greater Manchester, we have more people out of work due to a long-term condition than the England average, and more people on temporary sick leave. Mental health and problems with muscles and bones (like back pain) are the main reasons people claim sickness benefits. With the lifting of retirement age, we need to ensure that as many people as possible can be supported to live longer working lives.

So we are making work a priority in our population health plan. Greater Manchester has run a successful programme which has helped many people on benefits who've got health issues to return to work. But we need to tackle this issue on a much bigger scale to have the effect we really want.

We need to think bigger and be systematic in joining up health and care with attempts to tackle other things that affect people's health, such as housing and skills, and with employment support from partners like Jobcentre Plus.

This means making the most of key times when people are in touch with services – when they get given 'fit notes' for example – to direct them to suitable help at the right time to stop health issues growing worse and get them back into work as quickly as possible.

Communities in difficulty

There are parts of Greater Manchester that face a number of big problems, such as unemployment and poverty, which make poor health more likely. Simply providing more health services doesn't always work – they have to be the right sort of services to tackle underlying issues. Looking at individual problems in isolation can mean support is broken into pieces. This may lead to those with chaotic lifestyles who need the most help struggling to find their way around services.

Instead we want to do things in a 'place-based' way. This would involve local organisations like health, the police, councils, housing and fire services, voluntary groups and others coming together to agree a clear plan with the person instead of sending them to lots of different types of support and services. Sharing information and taking time to understand what's behind the challenges someone faces and the strengths they have to offer makes it easier to tackle problems more positively and much earlier.

Population health in action: Getting fit for work

Most (86%) Manchester GP practices regularly refer people to the Manchester Fit for Work service. It acts quickly to support those in work, but off sick, to get prompt treatment for common problems like back pain and address other issues such as housing, social or debt problems which may be impacting on their ability to work. The service also advises on adjustments in the workplace and helps talk to the person's employer – anything that can stop work-related health problems getting worse. The national Fit for Work programme doesn't really meet local needs, so we want to build on the success of our own service. So far it is available in North, South and Central Manchester.

Population health in action: Focusing care on 'invisible' patients

The 'focused care' approach we've developed with the Shared Health Foundation charity - and so far introduced at eight GP practices in deprived areas of Greater Manchester - is aimed at 'invisible' patients who face a lot of problems, are late getting help for serious conditions , and turn up frequently but randomly at A&E. They need help to sort out the chaos in their lives that's harming their mental and physical health, but are often passed from pillar to post because they aren't eligible for other services. GPs can do little for them in a typical 10-minute appointment.

With focused care, the main responsibility for the patient still lies with their GP but other organisations and professionals get involved in discussions on how best to tackle issues like debt, homelessness or violence. The patient and their family get one-to-one, regular support from a special focused care worker to stick to the plans everyone has agreed.

At the heart of this are GP practices – often the first places people go for help. But GPs in the poorest communities are already under pressure dealing with the complex medical needs often found in these areas. They're in a good position to explore what's causing a patient's poor health but rarely have the time to do so.

Healthier behaviour

In spite of efforts to change behaviours nationally and locally, too many people in Greater Manchester have unhealthy lifestyles – smoking, drinking, poor diet and not enough physical activity. As well as causing immediate health problems, these can lead to long-term, serious conditions like diabetes, obesity, heart and lung disease and cancer.

And unhealthy behaviours like smoking and drinking are linked to health inequalities and poverty as well as being more common in deprived areas.

But we know most people want to change, particularly by being more active, eating healthily and tackling stress. And there's evidence that targeting certain groups (for example, people who do manual work) and ages (especially 40-60 year olds) presents key windows of opportunity to get adults more involved in their own health and prevent disease in later life.

We're building on best practice identified through national projects such as diabetes prevention that have already been adopted in Salford, Bury, Oldham and Rochdale. From April 2017, people right across Greater Manchester known to be at risk of developing type 2 diabetes will be invited to attend special courses about how to prevent it.

As with other parts of this population health plan, working together across different organisations and areas is really important. For instance, local authorities could make

Population health in action: Coaching to tackle behaviour

The Being Well Salford project, delivered by the Big Life Centres charity, offers one-to-one or group health coaching to anyone who wants to make two or more healthy lifestyle changes. This could mean eating better, cutting down on smoking or drinking, being more active or tackling low moods.

Population health in action: Encouraging lifestyle change

We're developing a 'communities in charge of alcohol' project that will create a network of 'health champions'. This will help get local people more actively involved in improving their lifestyles. And we also plan to motivate people in other ways, like an interactive directory and digital platform that offers rewards for doing things like attending health screening. This could be linked to wider social media and online content for health champions to use.

more public places smoke-free or join with enforcement agencies to clamp down on sales of alcohol and cigarettes to young people and the trade in illegal tobacco. We want to work with Greater Manchester universities and trade unions to encourage more responsible attitudes to alcohol among students and workers.

We aim to develop the role of other health professionals, like pharmacists and dentists, in helping people change their behaviour. For instance, it makes sense for dentists to talk to patients about stopping smoking and harmful drinking because this can reduce the risk of mouth cancer.

We think building on the skills that Greater Manchester residents and communities already have to offer is a real opportunity to tackle unhealthy lifestyles. We also want to put responsibility for change firmly in people's own hands.

Cancer prevention and early detection

Cancer is a massive and growing burden on our health and care services. Every 30 minutes, someone in Greater Manchester is told they have cancer. There were 89,200 GP referrals for suspected cancer to hospitals in 2014/15. This is stressful and unpleasant for the patients, whilst being unsustainable for our health services.

We must seize the opportunity to help people change the lifestyle behaviours, particularly smoking, that cause four in 10 cases of cancer. Early diagnosis improves survival rates, so we want more people to go for bowel, breast and cervical screening.

We need to support our efforts with research that will give us a better understanding of what stops our population changing their behaviour and what motivates them. One way we aim to use what this new local research tells us is to refine a major campaign to promote bowel screening that we plan to create and run in partnership with Public Health England and Cancer Research UK.

Population health in action: Leading the way on cancer

The Christie in Greater Manchester is one of three specialist cancer centres that form the National Cancer Vanguard. As part of this it is developing and testing new forms of cancer care in our area, including aftercare services for breast, genitourinary (like bladder and prostate) and bowel cancers. We have a new Greater Manchester Cancer Board to oversee related activity and transform services so we're more geared towards preventing cancer and diagnosing it as early as possible. This is a chance for us to build on the cancer vanguard's work and other new ideas, like the Macmillan Cancer Improvement Partnership led by Manchester's three CCGs, which is trying out lung health checks for people at high risk of lung disease.

Even if we can't always prevent cancer, we can do more to stop it coming back (secondary prevention) with better local support for cancer survivors. Our plans for this include physical activity programmes tailored to the individual, mobile applications and digital platforms providing self-management information, and social support networks.

Tackling HIV

Nearly three people in every 1,000 in Greater Manchester have HIV. That's a lot more than the national average. In Salford and Manchester, the levels are high enough for the British HIV Association to recommend routine testing for all medical admissions and when people first register with a GP.

Treatment for HIV these days is very effective. But HIV symptoms are often missed, so not only are people being diagnosed late – when treatment is more expensive – there could be many others who don't know they have it. This not only affects their health and increases the risk of dying early, it means there's more chance they'll pass on HIV.

Our aim is to get rid of HIV within a generation by adopting methods being used successfully in similar areas to Greater Manchester and strengthening what we do here. This means working together across public, private and voluntary organisations and learning from similar challenges, like early diagnosis of hepatitis B and C.

We also want to make the most of our local communities' existing strengths and expand good practice in individual areas.

Key Live Well objectives

- Develop effective work and health support and help local areas to use it
- Test the focused care method more widely across deprived Greater Manchester communities
- Develop and test new ways to encourage self-care and healthy lifestyle changes
- Create 'wellness support', including a web portal, telephone advice and easier access to local services.
- Test different methods of cancer prevention, including public information campaigns to encourage people to change their behaviour and get screened
- Get experts to carry out research, profiling and evaluate campaigns of our local population to make future cancer prevention activity as effective as possible
- Evaluate and build on efforts to diagnose HIV earlier, increasing the uptake of HIV testing opportunities and develop new ways to target high risk communities.

Ageing well

Our ambition is for Greater Manchester to be a good place to grow old. We want ageing to be viewed positively and for people in later life to stay well and healthy in their own homes for as long as possible.

There is plenty happening already. Greater Manchester has been chosen as a European Innovation Partnership on Active and Healthy Ageing reference site. This recognises how

Population health in action: Easier access to testing

Manchester-based LGBT Foundation is working with local health equalities charity BHA and public health and sexual health teams to provide HIV testing in the community, including local venues like churches.

much we've done already to work together across Greater Manchester to help older people stay active and healthy. The national Centre for Ageing Better is helping fund the work of the Greater Manchester Ageing Hub, which brings together different organisations' skills and knowledge about old age. Salford Royal NHS Foundation Trust and the Haelo innovation centre are together focusing on improving the experiences of local people with dementia and their carers. The Greater Manchester Centre for Voluntary Organisation is leading a project to test community based solutions to reducing social isolation and creating age-friendly neighbourhoods.

Our population health plan is particularly focused on changeable issues associated with getting older that we know health, social care and housing services can do something about. But our work also recognises how problems like poverty and inequality build up over a lifetime and can mean some people face the physical and emotional health issues connected with ageing earlier than others.

The big issues in older people's health

Housing

Providing the right kind of homes - and more of them - is a priority for Greater Manchester for many reasons, including the need to accommodate our ageing population.

Poor housing has a massive impact on people's health at any age, but those who are older, disabled or have a long-term condition are generally affected most.

Living in cold, damp or otherwise inadequate accommodation can contribute to a wide range of problems, including heart disease, stroke, bad circulation, breathing difficulties, flu, hypothermia, falls and injuries, poor mental health, rheumatism and cancer.

A better home environment has many benefits. People are less likely to need help from health and social care services and, if they do have to be admitted to hospital, a suitably adapted, safe, warm and dry home means they can leave hospital and are likely to recover more quickly.

But often people aren't able to choose where they live. And as they get older especially, they may not be aware of the different types of housing (often combined with care) available or the help on offer that will make it easier to live independently.

Half of our local areas already offer handperson services to do small jobs as well as carrying out bigger repairs and adapting properties so they're suitable for disabled and older people. Good examples include Manchester Care and Repair, Bolton Care and Repair and St Vincent's Homecare and Repair.

We want to take this further and develop a form of home improvement agency (HIA) to test in parts of Greater Manchester Having one type of HIA would make it easier for health and care professionals to know where to refer people who need help with their housing.

The HIA could be linked to other kinds of support, like advice on benefits and housing options, assistive technology (such as emergency alarms), falls prevention, the Greater Manchester Low Carbon Hub's energy efficiency initiatives and the fire service's Safe and Well checks. And it may help us target people most in need - for instance, those with health conditions made worse by poor accommodation.

Population health in action: Salford's simple solution

A mixed team of professionals in Salford – including dieticians and Age UK – has come up with an easy way to spot when older people aren't eating properly. The PaperWeight Armband measures the person's upper arm and flags up possible weight and muscle loss problems. The armband isn't at all intrusive or uncomfortable, and has proved to be a good way to start a conversation about food and nutrition and what advice, information and support they might find helpful.

The team has also developed e-learning and other materials on how to use the PaperWeight Armband. It's already being adopted in other parts of the country and we aim to make it available across Greater Manchester with the help of our colleagues in Salford. This is a great opportunity to apply the same simple method across healthcare, social care and voluntary services, delivered as part of routine contact with older people. It may also be promoted at community events or other occasions that target older people, like flu clinics.

Nutrition and hydration

Malnutrition and dehydration pose a major risk to older people's health. Not eating or drinking properly can make it harder for someone to move around, make them unsteady on their feet, affect healing and recovery, and have an impact on mental alertness and energy levels.

But both malnutrition and dehydration often go unnoticed, and aren't diagnosed and treated until they've become serious conditions. Older people who live in their own homes are particularly at risk.

And those who need support at mealtimes or have to follow a special diet, whether they live in residential care or in the community (with home care help), are also vulnerable.

We're making it a priority in our population health plan because although it's a recognised issue in parts of health and social care (like hospital admissions and residential care homes) and there are pockets of work locally focusing on food and nutrition, we want to raise awareness of it more consistently across Greater Manchester. This is an opportunity for working more closely together that we shouldn't miss, especially because of the positive impact better nutrition and hydration can have both on individuals and the health and care system.

We also want to help older people themselves be much more aware of malnutrition and dehydration, as well as their families, carers and the health and care professionals they come into contact with. This includes promoting a better understanding of groups most at risk, like people living on their own, those who are recently bereaved, or who have memory or reasoning difficulties.

Falls and fractures

Preventing falls in older people is one of our priorities because of the massive impact falls can have – not just serious injury (including 'fragility fractures' of the pelvis, wrist, upper arm or hip that indicate osteoporosis or 'brittle bones') but loss of confidence, anxiety, increased isolation and reduced independence.

Falls trigger over 40% of admissions into nursing and residential care. Hip fractures caused by falls are the commonest reason older people need emergency surgery and a quarter of these injuries require long-term care. So they are traumatic for the individual and also put a lot of pressure on health and social care services and budgets.

Falls prevention is already a priority for every Greater Manchester local area. It's an issue we need to tackle together, including working

with care homes, physical activity providers, hospitals and other services that provide care for urgent health problems. We'll also work with experts like the National Osteoporosis Society on what's most effective.

Because of their far-reaching impact, we need to look at preventing falls in the same way we try to prevent other long-term conditions. We want to stop them happening as often and reduce the severity of injuries when they do.

The right sort of physical activity can help older people build strength and balance so they're less likely to fall – some recognised therapeutic exercise programmes can halve the risk. But it can be a challenge to get people to carry on with these exercises once they've recovered from a fall or injury. We want to train instructors – who could come from therapy or exercise backgrounds – and work with local areas to offer more activity classes designed to prevent falls.

Having one fragility fracture doubles the risk of breaking another bone, often within a year. So we need to focus on diagnosing and treating underlying osteoporosis, which weakens the bones, and addressing the possibility of further falls.

There are already fracture liaison services in hospitals, but we want to see more of them closer to home, like the extended community fracture liaison service (FLS) in Wigan. They usually involve a specialist nurse who acts as co-ordinator and a doctor who's an expert in bone disease.

They look across GP practices , community care and hospital care (like outpatient clinics and emergency departments) to identify older patients who've had a fragility fracture and/or been diagnosed with osteoporosis. Then the FLS offers each patient whatever support is most suitable for them, including assessment, treatment (like medication), telephone advice, and referral to the local falls prevention service. Staying in touch with a patient's GP and keeping a database record of people who use the service makes it easier to monitor their progress long term.

Key Ageing Well objectives

- Learn lessons from local home improvement agencies to develop and test out a comprehensive GM model for health improvement agency (HIA)
- Build on Salford's work to develop, test and roll out a way to tackle malnutrition and dehydration
- Use the findings from Wigan's fracture liaison service (FLS) and national guidelines to develop a type of Greater Manchester FLS to try out in local areas.

How will we do all this?

We want to develop a clear way of improving population health across Greater Manchester that makes the most of our workforce and their specialist skills, and can stand the test of time. Everyone needs to come together and make a contribution. Devolution is already enabling us to share our knowledge and skills throughout Greater Manchester - and we can build on that.

We're ready to remove barriers and change the traditional methods and culture of health and care so that we understand what people have to offer and learn from carers, patients, families and volunteers. They are all valuable and we need to use them more.

For our plan to work we have to rethink the role of population health and change things to make it happen. We aim to create new leadership, governance and delivery arrangements so it's clear who is responsible for what when it comes to achieving our population health goal.

The cost of population health change

We want to move away from previous ways of doing things that have focused on individual organisations and separate areas of spending. Devolution means we can use pooled budgets for activities both in local areas and across Greater Manchester. Working in a joined-up way and providing standardised core services is much more economical.

Our plan identifies how we'll draw on the expertise of New Economy Manchester, which works to deliver policy, strategy and research and help the whole of Greater Manchester grow stronger, particularly with things like evaluation and developing an evidence base.

This mean we will carry out 'cost benefit analysis' of each new iniative to ensure it is financially worthwhile and sustainable. Wherever we can, we'll make the most of the various local and national pots of funding available, such as the Work and Health Innovation Fund, Life Chances Fund, Social Impact Bonds, Better Care Fund and Greater Manchester Health and Social Care Transformation Fund. At the same time we'll try to 'future proof' what we do so that it won't be affected by funding cuts or changes at a later date.

Sharing and using learning

Fundamental to our population health plan is understanding what will make most difference to people's lives. So we'll test and evaluate every new approach, develop a solid business case setting out why we should expand individual activities and learn lessons from what's been done before and what's happening in different local areas. We need to share information and intelligence between different organisations so that everyone can work together closely and effectively.

We want to ensure that the population health activities we decide on for Greater Manchester are agreed by all the organisations involved to give them the best chance of working well in the long term.

Consistent but flexible services

Our plans for change include a more straightforward, more joined up way to design and buy ('commission') things that will improve population health, thinking about how these all come together to affect individuals and families at neighbourhood level.

Population health in action: Realising people's value

The aim of the national Realising the Value project is for health and care to help people get the knowledge, skills and confidence to be more active in managing their own health. In Salford, social enterprise Unlimited Potential and 'community anchor' charity Inspiring Communities Together have developed activities like Salford Dadz, where fathers in areas with a lot of challenges can find positive role models, share problems and improve their children's wellbeing and their own.

We're developing a commissioning plan and consistent specifications so that we buy the best and most appropriate services, which may be provided by specialist voluntary, community and social enterprise groups. We need them to be flexible enough to meet local needs, but we must also commission services efficiently, like Greater Manchester-wide screening and immunisation programmes (especially where there are limited numbers of staff available to provide these).

Adding value

We're looking at how best to spend public money on things that offer more 'social value' and benefit everyone. In the long term, this could mean people rely less on public services. We want to build the idea of 'social value' into our health and social care culture and policies, including through training and service design.

And as a major employer – responsible for 18% of jobs in Greater Manchester – health and care needs to be a positive role model for workplace health, helping our own staff to stay healthy and act as 'health champions' in their local communities.

Involving people

We intend the voluntary, community and social enterprise (VCSE) sector to play a central role in leading and delivering radical population health solutions, especially by helping to mobilise communities and networks that support people on their own terms.

Making the most of the huge resource offered by local people and the neighbourhoods they live in is at the heart of the 'person and community-centred' way of thinking essential to our population health plan. It's all about people doing more to support each other and their wider community. These methods may range from 'peer support' for those with long-term conditions to everyday community activities like gardening clubs and local sports teams.

We want to offer different ways for people to get more involved, based on individual needs and wishes. Some might work in partnership with their carers and health and social care professionals to draw up a tailored plan of what will help them most. Others may have personal budgets, giving them control over money allocated to their health and care, or 'social prescriptions' to use services and groups outside formal health and care. People from local communities may act as 'health trainers' and 'community navigators' to help others find services that are right for them.

What happens next?

This is only a summary – the full population health plan outlines our specific goals and details of how we intend to achieve them.

Our immediate priority is to establish a core team to drive changes set out in the population health plan. A programme will be created to organise, direct and ensure delivery of the work.

We are already delivering several key projects to help improve the health of the people of Greater Manchester. In particular, we are doing a lot of work around supporting communities to prevent cancer and improving health for children in their early years. From April 2017, we will also be seeking funding in order to roll out programmes to help older people eat more healthily and drink more water, improve dental health for our children, reduce smoking in pregnancy and finally roll out at scale the 'Focused Care' model across other deprived parts of GM which will help us to find those patients most in need and then help them access appropriate care via their Primary Care and Community teams.

However, there are lots of other issues identified in the plan we need to focus on, so we are developing and refining plans to tackle them. We will then agree how these plans will be funded and roll them out towards the end of the year and beyond.

The plan includes some longer-term goals too, such as strengthening the relationship between arts activities and health and care.

The next version of our population health plan is likely to particularly focus on everyone having the right home environment, because we know what a big difference housing makes to health and wellbeing.

The second part of the new population health planning process will also pay more attention to children and young people and helping them develop well. We know that three-quarters of adult mental health problems begin before someone is 18 and that only a quarter of young people get the right mental health support.

To begin with we'll be looking at the 5-19 age group, especially working with the education system to identify pupils who are struggling. Schools, colleges and universities have told us what they want to see in their local areas, including work with community organisations to offer a strong support network for children and young people and more focus on helping whole families to develop the strength to tackle issues. We plan to then set priorities to improve the lives of 19-25 year olds.

As well as helping people into work, we'll be exploring how to support local employers so that they protect the health of their staff and enable them to develop skills and progress in their career, which has been proved to aid long-term good health.


Rochdale
Bolton
Bury
Oldham
Wigan
Salford
Tameside and Glossop
Manchester
Trafford
Stockport

Standard 4 – Ensure a Pro-active Approach to Health Improvement and early Detection a) Winning Hearts and Minds – 'Healthy Hearts'	
Aims	• To improving the health of the local population • Reduce the rate of premature Cardiovascular Disease (CVD) mortality across Manchester to 50 per 100,000 by 2027 • Reduce the health inequalities associated with poor cardiovascular and mental health outcomes
Delivery	**1.WHM Engagement: develop collaborative approach to delivery of WHM with partners at neighbourhood level focussed on (but not limited to) 3 WHM challenges (see appendices)** a) The aim is for neighbourhoods to understand their local challenges and opportunities, particularly in relation to "the 3 challenges" (see appendices), and agree how to start addressing this from 2019/20. Through Neighbourhood/Locality meetings, practices are expected to engage with the WHM programme to co-produce approach to deliver "Healthy Hearts" outcomes. This will cover practice engagement to setting priorities, identifying clinical leads, development and delivery of education needs to support programme, development/agreement of clinical guidelines, development of communications approach, identifying and agreeing resources required to deliver outcomes, reviewing and peer reviewing baseline, development of project plans and monitoring requirement. For the statin challenge this should include considering any groups of patients that could safely be offered statins at scale (e.g. for statin switch) **2.Hypertension** a) Case finding: Practices to identify patients who are at risk of having hypertension but not yet diagnosed, so they can be offered investigations (3 or more readings >140/90 and where the last reading is still above >140/90). b) Optimisation: Practices to identify patients with last BP over 150, on one medication only and don't have a SBP below 130 in last 12 months to be reviewed and considered for second medication. (search will exclude palliative patients, on medication in last 6 weeks, nursing homes, home SBP <135, AMBP <135, Hypotension, CKD 3-5, Diabetic, white coat hypertension, max doses of medication, BP procedure refused, patients over 80, normal blood pressure code) **3.Lipids/statins** a) Case finding: Using an agreed search tool e.g. QRISK, search the whole population to identify patients who are above 20% risk of a CVD event, who are aged between 40-74 and who have not had CHD, Stroke or TIA. b) Optimisation: Two cohorts will be identified with two different solutions: i. Patients currently taking simvastatin with a cholesterol of >4 (to be offered statin switch to atorvastatin). ii. Patients with a QRISK score of over 20% to be reviewed and offered a statin medication. Practices to take a risk stratification approach to ensure patients most at risks are

	reviewed for a statin first. **4. Atrial Fibrillation** a) Practices to identify known AF patients not receiving treatment and carry out a clinical assessment for appropriateness of anticoagulation. This assessment should then be read coded in patient notes. Patient not suitable for treatment or declines treatment should be read coded with valid reasons. **5.Health Checks** a) Identification of priority groups for health check including o People aged between 40-74 identified **above 20%** risk of CVD event using QRISK2 as a search tool of practice list o Adults with severe mental illness (on SMI register – see standard 2) o People, communities or venues/locations that identified by Neighbourhoods (supported by Health Development Coordinators and Community Health Check Team)[1] b) Practices/Neighbourhoods to systematically invite eligible patients to receive a Health Check either delivered in the community or within the practice prioritising the groups above/most likely to be at risk c) Practices to ensure that people identified as high risk or diagnosed with a condition following a health check are offered appropriate treatment and support Health checks can be delivered via both the GP practices and the community outreach model. The Health Check will be modified appropriately depending on the characteristics of the patient in line with national guidance d) GP practices need to search on EMIS to find eligible patients and invite patients to attend, or health checks can be delivered with an opportunistic approach. If the community outreach team has arranged a health check delivery session in their local area, GPs will receive a request to invite a certain number of patients and as part of this standard. Northenden Medical Practice presently delivers the community health check sessions, and the results are sent to the patients GP so that the practice can enter the results in to the patients EMIS record. A proposal is being considered to use the Health Diagnostics System to carry out the searches and transfer results to the GP practice systems and minimise work for practices.
Reporting	● Activity will be collected through automated reporting templates. ● For NHS Health Check delivery: o If a practice holds a contract with Manchester City Council (MCC) to deliver health checks they should submit claims for all activity they do to MCC through the usual route o If a practice **does not** hold a contract with MCC to deliver health checks they should claim for activity through MHCC as part of the primary care standards scheme

[1] In practice this would mean sending invitations out to eligible people when community health check team are going to be in the area that covers the practice's registered population at a time that has been mutually agreed, and community engagement activity has taken place.

Baseline / Target

By 31st March 2020:

	Baseline (2017-18)	Target
Atrial Fibrillation (AF)	Approx. 1600 patients with diagnosed AF not treated, this is approximately 26% of the AF register.	• To clinically assess 95% of patients with a coded diagnosis of AF, not receiving anticoagulation, and assess if they are clinically appropriate for anticoagulation. Patients to be appropriately coded if not coagulated. • 65% to be on an agreed OAC
Hypertension	58.5% of patients in Manchester below the age of 80 meeting 140/90 treatment target. Approx. 42% (22,392) of patients not controlled within 140/80	• Improvement in the proportion of adults on treatment controlling their blood pressure to 140/90mmHg or below
Statins	Approximately 14,000 patients at High Risk (above 20%) not prescribed a Statin in the last 12 months This is out of 32,000 patients with Q risk over 20% in Manchester	• New and existing patients identified at High Risk of CVD event to be managed with an agreed Statin or clear documentation that a discussion has taken place
Health Checks	Eligible population 111,000 The projected figure for the number of health checks **offered** is **8300** The projected figure for the number of health checks **received** is **4600** In terms of the percentage of the eligible population this equates to: • offered 7% • received 4% SMI health check baseline TBD	• Increase in the number of health checks to 20% offered and 10% received each year. 2018/19 (9 months) Offer 16,500 Deliver 8,000 2019/20 (indicative) Offer 22,000 Deliver 11,000

Standard 4 – Ensure a Pro-active Approach to Health Improvement and early Detection b) Winning Hearts and Minds - "Healthy Minds"	
Aims	• To improve the physical health of people with Severe Mental Health Illness (SMI) • Reduce variation in quality of care, delivery and outcomes across Manchester
Delivery	**Winning Hearts and Minds (WHM) Engagement** ● Through Neighbourhood/Locality meetings engage with the WHM programme to co-produce approach to deliver 'Healthy Minds' Outcomes. This will cover practice engagement to setting priorities, identifying clinical leads, development and delivery of education needs to support programme, development of clinical guidelines, development of communications approach, identifying and agreeing resources required to deliver outcomes, reviewing and peer reviewing baseline, development of project plans and monitoring requirements **Physical Health Assessments ("Health Checks")** ● Primary care teams are responsible for ensuring that people with a SMI receive an annual physical health assessments (to include: BMI, blood pressure and pulse, blood lipid including cholesterol, HbA1c, assessment of nutrition, diet & physical activity, alcohol consumption, smoking status and drug use and appropriate follow-up care. This applies to: ○ patients with SMI who are not in contact with secondary mental health services, including both those whose care has always been solely in primary care, and those who have been discharged from secondary care back to primary care ○ patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised. ○ Patients with schizophrenia, bipolar affective disorder & non organic psychosis • Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for: ○ patients with SMI under care of mental health team for less than 12 months and / or whose condition has not yet stabilised ○ inpatients **Proactive care and support** ● Each GP practice to nominate a lead for mental health (can be practice nurse, nurse practitioner or GP) who will ○ Meet with MH provider (GMMH) quarterly though for larger practices (practices with a list size over 10,000) this should happen more frequently e.g. monthly /every 6 weeks ○ Cross check the people known to GMMH to ensure they are on the SMI QOF register ● To undertake a full annual physical health check as per the standard outlined in the 5 year forward view, following the initial health check completed in MH secondary care. (see Standard 4a) and ensure that patients are supported to engage with national screening programmes

<table>
<tr><td></td><td>

Ensure that the initial full annual physical health check (undertaken in MH secondary care and those undertaken by PC) results in appropriate follow up in primary care, including to referral appropriate services for physical health care and broader lifestyle and social support for wellbeing as appropriate
Ensure people are added to the relevant LTC QOF register as appropriate
Inform the GMMH link professional if people on the SMI register do not attend appointments and are not engaged with their GP or practice and physical health care
Determine a system, with the MH link worker, which promotes medication concordance and engagement

</td></tr>
<tr><td>Reporting</td><td>

Activity will be collected through automated reporting templates.
Nominate a lead for mental health and inform MHCC upon sign up to the scheme

</td></tr>
<tr><td>Baseline / Target</td><td>
Target – by 31st March 2019

Practice has an identified lead for mental health
SMI Register has been cross-checked and amended as appropriate
Regular review meetings with mental health link worker from GMMH are in place and focus agreed

<table>
<tr><th>For 2018-19</th><th>For 2019-2020</th></tr>
<tr><td>● 45% of all patients on the Practice SMI register who have a diagnosis of schizophrenia, affective bi-polar disorder and non-organic psychosis have had an annual health review in primary care and recommendations are clearly recorded and followed-up as appropriate</td><td>● 55% of all patients on the Practice SMI register who have a diagnosis of schizophrenia, affective bi-polar disorder and non-organic psychosis have had an annual health review in primary care and recommendations are clearly recorded and followed-up as appropriate (subject to changes in National target)</td></tr>
</table>
</td></tr>
</table>

Standard 6 - Improving Outcomes for People with Long Term Condition(s) a) Diabetes	
Aims	• To reduce the predicted growth in prevalence of diabetes over the next 5 years. • To ensure that all diabetic patients in Manchester receive their annual review in line with National Diabetes Audit and NICE Guidance/Principles. • To improve engagement and empower patients through education to help them self-manage their diabetes.
Delivery	Practices will be expected to: **1.Treatment of Diabetes** • Ensure patients are aware of the Essential Checks and services they should receive annually. • Ensure all 8 review processes are carried out and consistently coded as including foot and eye checks and those patients that do not engage as appropriate (as appropriate). • Ensure an annual foot check is incorporated into the annual review for all patients and that patients with increased risk are referred to/are attending podiatry services according to local guidelines. Provide written information to all patients where required. • Train new staff in foot checks, where appropriate, as they are recruited. • Ensure patients are given the opportunity to participate in care-planning. **2.Identification of Non-Diabetic Hyperglycaemic (NDH) patients** • Continue second round of National Diabetes Prevention Programme. Identify patients as NDH who did not attended the Healthier You programme in the first year. [2] • Practices to work in cluster groups with neighbouring practices to mobilise together working with CCG support teams and Provider. • Cleanse data where appropriate; send invite letters out with an SMS reminder. • Practices to code data received from Healthier You Provider to indicate patient's attendance to programme. • Conduct yearly review of patients of NDH register in concordance with NICE guidelines **3.Participation in local and national programmes** Practices will be required as a minimum to participate in the National Diabetes Audit. **4.Identification of patients with Diabetes or NDH** • Patients with a blood test result indicating NDH will be coded correctly and receive yearly follow up – to include HbA1c blood test. This will include searches for patients with existing HbA1c scores indicating NDH and identifying and reviewing patients at high risk. • NDH registers will be developed and maintained • Eligible patients will be invited to the National Diabetes Prevention Programme

[2] https://www.england.nhs.uk/diabetes/diabetes-prevention/

<table>
<tr><td></td><td></td></tr>
<tr><td>Reporting</td><td>

Quarterly data collection at practice level
Data Quality Team (for National Diabetes Prevention Programme)

</td></tr>
<tr><td>Baseline / Target</td><td>
Baseline: Diabetes 8 Process of Care
<table>
<tr><th>Area</th><th>Apr -17</th><th>Jul -17</th><th>Aug -17</th><th>Sep -17</th><th>Oct -17</th><th>Nov -17</th><th>Dec -17</th><th>Jan -18</th><th>Feb -18</th><th>Mar-18</th><th>Apr -18</th></tr>
<tr><td>Central (%)</td><td>50.6</td><td>47.5</td><td>48.4</td><td>47.4</td><td>47.3</td><td>47.6</td><td>48.5</td><td>48.8</td><td>47.9</td><td>49.7</td><td>51.7</td></tr>
<tr><td>North (%)</td><td>46.2</td><td>43.4</td><td>44.0</td><td>43.3</td><td>42.2</td><td>42.5</td><td>42.5</td><td>42.1</td><td>40.0</td><td>41.8</td><td>44.0</td></tr>
<tr><td>South (%)</td><td>36.6</td><td>32.4</td><td>32.7</td><td>32.7</td><td>33.9</td><td>35.0</td><td>36.6</td><td>37.6</td><td>36.8</td><td>39.0</td><td>40.7</td></tr>
<tr><td>City Wide (%)</td><td>45.2</td><td>41.9</td><td>42.5</td><td>41.9</td><td>41.8</td><td>42.3</td><td>43.0</td><td>43.3</td><td>42.0</td><td>43.8</td><td>45.9</td></tr>
</table>
Target for 2018-2020:

To be determined once latest baseline is determined
Practices to demonstrate an increase year on year

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Standard 6 - Improving Outcomes for People with Long Term Condition(s) b) Management of Diabetes in Preconception Period	
Aims	• To reduce the rate of diabetes (Type 1 and Type 2) related complications of pregnancy in women of child bearing age (16-45) • To ensure that all women with diabetes of child bearing age in Manchester receive brief awareness, advice and guidance on complications in regards to diabetes related pregnancies. • To offer women with diabetes looking to conceive proactive preconception planning care in line with NICE guidance (NG3) • General practices complete education modules to support management of care
Delivery	Practices will be expected to: **Health Care Professional Training** Minimum - The expectation is that: • 1 GP and 1 Practice nurse per practice to undertake CPD accredited Diabetes e-learning module http://www.cpd.diabetesonthenet.com/index.php?area=modules&page=lesson&courseId=86&lessonId=103&type=html5 • Copy of certificate or evidence of completion of course to be emailed to the primary care email box (address above) by 31st December 2018 • Guidelines and requirements of the standard to be shared with all practice staff at team meeting by 30th September 2018. (Date of discussion to be documented). • Report detailing Neighbourhood discussion to be completed and returned by 31st December 2018 Select module: **Preconception Planning and Care** • Develop register with women at child bearing age (16-45) with diabetes to offer advice • Import EMIS Diabetes UK Prescription information on to EMIS (Appendix 10) • Using Information prescription alerts discuss and offer preconception information prescription to cohort patients in annual reviews and opportunistically. Highlighting risk and necessary lifestyle advice. • Code as advice given. • For women trying to conceive in the next year follow pre conception management guidance (Appendix 11). Women who are taking contra-indicator medication and trying to conceive should be offered contraception until seen by the Community Diabetes team for medication review. • After birth – Refer women with pre-existing diabetes back to their routine diabetes care arrangements. Remind women with diabetes of the importance of contraception and the need for preconception care when planning future pregnancies. • Ensure diabetes 8 care processes are achieved, and the patients have been referred to diabetes structured education. **Dissemination of advice** • 100% of practices to be implementing the DUK information prescriptions by 31st December 2018 • Minimum of 50% of eligible patients to have received advice using DUK

	information prescriptions by 31st December 2019
Reporting	• All practices to have undertaken the e-learning module and sent evidence by the end of 30th September 2018 to mhcc.primarycare@nhs.net • All practices to have searched for women with diabetes of child bearing age and created a register by 30th September 2018 • All practices to have activated the information prescriptions (Appendix 12) and actively offering patients advice. • Neighbourhoods to consider how to engage with women with diabetes of child bearing age who do not engage with the practice (not attend annual reviews in the last 15 months).
Baseline / Target	• 100% of practices to have shared and discussed guidelines and expectations of the standard with all clinical practice staff by 30th September 2018. • 100% of practices to have discussed scheme at Neighbourhood meetings to identify how to best engage with women with diabetes of a child bearing age who do not attend annual reviews in Primary care. Practices to identify and engage with local organisations that may be able to support the communications. e.g. Local pharmacists, VCS groups, GUM clinicians by 31st December 2018 • 100% of practices to have completed the e-module training by the end of 30th December 2018 • 100% of practices to have created a register of women with diabetes of child bearing age and to be offering advice by issuing DUK information prescriptions by 31st December 2018 • 100% practices to have offered advice to a minimum of 50% of eligible patients by 31st Dec 2019.

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 8 January 2019

Subject: Primary Medical Care in Manchester

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

Summary

This report will focus on how quality in Primary Medical Care in Manchester is assessed and improved; this will include:

- Manchester's Quality Assurance and Improvement Framework;
- Care Quality Commission (CQC) ratings and improvement plans; and
- Primary Care Standards.

The report also updates the Committee on Primary Care access; including:

- Access to core Primary Care in hours;
- Enhanced 7 Day GP Access service; and
- New models of digital access.

Recommendations

The Health Scrutiny Committee is asked to note:

- The content of this report;
- The improvements made in CQC inspection ratings across Manchester;
- The development of an Early Warning System to proactively identify practices in need of support;
- The implementation of all 9 Primary Care Standards across Manchester to improve quality and provide a consistent population offer; and
- The work underway to proactively improve access to GP services.

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. Investment into the Primary Care Standards support GP Practice infrastructure through the employment of additional staff
A highly skilled city: world class and home grown talent sustaining the city's economic success	Patient education is a theme throughout the Primary Care Standards work programme. This will empower patients to manage their disease effectively. The Primary Care Standards is supported by an Education Programme to upskill staff through a range of different mechanisms
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	Provision of high quality Primary Medical Care for the local population. Developing and delivering consistent, high quality, safe and effective Primary Medical Care for the local population. Provision of a range of improved opportunities to access Primary Medical Care
A connected city: world class infrastructure and connectivity to drive growth	Learning from the Greater Manchester health and Social Care Partnership and other CCGs including those in Greater Manchester

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Background documents (available for public inspection): None

1.0 Introduction

This report will focus on how quality in Primary Medical Care in Manchester is continuously improved and assured; this will include:

- Manchester's Quality Assurance and Improvement Framework;
- Care Quality Commission (CQC) ratings and improvement plans; and
- Primary Care Standards.

The report also updates the Committee on Primary care access; including:

- Access to core Primary Care in hours;
- Enhanced 7 day GP access service; and
- New models of digital access.

2.0 Background

2.1 Primary Care in Manchester

Manchester Health and Care Commissioning (MHCC), has delegated responsibility for commissioning Primary Care services from NHS England (Greater Manchester Health and Social Care Partnership, GMH&SCP). This includes most aspects of quality and safety, excluding complaints and individual GP performance issues which remain with NHS England.

Currently there are 89 GP Practices in Manchester, of which 35 are in North Manchester (the area previously covered by the previous North Manchester CCG), 30 in Central, and 24 in South. There is significant variation in the size of practices, with numbers of registered patients ranging from 1,501 to 24,150 as of 1 December 2018.

Members will be aware that Manchester is experiencing significant population growth which has major impacts for health care; including General Practice. The City's registered population has grown by 100,000 in the last decade, with a further 90,000 projected population growth in the next 10 years. General Practice will be particularly impacted by the projected population growths in and around the City Centre.

In addition, whilst there are 540,000 people living in Manchester, the number of people registered with the City's GP Practices is 640,000.

It is recognised that General Practice in Manchester, like the rest of the country, is under significant pressure. For example, NHS Digital1 data shows that in October 2018 circa 266,500 appointments were delivered by General Practice across Manchester. This is despite a number of challenging factors such as workforce recruitment and retention issues, increasing complexity of patients and increasing demand from a rising population.

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https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/oct-2018

These factors provide a demanding environment which requires new ways of working including: a review of the current workforce and skill mix to successfully manage GP Practice caseloads; the development of new, innovative and integrated models of care and improving self-care to free up capacity within GP Practices to pro-actively and effectively assess and manage patients.

To address some of the challenges, MHCC is supporting practices to work together in a more integrated way across the 12 neighbourhood arrangements in Manchester. This includes aligning General Practice arrangements with those of the developing Manchester Local Care Organisation (MLCO).

Manchester's Strategy for Primary Medical Care sets out the vision for Primary Care over the next ten years.[2]

2.2 Quality Assurance and Improvement Framework

As a system MHCC is committed to addressing poor quality and unwarranted variation in a way that will also increase resilience and help ensure sustained improvements in primary care.

It is acknowledged that in previous years there was not necessarily a systematic approach to quality improvement in General Practice. This has changed following the introduction of the Care Quality Commission (CQC) inspection regime in recent years.

Since MHCC was established in April 2017 we have introduced a Quality Assurance and Improvement Framework for General Practice which, complements the CQC inspection regime, and enables the organisation to take a more proactive approach to quality overall. By identifying issues at an early stage, MHCC is in a better position to direct appropriate resource to support quality improvements, and help ensure GP practices retain a level of stability and resilience.

The overarching purpose of the Quality Assurance and Improvement Framework is to:

- Outline MHCC's approach to quality and safety for General Practice describing the processes that MHCC will follow. It also sets out the reporting and accountability structures and a clear escalation process for areas of concern.
- Ensure that tailored, wraparound support is provided to those practices that are rated Requires Improvement or Inadequate by CQC. The framework also proactively identifies practices that may be in need of support via the Early Warning System (see below) so that the organisation can agree next steps; and, where appropriate, intervene when in the best interests of patients.

[2] Available at www.mhcc.nhs.uk/publications

- Work collaboratively with GP practices, and internal and external stakeholders, to agree and implement support packages, and provide signposting to additional sources of support.
- Identify and embrace areas of good practice and promote sharing via neighbourhood working.

2.3 The Early Warning System

The Early Warning System (EWS) brings together a range of available data sources to identify a list of outlying metrics, which may be indicative of a practice being in need of support.

These metrics are reviewed internally on a regular basis and provide MHCC with the opportunity to contact practices to discuss any issues and support needs they might have.

GP Practice visits are then prioritised in accordance with the framework and support levels assigned. The support levels can be intensive, moderate or minimal, depending on the needs of the practice and taking into account various factors, including CQC rating. Visits and action planning with the practices also provide signposting opportunities to partner organisations and external sources of support e.g. The GP Excellence Programme and the Royal College of GPs (RCGP). Signposting to GP wellbeing services can also be offered where appropriate.

The EWS currently draws on the following data sources to indicate where support may be required:

- CQC rating
- GP Patient Survey Results
- Friends and Family Test
- Secondary Care data:
    - Referral rate
    - Referrals returned (to practice)
    - A&E Attendance Rate
    - Emergency Admission Rate
- Average Prescribing Cost (per patient)
- Patient Online
- List Size Changes 20-74
- Primary Care Standards indicators:
    - Diabetes 8 Care Processes
    - Asthma reviews
    - COPD reviews
    - Dementia annual reviews
    - SMI (Serious mental illness) health checks

2.4 Current CQC ratings for GP Practices across Manchester

The majority of GP Practices have been inspected by the Care Quality Commission (CQC) during the last three years and received a rating of Outstanding, Good, Requires Improvement or Inadequate. The full list of

practices, along with their CQC rating as at December 2018 can be found at Appendix 1.

Table 1 below illustrates a positive picture of CQC ratings in Manchester with circa 90% of practices rated Good or Outstanding by the CQC. (Where a practice is due to have a CQC inspection due to a change in Provider, it will categorise as Not Rated.

CQC Inspection Rating	Number of GP practices	%	Practices
Outstanding	4	4.6%	The Docs, Urban Village Medical Practice, Five Oaks Family Practice, West Gorton Medical Centre
Good	74	85%	
Requires Improvement	1	1.2%	Woodlands Medical Practice
Inadequate	1	1.2%	Cornerstone Family Practice
Not Rated	7	8%	Brookdale, Burnage, Charlestown, Fallowfield, Lime Square, Merseybank, Victoria Mill
Total	**87**[3]	**100%**	

Table 1: CQC Inspection Ratings for Manchester GP Practices

Looking at the national picture, where around 88% of GP Practices are rated 'Good' or 'Outstanding', one in 11 'Requires Improvement' and 3% are 'Inadequate'[4] Manchester shows a positive position.

2.5 Update on practice CQC ratings since the previous report to Health Scrutiny Committee (January 2018)

Practices rated Outstanding

There has been an increase in the number of practices in Manchester rated Outstanding by CQC from 3 to 4 during 2018. The Docs, Urban Village Medical Practice and Five Oaks Family Practice were previously rated Outstanding by CQC. Following their inspection in May 2018, West Gorton Medical Centre has also improved their position from Good to Outstanding.

[3] There are currently 89 GP practices in Manchester. Artane Medical Centre does not show in this data table due to being incorrectly registered with CQC. Queens Medical Centre also does not feature in the data table as they are inspected by CQC alongside Cheetham Hill Medical Centre.

[4] https://www.gponline.com/map-gp-practices-across-england-fared-cqc-inspections/article/1334900

Improvement highlights during 2018
Since the last report to Committee members in January 2018, the number of practices rated Inadequate by CQC in Manchester has decreased from 4 to 1.

Artane Medical Centre
Members will recall intensive work with this practice following a series of CQC inspections throughout 2017 and the continued failure of the provider to achieve contractual compliance. In December 2017, it became necessary, in the best interests of patients, to secure primary care provision with an alternative provider. A neighbouring practice took responsibility to care-take the patient list for those patients registered with Artane Medical Centre. MHCC is pleased to report that the practice has since met all areas of their plan and patient feedback is positive. The future of the patient list is to be determined and engagement with patients and key stakeholders, including Councillors, will take place in the early part of 2019.

Brookdale Surgery
The CQC undertook an announced re-inspection of Brookdale Surgery on 3 May 2018 following a series of inspections that resulted in an Inadequate CQC rating on 3 separate occasions. Subsequently, the CQC advised MHCC they would be moving to an urgent cancellation of Brookdale Surgery's CQC registration under their enforcement procedures.

To ensure continued provision of Primary Care Medical Services, an alternative primary care provider was appointed by MHCC to manage the practice contract for a fixed period, with an option to extend should this become necessary. The new provider undertook an immediate diagnostic assessment of the practice and produced a comprehensive action plan which was shared with MHCC.

The practice was re-inspected by CQC in December 2018 and early signs are positive.

Merseybank Surgery
Following an Inadequate rating by CQC in May 2017, a merger between Merseybank Surgery and a neighbouring practice is underway. The lead practice is working to an action plan and is meeting regularly with MHCC to provide assurance that high quality, safe and effective care is being maintained for patients registered at both practices. Further patient and stakeholder engagement is due to commence in early 2019 ahead of the formal merger.

Wilmslow Road Medical Centre
In June 2017 Wilmslow Road Medical Centre was rated Inadequate by CQC. At a follow up inspection in December 2017 the practice was taken out of special measures and given a revised rating of Requires Improvement.
A series of clinically led support visits took place throughout 2018 and the practice has worked hard to meet the requirements of both the CQC action plan and the GM contractual Compliance Plan. A further CQC inspection took place in November 2018 and the practice is now rated Good in all areas.

2.6 Current issues

Woodlands Medical Practice
This practice is currently rated Requires Improvement following a CQC inspection report in June 2018.

Regular meetings with the practice to support CQC, contractual, and quality improvement planning, in line with the Primary Care Quality Assurance and Improvement Framework, are in place.

A visit in November 2018 to review the practice's action plan showed positive signs of improvement by the practice. In addition, the Practice has recently appointed a new Practice Manager who will oversee the improvements.

A further CQC inspection will take place in early 2019; in the meantime MHCC will continue to support the practice.

Cornerstone Family Practice
Cornerstone Family Practice was rated Inadequate by CQC in September 2018. MHCC has initiated a programme of support and is meeting with the practice on a regular basis to help drive quality improvement and achieve compliance. This includes external support, via the GM Excellence Programme, to aid delivery of a tailored action plan and identify next steps that are aligned to CQC and MHCC action plans.

2.7 Next steps

Building on the positive work undertaken with practices this year, MHCC has held a number of workshops to review the work undertaken to date and to identify any themes and trends.

As the number of practices rated Requires Improvement or Inadequate reduces, the focus of MHCC's quality and improvement work will increasingly shift to working more closely with those practices rated Good to ensure increased sustainability, as well as sharing good practice between practices and across neighbourhoods. The aim is for all Manchester GP Practices to achieve a minimum CQC inspection rating of Good.

MHCC is also developing a GP Practice visit tool to ensure CQC-readiness. The tool will be based on supporting practices to improve quality through support and signposting to various schemes and opportunities i.e. the Primary Care Standards. The tool will encompass the CQC Key Lines of Enquiry (KLOEs)[5]. This will help practices to self-assess against the CQC domains, focus on any areas of improvement, and address these ahead of any formal CQC inspection. It is anticipated the tool will be rolled out in the early part of 2019.

[5] Further detail relating to CQC KLOEs can be found in the link below:
https://www.cqc.org.uk/guidance-providers/healthcare/key-lines-enquiry-healthcare-services

Further improvements in General Practice will be delivered through investment into key areas such as Workforce, Estates and Information Management & Technology (IM&T). This work is already underway through the recruitment of resources to support engagement with and across General Practice, partners and stakeholders (including Councillors, Community and Voluntary Sector and patient groups).

3.0 Manchester Primary Care Standards

The City of Manchester has developed 9 Primary Care Standards based on the Greater Manchester Primary Care Standards. The 9 Standards have been localised to meet the needs of our local population.

The aim of the Primary Care Standards is to deliver the following:

- A consistent population offer to the people of Manchester.
- Improved quality of care.
- A reduction in unwarranted variation.
- Improved patient outcomes and experience.
- A reduction in health inequalities.

The implementation of the Primary Care Standards across Manchester is a key element of Manchester's Strategy for Primary Medical Care[6] which has been approved by the MHCC Board. In line with the GP Forward View[7], investment has been made into General Practice through the Primary Care Standards to provide resilience and ensure it is in a position to continuously, and pro-actively, improve the quality of care being delivered.

The 9 Primary Care Standards are:

- Standard 1 – Improving Access to General Practice
- Standard 2 – Improve Health Outcomes for Patients with Mental Illness
- Standard 3 – Improving Cancer Survival Rates and Earlier Diagnosis
- Standard 4 – Ensure a Pro-active Approach to Health Improvement and early Detection
- Standard 5 – Improve the Health and Wellbeing of Carers
- Standard 6 - Improving Outcomes for People with Long Term Condition(s)
- Standard 7 - Embedding a Culture of Patient Safety in Primary Medical Care
- Standard 8 - Improving Outcomes in Children
- Standard 9 - Proactive Multi-Disciplinary Working as Part of an Integrated Neighbourhood Team to Improve Outcomes

[6] Manchester Strategy for Primary Medical Care - https://www.mhcc.nhs.uk/wp-content/uploads/2018/02/Manchester-Strategy-for-Primary-Medical-Care-V5-Edited-1.pdf

[7] GP Forward View 2016 - https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

The Manchester Primary Care Standards have not been developed as a short term aspiration to improve the quality of care for Manchester patients but that they should be implemented through a phased approach to deliver longer term improved health outcomes across the City building on the prevention work and based on Our Manchester.

To ensure a collaborative approach and early engagement, the Standards have been co-produced with partners including Manchester Primary Care Partnership (MPCP) and the Local Medical Committee (LMC).

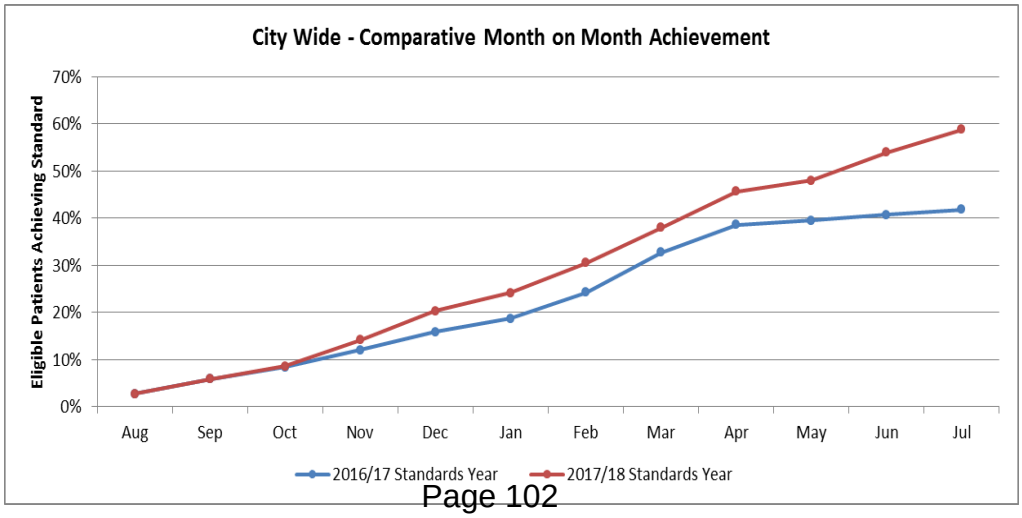
Over the last two years, a phased approach to implementation across the City has taken place. This was supported by a prioritisation process, based on need, which mobilised 3 of the Standards in 2016-17, rising to 4 of the Standards in 2017-18, and resulting in all 9 Standards being implemented from 1st July 2018.

The current Primary Care Standards Scheme, which runs from 1st July 2018 – 30th March 2020, forms part of an agreed MHCC multi-year investment approach to General Practice. The 21 month Scheme, to which all 89 GP Practices have signed up, will deliver much-needed improvements in patient care and outcomes, specifically in the areas of access, proactive care, prevention and patient safety. It will also provide resilience and enable GP Practices to invest in changes to their infrastructure to enable delivery and achievement of the 9 Primary Care Standards.

Although the Primary Care Standards have been implemented to deliver longer term improved health outcomes for our population, data from the 2017-18 Scheme has already shown some real improvement across General Practice. Examples of this include:

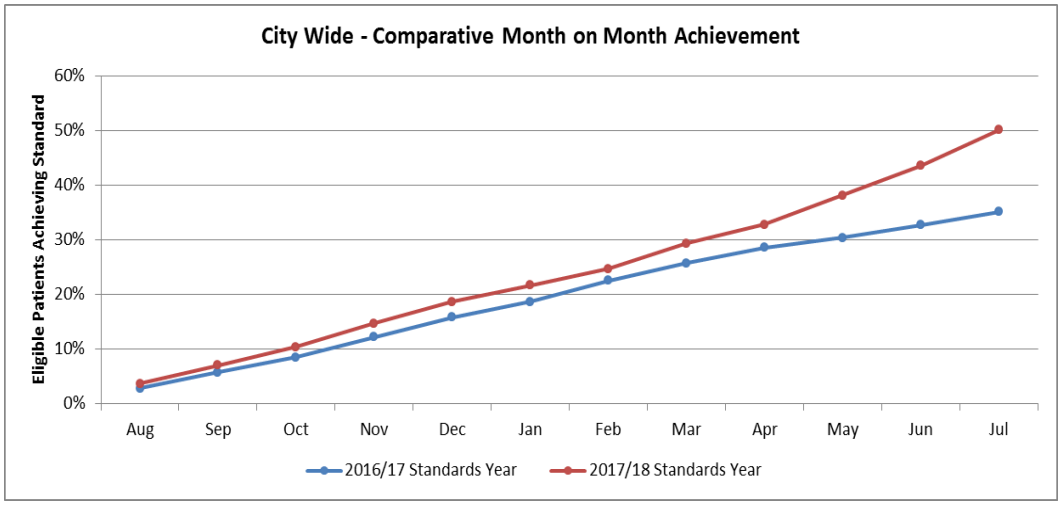
- **Standard 1 – Improving Access to General Practice** - Improved access to primary care which has seen a significant increase in the number of practices delivering access to 10 sessions of primary care per week; and 50% more patients now being offered all 7 elements of the Access Standard (see section 4.1 below)

- **Standard 2 – Improving Health Outcomes for people with Mental Illness (Learning Disabilities)** - a 17% increase in the uptake of Learning Disability Annual Health Checks.



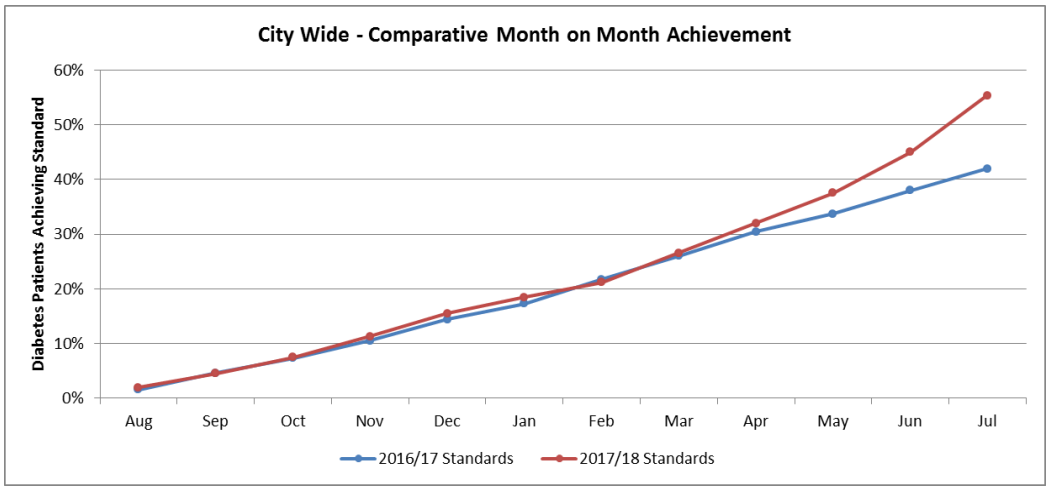
Graph 1 - increase in uptake of the Learning Disability Annual Health Check across Manchester. Data is presented as a percentage due to changes in eligible population year on year (e.g. population growth)

- **Standard 6 – Improving Outcomes for People with Long Term Conditions (Asthma Reviews)** – a 15% increase in uptake in adults diagnosed with Asthma receiving a review.



Graph 2 – Increase in uptake of Asthma Reviews across Manchester. Data is presented as a percentage due to changes in eligible population year on year (e.g. population growth)

- **Standard 6 – Improving Outcomes for People with Long Term Conditions (Diabetes 8 care processes)** – a 13.4% increase across the city for people with Diabetes receiving all 8 processes of care.



Graph 3 – Increase in people with Diabetes receiving all 8 processes of care. Data is presented as a percentage due to changes in eligible population year on year (e.g. population growth)

The Primary Care Standards are subject to on-going evaluation through regular review and monitoring of the data.

4.0 Access

4.1 Core access in hours

A wealth of national and local patient engagement and feedback informs us that access to General Practice remains a top priority for patients and the public. Access is important in that a patient's ease of access to their practice, and preferred GP, can affect their quality of care and health outcomes.

The GP contract (both GMS and PMS[8]) requires General Practice contractors to provide essential and additional services at such times within core hours, "as are appropriate to meet the reasonable needs of patients," and requires the contractor (the Practice) to have in place arrangements for its patients to access those services throughout core hours in case of emergency. Core hours for GMS/PMS practices are 8:00am - 6:30pm, Monday - Friday, excluding weekends and bank holidays.

As described above, the Manchester Primary Care Standards, to which all 89 Manchester GP practices are signed up to deliver, aims to address the challenges of both access to General Practice and continuity of care. Standard 1 is focused on Access, and, in summary, states that Practices should ensure the following:

- Patients are able to book routine, pre-bookable appointments until 8pm, 5 days per week; and at weekends[9];
- The provision of pre-bookable, longer appointments were necessary, for those patients with complex needs;
- Any patient who is considered as having an urgent clinical need should have same day access – which can be supported by the neighbourhood model;
- Patients are able to book appointments and order repeat prescriptions online;
- Patients have access to alternative modes of consultation, such as telephone consultations, online consultations, group consultations etc.;
- Access to both male and female clinicians; and
- Pre-bookable appointments 1 month in advance with a named clinician.

As at July 2017, 278,764 patients were registered with a GP Practice in Manchester achieving all 7 access criteria listed above; as at July 2018 this had risen to 419,375 patients, a rise of 50% more patients now having improved access during the full core hours.

In addition, the most recent GP Practice self-declaration data (July 2018) showed that there has been an increase in the number of GP practices across the City that are open for their full contracted hours. There are a small number of practices that have a half day or early closure and some GP Practices which close either at lunchtimes, early morning (8.00am-8:30am) or late

[8] General Medical Services and Personal Medical Services respectively
[9] Between 6:30-8:00pm those appointments are through the Extended Access service.

afternoons (6.00pm-6:30pm). During these times, GP practices have arrangements with, and switch their phones, to gtd healthcare to ensure patients can access General Practice. The variation in access across the City is being addressed through Neighbourhood meetings.

During 2019-20, Standard 1 – Improving Access to General Practice will evolve further to move Manchester to a position where all practices are open for their full contracted hours by March 2020.

GP practices will submit a further self-declaration at the end of December 2018. This information will be analysed in January 2019 to provide an update position. In addition, all GP Practices will take part in a Neighbourhood level Peer Review specific to Access during March 2019.

4.2 GP Access Policy

Feedback from practices shows that, as well as the need to ensure good access for our patients, there is also a need for clarity to support Practice and Team development and by supporting a degree of planned closure for training this should result in more practices being open regularly for their 10 sessions per week. In addition, Practices which have full regular opening for 10 sessions per week will still be able to claim for a national enhanced service for Extended Hours should they wish to do so; thereby maximising the funding available to them, and to Manchester's health economy.

MHCC has therefore developed a GP Access policy, which reflects the core contractual requirements, guidance from NHS England, and the relevant Manchester Standard. The policy proposes formal approval for a maximum of one half day closure, per calendar month, for each Practice in Manchester to undertake team training; provided that it is able to demonstrate that proper alternative arrangements are in place to meet the reasonable access needs of their patients. Under the policy, being launched to Practices in January 2019, each practice application will be considered individually, and Practices will be asked to show:

- That they have put in place reasonable alternative arrangements to meet patient needs.
- That they have engaged with, and informed, their patients.

4.3 Enhanced 7 Day Access service

Manchester has continued to invest in the Enhanced 7 Day Access (7DA) Service to General Practice, by developing the existing provision of improved access to routine GP care and ensuring that the service is integrated into the 'wider' system to improve patient outcomes and achieve optimum benefits to the whole system. Through the service Manchester's registered population can access a primary care appointment across 13 community hub sites, weekdays from 4pm till 8pm and at weekends from 9am till 6pm (times vary across each of the hub sites). The service has access to the patients' GP health record to enable them to review these in consultation with the patient,

as this is linked via the same IT systems used in the practices across Manchester.

Evening and Weekend Utilisation 1 April 2018 – 30 November 2018

Utilisation rates for the service vary by clinical type, on average 75% for GP, 54% for Health Care Assistants[10] (HCA) and 51% for Nurses[11]. Weekday appointment utilisation is higher than at the weekend, as shown in the table 2:

		PCM Central		North GPPO North		SMGPF South		Total		Grand Total
Service	**Quarter**	**Weekday**	**Weekend**	**Weekday**	**Weekend**	**Weekday**	**Weekend**	**Weekday**	**Weekend**	
GP	Q1	81%	74%	80%	63%	74%	56%	78%	64%	**75%**
	Q2	80%	73%	78%	53%	77%	50%	78%	58%	**74%**
	Q3	80%	64%	84%	78%	81%	59%	81%	66%	**78%**
HCA	Q1	78%	62%		26%	65%	54%	70%	43%	**57%**
	Q2	79%	62%	8%	34%	62%	47%	54%	49%	**52%**
	Q3	56%	60%	20%	51%	57%	27%	50%	54%	**51%**
Nurse	Q1		46%	60%	26%	5%	6%	55%	36%	**43%**
	Q2		57%	59%	38%	23%	8%	55%	51%	**52%**
	Q3	61%	58%	71%	58%			66%	58%	**61%**
Total	Q1	80%	63%	77%	42%	71%	54%	76%	52%	**69%**
	Q2	80%	65%	68%	45%	71%	48%	73%	54%	**67%**
	Q3	74%	61%	70%	67%	74%	49%	73%	60%	**70%**
Grand Total		**78%**	**63%**	**72%**	**46%**	**71%**	**51%**	**74%**	**55%**	**68%**

Table 2 – Utilisation rates for 7DA service

Weekend utilisation continues to be monitored and the lower uptake is seen in part as being as a result of patients not being able to cancel appointments outside of core hours and an inability to rebook these appointments.

A dedicated cancellation telephone line has recently been introduced and this went live in December 2018. This allows patients and GP practices the ability to cancel appointments directly with the 7DA Service. This means that these appointments can be reused and booked again.

Overall the 7DA service helps to improve accessibility for patients, whereby it allows better choice for patients and in particular caters for people who work and/or are carers, by offering extended hours.

[10] The HCA capacity is to support GP Practices in being able to offer adult phlebotomy, blood pressure checks and new patient checks.
[11] The additional nurse capacity offers access to Long Term Condition reviews such as Asthma, COPD and Diabetes in addition to providing cervical smears.

Next steps

As table 2 above shows, across Manchester different types of appointments are more popular than others. As a result, the service is reviewing the professional skill mix based on utilisation uptake and patient feedback; with the option to look at extending their workforce skill mix i.e. Physiotherapist appointments.

Other initiatives to increase utilisation include:

- Implementation of a 'text messaging' service to send patients reminders of their upcoming appointments
- A pilot commencing January / February 2019, initially in 1 of the hub sites in North Manchester, to allow NHS111 to directly book patients into the 7DA service appointment slots following appropriate triage. The intention after the pilot is to roll this out across all the Manchester sites to further improve utilisation.
- Increasing the clinical scope of the nurse in South.
- A communication Awareness Campaign. The campaign will include:
    - Re-issuing of promotional materials to every practice and hub sites in the form of pull up posters, leaflets and undertaking relevant patient feedback surveys
    - Ensuring all staff in practices are re-trained and made aware of the service
    - Promoting the service in the Health Watch Bulletins, Manchester Local Care Organisation bulletins and MHCC bulletins
    - Organising a programme of radio interviews to ensure full coverage across the local population
- Provider will be working in partnership with other service providers to look at integration with the 'wider' system.

It is envisaged that with these new initiatives utilisation will increase.

Developing the service

The expectation from NHS England is that extended access to Primary care up to 8:00pm weekdays and provision at weekends becomes a national requirement, and offer, by 2020.

A national specification has been developed, which includes:

- Pre-bookable and same day appointments, evenings and weekends
- A minimum of additional 30 minutes consultation capacity per 1,000 population, rising to 45 minutes per 1,000
- The service being available 365 days per year, including bank holidays
- Ensuring services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity in the community, so that it is clear to patients how they can access these appointments and associated service
- Ensuring ease of access for patients including:

- all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
- patients should be offered a choice of evening or weekend appointments on an equal footing to core hour's appointments.

Manchester has already incorporated these indicators within the existing Enhanced 7DA Service and the majority of these national requirements are being delivered. A plan has been developed, in conjunction with the provider, to ensure delivery of these requirements within the expected timescales.

MHCC is also exploring opportunities for a more integrated model of enhanced and urgent primary care, including how the Enhanced 7DA Service and existing Out of Hours services work more closely together to improve the offer to patients.

5.0 Digital Access

Patient access to General Practice is changing, with fast moving technological advances meaning there are now more innovative ways patients can, and choose to, access health services.

'Digital first primary care' is a delivery model through which patients receive advice and treatment they need from their home or place of work via online symptom checking and remote rather than through face to face consultation.

In some parts of the country new 'Digital First' models have started to develop, offering new digital first models of primary care access. An example is 'GP at hand', a GP Practice based in London, commissioned by Hammersmith and Fulham CCG, which offers digital and in person consultations to patients who are registered with them; including patients who register from out of their area. This uses a mobile app, provided by Babylon Health. Patients who wish to use the service would need to de-register from their existing GP Practice and join the GP at hand Practice.

The service is designed to benefit people with episodic, well defined needs, those who are digitally confident, and those who find it difficult to access services near where they live. The GP at hand digital first service is not suitable for everyone; so patients who have urgent issues or with complex needs are advised by the provider to register elsewhere. Several groups of patients are not eligible to register as out of area patients, and are advised by the practice not to register with them; including:

- Pregnant women
- Adults with a safeguarding need
- People with complex mental health conditions
- People with complex physical, psychological and social needs
- People with dementia
- Older people with conditions related to frailty
- People requiring end of life care

- Parents of children who are on the 'Child at risk' protection register
- People with learning difficulties
- People with drug dependence.

We are not aware of any current plans to seek to expand GP at hand to Manchester.

There have been significant concerns raised about the approaches from the new companies promoting digital first approaches to General Practice, from representative bodies including the Royal College of GPs (RCGP), British Medical Association (BMA) and others. The concerns are that the new models could destabilise core primary care, and provide a two tier service whereby healthier patients with less need and less complex conditions can get online appointments quickly.

There is a more mainstream roll out of online consultations from core General Practice, which MHCC is currently rolling out across Manchester; in addition certain Practices within the City have sought to pilot such approaches.

MHCC is developing a citywide approach to online consultations using a particular software system[12] which interacts with the EMIS GP Practice systems; this is being piloted in particular practices prior to citywide roll-out. In addition, a number of practices and neighbourhoods in the City have developed revised web presences with improved potential for interaction, through the Footfall system, which accelerates practice productivity by enabling patients to do more online via a comprehensive digital practice that covers all aspects of the work of a GP Practice.

Despite the absence of robust evidence, it seems there is real potential for digital innovations to play an important role in new models of delivering Primary Care; and it is anticipated that, given the large numbers of young people including students within Manchester, such models are likely both to be attractive and appropriate for groups of patients. In addition, such digital innovations have the potential to support the primary and community based care system cope with population growth and pressures on the estate; and can also be seen as key aspects of new models of care delivery.

MHCC is therefore continuing to investigate the potential for digital consultation models, to come alongside and as part of core General Practice, rather than awaiting new providers and new forms which may, as GP at hand currently does, require de-registration with a person's GP Practice. The aspiration is also to go beyond the digital first models of General Practice, and develop a common approach on key themes, such as approaches to integrated records, referrals, outbound communication, practice websites, online triage and others.

The intention is that this all comes together into a Manchester Strategy for Primary Care IM&T, which would fit into the City's overall Strategy for Primary

[12] Known as Egton

Medical Care. Like the overall Strategy, this would also be co-designed and co-produced with key partners, including MLCO, Manchester City Council, the acute sector, Manchester LMC and other agencies.

6.0 Recommendations

The Health Scrutiny Committee is asked to note:

- The content of this report;
- The improvements made in CQC inspection ratings across Manchester;
- The development of an Early Warning System to proactively identify practices in need of support;
- The implementation of all 9 Primary Care Standards across Manchester to improve quality and provide a consistent population offer; and
- The work underway to proactively improve access to GP services.

Appendix 1 – MHCC GP Practices: CQC rating by Neighbourhood

MHCC – GP Practice CQC rating by Neighbourhood – updated December 2018		
North	**Central**	**South**
Ancoats, Clayton and Bradford	**Ardwick and Longsight**	**Didsbury Burnage and Chorlton**
Five Oaks Family Practice Urban Village MP Lime Square MC Drs Hanif and Bannuru Cornerstone Family Practice Florence House Medical Practice Eastlands Medical Practice New Islington Medical Centre Mazhari & Partner	Drs Ngan & Chan Ailsa Craig Medical Practice Surrey Lodge Group Practice Dickenson Road Medical Centre Dr Cunningham & Partners Drs Chiu, Koh & Gan Parkside Medical Centre Longsight Medical Practice New Bank Health Centre	Kingsway Medical Practice Barlow Medical Centre Merseybank Surgery David Medical Centre Didsbury Medical Centre Burnage Healthcare Practice
Crumpsall and Cheetham	**Chorlton, Whalley Range and Fallowfield**	**Withington and Fallowfield**
Artane Medical Centre The Neville Family Practice Collegiate Medical Centre Cheetham Hill Medical Centre Wellfield Medical Centre Queens Medical Centre Park View Medical Centre Jolly Medical Centre	Ashville Surgery The Range Medical Centre Princess Road Surgery Chorlton Family Practice The Wilbraham Surgery The Alexandra Practice Corkland Road M P	Borchardt Medical Centre Ladybarn Group Practice Mauldeth Medical Centre Bodey Medical Centre Fallowfield Medical Centre Al-Shifa Medical Centre
Higher Blackley, Harpurhey and Charlestown	**Gorton and Levenshulme**	**Wythenshawe**
Valentine Medical Centre Beacon Medical Centre Conran Medical Practice The Avenue Medical Centre Singh Practice Fernclough Surgery Willowbank Surgery Dam Head Medical Centre Charlestown Surgery	Levenshulme Medical Centre West Point Medical Centre Gorton Medical Centre Mount Road Surgery West Gorton Medical Centre Ashcroft Surgery Hawthorn Medical Centre	R K Medical Practice Peel Hall Medical Practice Maples Medical Centre Bowland Medical Practice Benchill Medical Practice Cornishway Group Practice Tregenna Group Practice
Miles Platting, Newton Heath, City Centre and Moston	**Hulme, Moss Side and Rusholme**	**Wythenshawe and Northenden**
Brookdale Surgery Droylsden Rd Family Practice St Georges Medical Centre Whitley Road Medical Centre Hazeldene Medical Centre Newton Heath Health Centre Victoria Mill Medical Practice Simpson Medical Practice City Health Centre	The Robert Darbishire Practice Manchester Medical Wilmslow Road MC The Arch Medical Practice The Whitswood Practice Cornbrook Medical Practice The Docs	Northenden Group Practice The Park Medical Centre Brooklands Medical Practice Northern Moor Medical Practice Woodlands Medical Practice

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 8 January 2019

Subject: Delivering the Our Manchester Strategy

Report of: Executive Member for Adults, Health and Well Being

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Summary

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 Adults, Health and Well Being.

Recommendations

The Committee is asked to note and comment on the report.

Contact:

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1.0 Introduction

The Our Manchester Strategy was formally adopted by the Council in January 2016 and sets the ambitions for the city for the next ten years, to 2025, for Manchester to be:

- Thriving – creating great jobs and healthy businesses;
- Filled with talent – both home-grown talent and attracting the best in the world;
- Fair – with equal chances for all to unlock their potential;
- A great place to live – with lots of things to do and
- Buzzing with connections – including world-class transport and broadband.

Executive Members are collectively and individually responsible for supporting the delivery of the Our Manchester Strategy and for providing political oversight and direction to officers for the better outcomes for Manchester residents. In October, the Executive also published its collective political priorities and those of individual Executive Members, all of which are aligned to the Our Manchester Strategy.

This report sets out how I as the Executive Member for Adults, Health and Well Being have sought to deliver these priorities since taking up my post on in May 2017, and is the second of my six monthly updates.

2.0 Executive Member for Adults, Health and Well Being - Portfolio

As Executive Member for Adults, Health and Well-Being, my portfolio includes:

- Adult Social Care;
- Population Health and Prevention;
- Learning Disabilities;
- Mental Health;
- Supporting People;
- Learning Disabilities;
- Health Services as part of MHCC and MLCO
- Health and Social Care Integration (Manchester and GM)
- Public Service Reform (Health and Social Care);
- Asylum Seekers and Refugees

3.0 Progress and action update in the last 6 months

I took up this position in May 2017 and from Day 1 have focused my attentions on the role in a full time capacity. I regularly visited staff and front line teams, taken part in Our Manchester Listening in Actions Sessions and the Our Manchester work, while encouraging colleagues from across the council and health to do the same.

I’m passionate that as a council we talk more about the positive and great work that our health and social care do, helping to boost morale and increase the reputation and appeal of the sector. I want to take this opportunity to thank all of our staff across health and adults services for the valuable jobs they do.

4.0 Overview and Improvement journey

Since taking up this role in 2017, I have spent time working with our staff to understand what areas of our service need the most focus, attention and in places improvement. Eight years of austerity and local government cuts have impacted on our services, and indeed the lives of Manchester people and we see this on the front line in adult social care. In 2010 the Council spent £188m on Adult Social Care, and in 2018 this figure is £192m, using a crude indication of inflation alone (before adding additional demographic growth and funding) the 2010 budget would have risen to over £240m. This is why the Council took the decision in 2017 to invest £35m over 3 years in the adult's budget.

There is a growing demand for our services, and similar to Children's Services the number of people being referred for safeguarding concerns has grown, almost doubling in the last 3 years. Detailed analysis of our services has been pulled together as part of the Adults Services Improvement and this will have significant political and senior oversight.

I am absolutely clear, adult's services are a core statutory and moral function of our role as a council, and people of Manchester should be entitled to high quality services, designed with them in mind, when they need them.

The 2018 Manifesto committed the following pledges, and these are covered in more detail in this report.

1. **Real Living Wage for Homecare Workers: Delivered**
2. **Employ more people to support vulnerable residents with the 1.5% increase in Council Tax: Delivered**
3. **Start work on 200 Extra Care Homes: On track**
4. **Invest and improve mental services: On track**

5.0 People

In the last 6 months we have seen the departure of Dr Carolyn Kus, the Strategic Commissioner for Health and Social Care. Bernie Enright our Director of Adult Services in the Local Care Organisation has been acting up as the Statutory Director of Adult Services with support from Craig Harris and MHCC colleagues. When Elected Members raise concerns, questions and casework Bernadette is the point of contact. We will be recruiting a replacement to the Strategic Director of Commissioning to focus on MHCC's relationship with the LCO.

Within the Local Care Organisation we have now strengthened the Senior Adults Management team, and welcome Paul Covell (Assistant Director for Integration/ PSU), Tracy Cullen (AD for Complex Lives), and after Christmas will welcome our new AD for Front Door/ hospital services, to sit alongside Karen Crier (Strategic Lead for Provider i.e. In-house Services).

Since taking over this portfolio I have made staff morale and engagement a key priority, recognising that amidst the difficulties of local government and social care- we need to demonstrate the value we place on all our staff. The directorate does a lot

of work around engagement through traditional 'you said, we did' work but also through the likes of the Activators programmes and a regular programme of engagement. The Council does the Bheard survey annually and this year we have seen a massive boost in number of responses and positivity of responses from Adults Services- making us the second highest rated area of the Council. Thank you to all our staff.

6.0 Our Healthier Manchester Plan

Good progress has been made on the integration of Health and Social Care and the following two pillars of the Locality Plan are particularly relevant to this agenda. Scrutiny will be familiar with the developments in line with the Locality Plan.

I have arranged 12 Neighbourhood briefings for elected members, led by the LCO and supported by commissioners to discuss what will be happening in their local area and what joint priorities look like.

6.1 Manchester Health and Care Commissioning

Manchester Health & Care Commissioning (MHCC) was formally established in May 2017, between Manchester City Council and NHS Manchester Clinical Commissioning Group to jointly commission health and wellbeing services for the city. I sit on the Board as Deputy Chair (non-remunerated of course), chair the newly formed strategy committee and sit on the finance committee.

From April 2018 we have a pooled budget in place, which I have been leading on bringing the principle of this in to practice and meet frequently with officers around specific work areas. We are actively looking at how MHCC can help grow the LCO as part of a piece of work called Phase 2 were we try and break down unnecessary arbitrary NHS boundaries and make sure that the LCO has the right resources to take on new responsibilities and improve lives.

7.0 Local Care Organisation

The Manchester Local Care Organisation, a public sector partnership between MCC, Manchester Foundation Trust, GPs and the Mental Health Trust went live on 1st April 2018. Over the next 12 months we will see a phasing of our council staff moving in to the LCO (they remain employees of the council and keep their terms and conditions etc.). As a city we are committed to this being delivered on a firm basis of a publically funded and publically delivered health and social care system. I sit as one of the council's two places on the Shadow Provider Board (made up equally of the 4 partners; MCC, Manchester Foundation Trust; GP Federations and the Mental Health Trust). This involves monthly board meetings, and frequent meetings with senior LCO staff to monitor progress and shape services. We have seconded expertise from the VCSE into the LCO to help shape more engagement of communities and the VCSE sector in neighbourhood working.

7.1 Neighbourhood Teams and Working:

The key mission of the LCO is the integration of health and care services into 12 integrated Neighbourhood Teams. This is an enormous programme of change which impacts on front line staff in the council and we have made a strategic decision to do this over a longer period to ensure that staff are properly prepared.

The Neighbourhoods are led by Neighbourhood Team Managers, and a 'quintet' of professional leadership; a lead GP, lead Social Worker, Lead nurse and Lead Mental health worker. Recruitment to the Neighbourhood roles have been slower that I anticipated, but almost all of the Manager posts have been recruited, the 12 Lead GPs are in place and we are finalising the Lead Social worker posts.

There is a clear engagement timeline for elected members:

- January: I will email Councillors about the plans for Neighbourhood teams go-live dates (these are staggered for service sustainability
- Early Feb: Drop in sessions for Cllrs to discuss neighbourhood teams/ LCO/ Process (this is aimed at elected members who perhaps don't have Health Scrutiny knowledge or are newer members)
- Throughout Feb/ early March: Wards will receive briefing packs on the health and care issues in their wards, will meet with Neighbourhood Managers/ Teams and will be involved in how the Neighbourhood health plans will be shaped.

7.2 Pledge: Employ more people to support vulnerable people in their homes using the 1.5% council tax increase for ASC:

The **reablement** service is vital to supporting people to live well in their own homes. Unlike some local authorities this is still provided by committed City Council staff and evidence shows how well it works, so the service is being expanded with additional funding for over 70 new staff.

Recruitment: A key piece of this work was also helping Manchester residents who had been unemployed get access to these jobs. In a joint partnership with the work and Skills Team and the Manchester Growth Company we ran a Pre-Employment Development course recruiting a number of people who were previously struggling to access work. Learnings from this include that while this is absolutely yhr right thing to do, it does take longer and that more time needs to be built in to the process to allow this.

Success: Our new staff have supported almost 1000 people to stay in their homes. this alongside our extra care schemes and neighbourhood apartments (short stays) has seen more people able to stay at home with the right level of support.

The Neighbourhood Apartments which is a reablement focused short stay in an existing extra care scheme, for example in Wythenshawe 135 Village we have 6 apartments for people requiring something different to hospital, home or a residential home with beds across the city. To date the scheme is going well and we continue to expand.

8.0 Pledge: Extra Care is a key part of the housing and social care support offering of the city, with over 550 units to be built by 2020. After some problems with national funding, the programme is back up and running, with the aim of starting work on up to 200 units this year.

On top of the 7 existing schemes such as the flagship Wythenshawe Village 135 schemes, we are building over 400 extra-care homes for older people by 2021. We are on site for a number of these schemes with a target for over 200 social rent units to be finished by 2021. Work is already commencing on site for a number of these programmes.

We recently announced that subject to planning permission the LGBT Extra Care Scheme would be happening in Whalley Range. This ground-breaking scheme has received positive attention from across the country.

9.0 Learning Disabilities and Autism

I am Chair of the Learning Disability Partnership Board which is led by input of adults with learning disabilities and supported by partners. We have been working with colleagues across GM to see where we can work together to improve outcomes and services for people with Learning Disabilities and have signed up to a new GM Plan. Manchester is leading on two pieces of work as part of our 100 Day Challenge imitative. The first is Homes for People; where we are expanding the Shared Lives Scheme and building 70 new homes for people with learning disabilities across the city.

Cllr Joanna Midgely as my Assistant Executive Member, deputises for me at the Partnership Board when necessary and is overseeing a piece of work on the transition for young people with learning disabilities about which we brought an introductory piece to Scrutiny last month.

Autism and ASD- we are currently reviewed what we can do to make Manchester an Autism friendly city and looking at the services and support we have available. Cllr Midgely will be chairing a working group on this and it will complement the recent GM Autism Strategy which is currently being developed.

A special mention should go to the Hall Lane Day Services who have recently installed solar panelling to the site, making it the first Daytime Support Hub to take all its external energy requirement away from the national grid. This has been made possible by the funding received from the Quality Action Group following a successful application for funding from the Airport Trust.

Equipment, adaptations and Blue Badge Team: Recruitment of the additional 6 occupational therapists and 2 blue badge assessors with estimated start dates of early February will increase the number of assessments completed each month and will also help to reduce the waiting times for complex assessments and Blue Badge Assessments.

10.0 Home care and Residential Care Improvements

Manchester people tell us repeatedly they want good quality care, close to home to help keep them active and independent for as long as possible to get the most out of life. A priority for me of the last 18 months has been to look specifically at how we deliver homecare in the city.

10.1 Homecare: Manchester hadn't reviewed its homecare model in a decade, and I was concerned that the model was outdated and deliver best for Manchester people so in June 2017 I made it a priority area of work. We began to review existing services, engage with people in receipt or caring for people in receipt of services, and began a new model. In April 2018 we brought in the Real Living Wage for Homecare Workers. I brought the transformation of Homecare to Scrutiny in the Autumn, and this has been a length piece of work.

Since then the procurement process has been underway and the results are proving positive. We chose to commission on a model of 50% Quality, 30% Social Value and 20% Cost. Commissioners are currently undergoing the due diligence process and there is a clear process in place for engaging and working with providers and citizens from January onwards. A note to members will be sent mid-January, with drop in sessions in early February about the implications of any changes so that Councillors are equipped to reassure any concerns residents might have.

There will be a proper mobilisation team with a Senior Responsible Officer in place to oversee the new process throughout the Spring and Summer. This is an area of complexity and risk, but to do nothing and simply allow the old model to continue does a disservice to the citizens of Manchester and the staff working in this industry.

10.2 Residential and nursing care remains under pressure, and in the way we approached homecare from an evidence based way- we are turning out attentions to this sector with a proper review. For too long we have had too many inadequate and requires improvement nursing and residentially homes in this city, and I have set an ambitious target of getting all homes to Good or Outstanding. Starting with inadequate homes we have been reducing them, and are developing targeted programmes to get Requires improvement Homes to Good or Outstanding.

11.0 Improving Mental Health Services and Prevention of Mental Illness

I meet regularly with GMMH and Manchester Commissioners to monitor the progress of the ambitious two-year programme of service transformation, to improve both the mental health outcomes for people receiving services and support the wider mental wellbeing of Manchester residents. A report was recently received at health scrutiny.

I have previously updated on the work to improve Harpurhey Wellbeing Centre led by GMMH, supported by council and health commissioners to improve access to services for people in the North of the city. This will see an investment of £800,000 for services that support people with mental health difficulties and local wellbeing groups. Following the ongoing issues being raised with scrutiny, issues were resolved and there have been no reported issues since. Construction work is still ongoing on the building but in the mean-time existing services and groups are

operating out of the Harpurhey Neighbourhood Project (with necessary rental being paid to HNP, helping with their sustainability).

There has been a specific piece of work to review of the transition between young peoples and adults services for mental health, with a number of recommendations that are being implemented.

I referenced at the last meeting that a large piece of work around Children and Young people's mental health services is ongoing, and was reported to Health Scrutiny Committee.

12.0 Population Health and Prevention of ill-health

The Population Health and Wellbeing Directorate at Manchester Health and Care Commissioning (MHCC) have led the co-production of the Manchester Population Health Plan with a wide range of stakeholders. As Executive Members for Adult Health and Wellbeing I maintain oversight of the statutory functions (e.g. health protection) and mandated responsibilities (e.g. sexual health services) of the Director Public Health at MCC who is also the Director of Population Health for MHCC.

12.1 The Be Well Social Prescribing Service is now fully operational across the city with the south and central service commencing in November 2018. The service is designed to improve the health and wellbeing of local residents with long term health conditions or whose social circumstances mean that they are at increased risk of poor health. Following a referral from their GP, people will be offered one to one support tailored to their needs. The service is an integral part of the Prevention Programme, delivered through the Manchester Local Care Organisation and has a strong neighbourhood focus.

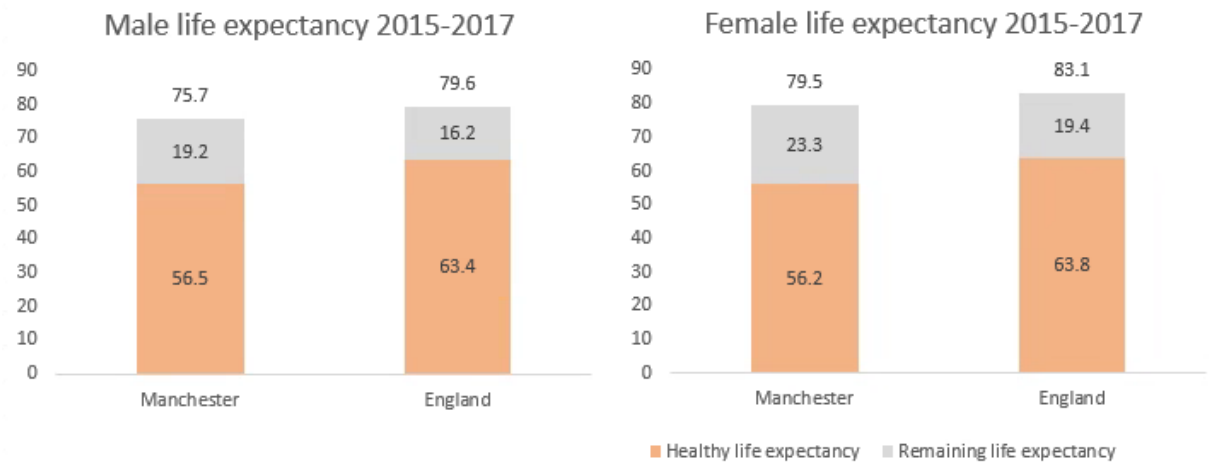
12.2 Winning Hearts and Minds is a programme of work to improve heart and mental health outcomes in the city, with an initial focus in north Manchester. In this part of the city, the rate of early deaths from heart disease is 96.2 deaths per 100,000 people compared to the England rate of only 40 deaths per 100,000 people. Funding for the programme from NHS resources has just been agreed by the Manchester Health and Care Commissioning Board to roll this out primarily across North and East Manchester. I will ensure that local Councillors receive regular briefings on the implementation of the programme and have proper involvement in projects in their area.

12.3 Smoking Services I have recently raised concerns at Scrutiny that due to cuts to public health funding our Smoking Services have been hit hard and given that Manchester has one of the highest rates of smoking in the country we need effective stop smo9king services. Funding has recently been approved for additional services, and I will bring a fuller update on this.

12.4 Achieving successful outcomes

One of the main aims of the Population Health Plan is to increase the proportion of life years spent in good health. This measure is known as Healthy Life Expectancy. Manchester is well below the national average for both life expectancy

and health life expectancy. The latest figures released in December 2018, show a welcome increase in Healthy Life Expectancy for both Males and Females in Manchester, from 54.3 and 54.6 years respectively in 2014-2016 to 56.5 and 56.2 years in 2015-2017. This is a statistically significant increase of 2.2 years for Males and an increase of 1.6 years for Females, compared to an increase of 0.1 for Males and a decrease of 0.1 for Females in England. Although Healthy Life Expectancy in England is still higher, with a figure of 63.4 years for men and 63.8 years for women, the gap with England has been narrowed and this will really contribute to our efforts to reduce health inequalities (see graph below).



There is still an awful lot of work to be done, but Manchester is moving in the right direction and we need to make sure that despite ongoing government cuts, we focus on prevention and wellbeing.

12.5 Sexual Health Sexual health services in Manchester are under increasing pressure from a growing population and rising demand. I recently visited the leadership team of Northern Sexual Health Services at the Hathersage Centre in Central Manchester. We discussed a number of important issues, including some of the work they are doing to reduce queuing times for drop in services by allowing some advance bookings.

The issue of PrEP (a treatment aimed at preventing the contraction of HIV) has come up a number of times. As it stands the Government and NHS England are preventing wider access due to its restrictions around extended trials. The evidence base is now robust in terms of its clinical effectiveness (and cost effectiveness) and many, including myself see the current approach as simply the Government rationing health care access - which is unacceptable.

In the new year I will be working more on this, bringing together clinicians, the VCSE and politicians to discuss what more can be done. Manchester has signed up to be a Fast Track City to eradicate the new infections of HIV, and this is an important component of our success.

13.0 Unwaged Carers

I previously brought a report to Scrutiny outlining our ambitious new approach for supporting carers in the city, both in terms of a new charter and also a new model of service. This will require significant investment of over £1million over 3 years. Since the report was brought in the Autumn we have been looking at getting the additional funded needed. This is an exciting development and can report we are now in an optimistic position and I will report back in detail to scrutiny in the Spring.

14.0 Greater Manchester Health and Social Care Board and Executive

I attend this strategic partnership board on behalf of Manchester and sit as one of two local government representatives on the GM HSC Executive (meeting monthly). This body covers a range of issues around health and social care devolution across GM. In December we had the first quarterly Joint Commissioning Board which brings political and GP accountability to the decisions made by Commissioners at a GM level.

Some of the issues we have made decisions on and discussed include: Learning Disabilities; Autism; Population Health; Stopping Smoking and Acute Hospital Services. On the point of Acute Services I will be organising a briefing for elected Members with Jon Rouse and the Team at the GM Health and Social Care Partnership.

15.0 Asylum Seekers and Refugees

This is an addition to my portfolio since late May 2018.

Initially I organised a round table of senior council officers to pull together a coherent approach to asylum seekers and refugees in the city which currently sits across a number of service areas in the council to develop a plan. I have also been out to visit a large number of excellent organisations who work with refugees and asylum seekers in the city, and am moved by the great work they do, often in difficult circumstances.

Politically I am not afraid to re-state that asylum seekers leave their homes and countries of origin due to often horrific circumstances and fear for their safety, often embarking on perilous journeys to reach a place of safety. The UK should be that, and the current Government outsourcing of support and housing, alongside the climate of hostility they create. In Manchester of a population of over 550,000 we have just over 1,000 asylum seekers in our city who the Government are failing, but our city tries it's best to support.

Health: Working with MHCC officers there is a piece of work to improve access to GP's and we are looking at creating new model focusing on 'inclusion health' potentially in areas where we know there are asylum seekers and refuges living. There is a lot of additional detail to this work I'm happy to discuss and it shows a new model of working with primary care and local services. This is an approach that also includes other vulnerable groups like homeless people and sex workers, and there is lots of good practice in the city.

16.0 Ongoing commitments

Multi-Agency Adults Safeguarding Board: I regularly attend the Manchester Safeguarding Adults Board last week and meet regularly with our Independent Chair Julia Stephens-Row. Nationally there are changes to how Children's Board work so we are reviewing our current structures to make sure they are in line with Children's developments and ensure that we have the most effective model to keep adults safe.

I continue to attend **Our Manchester Listening in Action Events** with staff, continue to be very impressed by the contributions and commitment of our staff.

Visits to services: I like to visit staff and partner organisations such as hospitals as much as possible and am currently working through a cycle of front line visits to see what staff have to say. If you have an issue or service in your ward, I am more than happy to arrange a visit.

I welcome any feedback and suggestions from members of Scrutiny on the information in this document or other areas of work in this portfolio.

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Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 8 January 2019

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
6 November 2018	HSC/18/47 Prepaid Financial Cards - Adult social care (MLCO)	Request that information on the Risk Register be circulated to the Committee.	This information was circulated to Members via email 29 November 2018.	Zoe Robertson Strategic Lead

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 December 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**
Cornish Close Scheme Ref: 2017/05/31B	Appointment of a support provider for the Cornish Close Scheme which includes 14 supported accommodation units over 5 properties, 6 short break beds.	Strategic Director of Adult Social Services	March 2018 or later	Report and Recommendation	Lesley Hilton-Duncan 0161 234 4419 lesley.hilton-duncan@manchester.gov.uk
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
Dr Mark Northfield	St George's Medical Centre St Georges Drive Moston Manchester M40 5HP	https://www.cqc.org.uk/location/1-541783599	20 November 2018	Dr / GP	**Overall: Good** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Good
Nuffield Health	Nuffield Health Manchester Diagnostic Suite City Labs, Nelson Street Manchester M13 9NQ	https://www.cqc.org.uk/location/1-2373927706	26 November 2018	Dr / GP	**Overall: Good** Safe: Good Effective: Unable to rate Caring: Good Responsive: Good Well-led: Good
Marie Stopes International	Marie Stopes International Manchester Centre 5 Wynnstay Grove Fallowfield Manchester M14 6XG	https://www.cqc.org.uk/location/1-130902826	28 November 2018	Clinic, Urgent care centres	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Requires Improvement

Medserena Upright MRI Ltd	Medserena Upright MRI Centre 26-28 The Boulevard Didsbury Manchester M20 2EU	https://www.cqc.org.uk/location/1-4437744209	27 November 2018	Diagnosis/screening	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Caring: Good Responsive: Good Well-led: Requires Improvement
Wilmslow Road Surgery	Wilmslow Road Surgery Wilmslow Road Medical Centre 156 Wilmslow Road Rusholme Manchester M14 5LQ	https://www.cqc.org.uk/location/1-542136268	4 December 2018	Dr / GP	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Miss Elaine Hawthorn	Church Lane Dental Practice 187 Church Lane Harpurhey Manchester M9 4LY	https://www.cqc.org.uk/location/1-188689902	6 December 2018	Dentist	**No Action Required**
Mediline Supported Living Ltd	Mediline Supported Living Averill 47 Averill Street Newton Heath Manchester M40 1PH	https://www.cqc.org.uk/location/1-191191147	12 December 2018	Residential Home	**Overall: Good** Safe: Good Effective: Requires Improvement Caring: Good Responsive: Good Well-led: Good

BoJo Care Services Ltd	BoJo Care Services Ltd 808 Hyde Road Manchester M18 7JD	https://www.cqc.org.uk/location/1-1921056762	12 December 2018	Homecare Agency	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Requires Improvement
Brooklands Medical Practice	Brooklands Medical Practice 594 Altrincham Road Wythenshawe Manchester M23 9JH	http://www.cqc.org.uk/location/1-545937960	12 December 2018	Dr / GP	**Overall: Good** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Good
HC One Ltd	Averill House Averill Street Newton Heath Manchester M40 1PF	https://www.cqc.org.uk/location/1-319159457	21 December 2018	Nursing Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

ZMA Manchester Ltd	Ashley House Residential Home 155 Barlow Moor Road Manchester M20 2YA	https://www.cqc.org.uk/location/1-1162706973	19 December 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement
Mr Bradley Scott Jones & Mr Russell Scott Jones	Brownlow House 142 North Road Clayton Manchester M11 4LE	https://www.cqc.org.uk/location/1-131420845	19 December 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Inadequate

Abbeyfield Society	Downing House 14 Swinbourne Grove Withington Manchester M20 4PP	https://www.cqc.org.uk/location/1-137749784	22 December 2018	Residential Home	**Overall: Requires Improvement** Safe: Good Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Requires Improvement
EHC Moston Grange Ltd	Moston Grange Nursing Home 29 High Peak Street Manchester M40 3AT	https://www.cqc.org.uk/location/1-143921728	18 December 2018	Nursing Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Requires Improvement
Surrey Lodge Group Practice	Surrey Lodge Group Practice 11 Anson Road Victoria Park Manchester M14 5BY	https://www.cqc.org.uk/location/1-565594964	21 December 2018	Dr / GP	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

Health Scrutiny Committee
Work Programme – January 2019

Tuesday 8 January 2019, 10am (Report deadline Thursday 27 December 2018)				
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 across the city.	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. This report will also provide an update on the delivery of the 7 day GP access service.	Cllr Craig	Nick Gomm	
Overview Report	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.		Lee Walker	

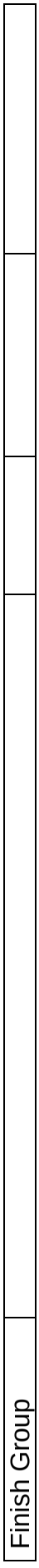
Tuesday 5 February 2019, 10am (Report deadline Thursday 24 January 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Single Hospital Service – Progress report	To receive a progress report on the implementation of the Single Hospital Service. This report will provide 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	
Manchester Local Care Organisation	To receive a progress report on the delivery of the Local Care Organisation. This will include specific information on the establishment of the Integrated Neighbourhood Teams.	Cllr Craig	Professor Michael McCourt	
Overview Report			Lee Walker	

Tuesday 5 March 2019, 10am (Report deadline Thursday 21 February 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Supporting People Housing Strategy		Cllr Craig Cllr Richards	Jon Sawyer	Executive Item
Overview			Lee Walker	

Report				

Items To be Scheduled				
Item	Purpose	Executive Member	Strategic Director/ Lead Officer	Comments
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	Cllr Craig	Nick Gomm Professor Craig Harris	To be considered at the March 2019 meeting. See minutes of October 2017. Ref: HSC/17/47

	Access to Psychological Therapies (IAPT) services in the city.			
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 be sent to Vicky Szulist and Neil Walbran, 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
Assistive Technology and Adult Social Care	To receive a report on how assistive technology will be used to support people receiving adult social in their home.	Cllr Craig	The Executive Director of Commissioning & DASS	
Recommendations of the Public Health Task and	To receive a report on how the recommendations of the Public Health Task and Finish Group are being implemented.	Cllr Craig	David Regan	See minutes of December 2018


Finish Group