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MANCHESTER CITY COUNCIL

Health and Wellbeing Board

Date: Wednesday, 3 November 2021
Time: 10.00 am
Venue: Council Chamber, Level 2, Town Hall Extension

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Membership of the Health and Wellbeing Board

Councillor Richard Leese, Leader of the Council (Chair)
Councillor Craig, Deputy Leader of the Council
Councillor Midgley, Executive Member for Adult, Health and Wellbeing (MCC)
Councillor Bridges, Executive Member for Children and Schools Services (MCC)
Dr Ruth Bromley, Chair Manchester Health and Care Commissioning
Katy Calvin-Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust
Mike Wild, Voluntary and Community Sector representative
Vicky Szulist, Chair, Healthwatch
Dr Tracey Vell, Primary Care representative - Local Medical Committee
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Dr Murugesan Raja Manchester GP Forum
Dr Geeta Wadhwa Manchester GP Forum
Dr Doug Jeffrey, Manchester GP Forum
Dr Shabbir Ahmad Manchester GP Forum (substitute member)
Dr Denis Colligan, Manchester GP Forum (substitute member)

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 1 September 2021.

5. Winter Planning: COVID-19 and Flu 13 - 46
Report of the Director of Public Health and Medical Director, Manchester Health and Care Commissioning

The attached slideset describes the planned approach to delivering both the COVID-19 and flu vaccination programmes over the coming months. These programmes sit alongside the winter plans of local NHS Trusts and Adult Social Care and the overarching national Autumn/Winter Plan. An additional update on the latest data and intelligence will be provided at the Board meeting.

6. Manchester Climate Change Framework 2.0 47 - 56
Report of the Director, Manchester Climate Change Agency

The purpose of the report is to highlight the increasing evidence of a strong correlation between climate vulnerability and health inequalities, to provide an update on the refresh of the city's Climate Change Framework (Framework 2.0) and to seek guidance on the best way to bring expert advice on Health & Wellbeing into the Framework refresh, both in the short and longer term.

7. 'Our Year' 2022 57 - 66

The report of the Strategic Director of Children and Education Services is enclosed.

The report and slide set provides an overview of the citywide approach to listening to what children and young people need to help direct collective resources, support and communities to bring more opportunities, training and experiences for the next generation.

Information about the Board

The Health and Wellbeing Board brings together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from HealthWatch to plan the health and social care services for Manchester. Its role includes:

- encouraging the organisations that arrange for the provision of any health or social care services in Manchester to work in an integrated manner;
- providing advice, assistance or other support in connection with the provision of health or social care services;
- encouraging organisations that arrange for the provision of any health related services to work closely with the Board; and
- encouraging those who arrange for the provision of any health or social care services or any health related services to work closely together.

The Board 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.

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Agenda, reports and minutes of all council committees can be found on the Council's website www.manchester.gov.uk

Smoking is not allowed in Council buildings.

Joanne Roney OBE
Chief Executive
Level 3, Town Hall Extension, Albert Square
Manchester, M60 2LA

Further Information

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

Andrew Woods
Tel: 0161 234 3011
Email: andrew.woods@manchester.gov.uk

This agenda was issued on **Tuesday, 26 October 2021** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Lloyd Street Elevation), Manchester M60 2LA

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 3 November 2021

Subject: Better Care Fund (BCF) return

Report of: Senior Planning Manager, MHCC

Summary

NHS England have requested that a BCF return is completed for Manchester which demonstrates the plan to successfully deliver integrated health and social care.

The plan focuses on the requirement to reduce long length of stay in acute settings and to provide support for people to remain in the community by having effective discharge pathways and social care provision.

NHS England request that the plan is approved by the Health and Wellbeing Board prior to being submitted to them by 16 November 2021.

Recommendations

The Board is asked to:

1. Approve the Better Care Fund return

2. Approve the narrative return in support of the Better Care Fund plan.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Enabling people to keep well and live independently as they grow older	The plan sets out the support that is in place to support people to remain in the community. This includes the support that is provided by the crisis team to reduce the likelihood that patients will require hospital care. It also includes having effective discharge pathways including discharge to assess provision to minimise the length of stay of patients in hospital. The plan also includes the support that is provided to help people remain in the community once they leave hospital such as the reablement provision and the neighbourhood apartments which provide short term support to rehabilitate patients.
One health and care system – right care, right place, right time	
Self-care	

Links to the Manchester Health and Social Care Locality Plan

The three pillars to deliver the Manchester Health and Social Care Locality Plan	Summary of Contribution or link to the Plan
A single commissioning system ensuring the efficient commissioning of health and care services on a city-wide basis with a single line of accountability for the delivery of services	CCG funding is provided to support effective discharge pathways and community provision including care home support.
'One Team' delivering integrated and accessible out of hospital community-based health, primary and social care services	There is an integrated community approach including support which is being provided by crisis teams, reablement, intermediate care, residential and nursing care.
A 'Single Manchester Hospital Service' delivering consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the city	The hospital discharge policies have been produced in consultation with MFT to ensure that patients are able to leave hospital as soon as they are medically fit to do so.

Lead board member: Cllr Midgley

Contact Officers:

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

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based:

- BCF planning template
- BCF narrative return

1.0 Introduction

1.1 This paper provides the Health and Wellbeing Board with an overview of the Better Care Fund (BCF) planning guidance for 2021/22 and the related reporting requirements related to the BCF plan and pooled budget.

Background

1.2 The Department of Health and Social Care (DHSC) have issued a policy framework for the implementation of the Better Care Fund in 2021/22. The framework sets out that plans should have stretching ambitions for improving outcomes against the national metrics.

1.3 From March 2020, in response to the pandemic, the Hospital Service Requirements set out revised processes for hospital discharges in all areas, including a requirement that people are discharged on the same day that they no longer need to be in an acute hospital; and implementation of a home first approach. This policy is supported by additional funding in 2021/22 for health and social care activity to support recovery outside hospital and to implement a discharge to assess model.

1.4 Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) are paid to local authorities with a condition that they are pooled into the BCF and spent on specific purposes set out within the BCF framework.

1.5 The reporting requirement requires the reporting template to be populated with the CCG minimum contributions to the BCF, Disabled Facilities Grant and the Improved Better Care Fund.

2.0 Reporting requirements

2.1 The BCF returns need to be submitted to NHS England by 16 November. There is a local requirement to submit the return to the GM Assurance office by 10 November in order that they can verify the return before forwarding to NHS England.

2.2 Part of the requirements of the return are that the approach and return must be agreed by stakeholders including the CCG, Local Authority and the Voluntary Sector and signed off by the Health and Wellbeing Board.

2.3 The return requires consideration of how health inequalities are taken into consideration in the delivery of services. Actions undertaken including trying to have a culturally competent workforce, having availability of translation services and engaging with communities at a neighbourhood level.

2.4 The BCF funding also requires that there is Section 75 agreement between the CCG and Adult Social Care for the pooling of health and social care budgets. A new Section 75 agreement is now in place between the MLCO and MCC as the deliverers of integrated health and social care. The CCG does however retain oversight of the BCF process by providing a CCG

contribution to MLCO activity and by MCC representation being retained on the MHCC Board and Strategy Committee.

3.0 Key aspects of the return

3.1 The BCF plan complies with the 4 BCF national conditions for 2021/22 which are:

1. A jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
3. invest in NHS-commissioned out-of-hospital services
4. a plan for improving outcomes for people being discharged from hospital

3.2 The activity within the plan has been agreed by health and social care colleagues from the CCG, MCC and MLCO and the funding has been agreed in line with the NHS uplift requirements for the programme.

3.3 The programme concentrates on a range of activity to support people to be cared for in the community meaning that they either do not need to enter hospital such as by receiving support from the crisis response team or by having effective pathways in place to support people to be discharged from hospital on the day that they no longer need to be there.

3.4 A key aspect of the plan are the discharge pathways which are:

- Pathway 0 – Discharge home with no further care needs
- Pathway 1 – Discharge home with care needs
- Pathway 2 – Discharge to intermediate care
- Pathway 3 – Discharge to Residential or nursing care.

3.5 For patients that are unable to be discharged home straight away the care that they are able to access includes neighbourhood apartments which offer a short term solution to help support patient rehabilitation. Additionally, Pathway 3 includes Discharge to Assess beds within residential and nursing homes, helping to support patients who may have more complex short term care needs on leaving hospital.

3.6 Further details of the BCF plan are contained within the BCF narrative return.

4.0 Recommendation

4.1 The Health and Wellbeing Board are asked to approve the BCF planning template and narrative return and provide confirmation of sign off for the plan.

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Manchester Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The BCF plan has been completed in collaboration with Adult Social Care and community care colleagues from Manchester City Council (MCC) and the Manchester Local Care Organisation (MLCO). Data has been gathered from the Business Intelligence information gathered from Manchester Foundation Trust and from Quality Improvement managers who undertake performance reviews and sit on acute boards. The plan has been presented to representatives of the VCSE via the Health and Wellbeing Board. A process for the development of the plan was put in place for 2021 in which finance colleagues from the CCG and MCC agreed on the funding allocation for BCF activity along with the reporting arrangements. Meetings have taken place with colleagues from the MLCO, Provider Quality, Improvement and Reform and Business intelligence to develop the approach.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

Key priorities for the BCF plan are:

1. Ensuring that there are effective discharge pathways in place to allow people to leave hospital as soon as possible.
2. To deliver effective crisis response activities in place to prevent admissions
3. Ensure there is sufficient reablement provision to maximise the amount of people who are able to remain at home 91 days after leaving hospital
4. To ensure there is sufficient residential care and nursing care to meet the needs of the cohort

Plan involves working with North West Ambulance Service (NWAS) to have crisis responses that minimise the number of people who need to enter hospital. When NWAS workers receive a call an assessment can be made of the level of support that is needed. The crisis team are embedded within the City and include a nurse, a therapist and practitioner who can also call upon additional help to support people to stay at home. For patients who are supported to stay at home they also receive a reablement response with 72 hours which provides a long term approach to help them stay at home.

For people who do enter hospital, MLCO colleagues work closely with hospital discharge teams to ensure that they are able to be discharged once they are medically fit to do so. There are 4 pathways in place to support the discharge process:

Pathway 0 – Discharge home with no further care needs

Pathway 1 – Discharge home with care needs

Pathway 2 – Discharge to intermediate care

Pathway 3 – Discharge to Residential or nursing care.

Although currently not formally part of the BCF pooled budget, the discharge arrangements out of hospital in to pathway three have been significantly invested in since the previous BCF plan, in particular in response to the pandemic. Manchester are working on how on consolidate plans post HDP funding cessation – with proposals on continuation of blocked booking arrangements and risk share with the local authority on costs.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Governance of the BCF plan has been approved by the Health and Wellbeing Board.

The Discharge process and the delivery of all community activities have been approved by the MCLO Reform, Recovery and Portfolio Board which also has representation from Manchester Health and Care Commissioning.

The overall approach is supported by a crisis team who help to minimise the amount of people who need to attend hospital. For those who do need to be discharged from hospital there is an acceptance that many people may need significant support on leaving hospital. This is done in several ways including having Extracare provision which allows for intermediate support to be offered to people who are not fully capable of a return home following their stay in hospital. The provision is 25 short stay beds which is helping to get people out of hospital as soon as possible. With a further 5 Extracare beds becoming available for 2022/23 there will be further opportunities to support people to leave hospital in a timely manner.

Sufficient provision has also been procured with residential and nursing care to allow the system to maximise the speed of patient discharge. Additional support is also provided to care homes to ensure that people are reviewed within 4-6 weeks to ensure that they are moved to appropriate long term provision.

Overall system governance is also provided by review panels of experts and practitioners who ensure that when service users circumstances change that they are provided with the most appropriate provision for their needs.

The Health and Wellbeing Board sits every month and is able to ensure that there is fidelity within the system.

The Manchester Partnership Board is also in place including stakeholders from health, social care, Manchester City Council and the Voluntary and Community sector, working together to set Manchester's priorities and strategy.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Health, social care and housing all have the priorities to support being able to remain at home or their normal place of residence for as long as possible. This is supported through crisis response activity which involves collaborative working between NWAS and social care to ensure that people are given the appropriate support to stay at home with support where their condition does not warrant attendance at hospital.

Reducing long length of stay is a joint priority. This involves community services working closely with hospital discharge teams to ensure that patients can be discharged as soon as they are medically fit to do so.

As a system four discharge pathways have been agreed, which ensure that when discharged patients are given access to the appropriate level of care for their needs. One of the overarching areas of support to help keep people at home is the reablement programme. The reablement team provide support to patients to cope with or manage their condition. The team are also able to work closely with adult social care colleagues to provide additional support if needed.

Reablement support is highly effective in Manchester. In 2019/20, 82% of people who were discharged from hospital with a reablement package (not including intermediate care) were still at home 90 days after discharge. Where patients are not able to return home straight away Short term neighbourhood apartments provide a viable short term solution to help support patient rehabilitation. Due to the success of the reablement programme it is believed that 85% of people discharged from hospital with reablement in 2021/22 will be able to remain at home 90 days after discharge.

There are currently 25 neighbourhood apartments, with 130 people benefiting from the provision since 2019/20, only 4% of which returned to hospital following their stay in the neighbourhood. 25% were able to return to their original home and 31% moved into long term Extracare provision. These neighbourhood apartments also provide step down provision from residential care. The neighbourhood apartments are also located in places which allow the provision to align with the Integrated Neighbourhood teams offer.

The main changes to the system for 2021/22 are discharge pathways and the increase in neighbourhood apartments.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The processes that are in place to support safe, timely and effective discharge include having appropriate pathways and support in place. The BCF plan for Manchester aims to continue to build on the processes that were put in place during the pandemic by facilitating a reduction in long length of stay in 2021/22. Data analysed for 2021/22 so far suggests that over 96% of people who are discharged from hospital will be able to be discharged to the normal place of residence and is expected to continue for the rest for 2021/22.

Community discharge to assess teams including reablement teams (focusing on pathway 1) help to support the discharge process including making sure that patients receive the support that they need once released. Over 80% of people who have been discharged from hospital with a reablement package are still at home 90 days after being discharged.

On discharge from hospital patients current care needs will be checked to make sure that they are still appropriate and if not their care needs will be reviewed and alternative support put in place. The availability of neighbourhood apartments to provide a short term opportunity for patients to be rehabilitated to a level where they are able to return home also ensures an effective discharge which minimises the likelihood of the patient needing to return to hospital.

For those patients on pathway 3, in response to the pandemic a dedicated team was established to facilitate timely discharge from hospital. This team is part of the community service offering, and is fully integrated between health and social care – with all placements being made by one dedicated 'control room'. To ensure consistency of service and availability of beds Manchester had adopted a block booking approach – creating dedicated discharge to assess beds. Evidence to date has shown that patients discharged in to one of these dedicated beds is likely to receive all assessments required on a much more timely basis, and also more likely to be discharged home than those who have gone to a 'spot purchase' bed. Manchester is currently exploring the potential to invest in expanding the block booking approach, and investing post hospital discharge programme (HDP) funding expiry. It is noted that Manchester currently does not flow HDP funding through its BCF agreement, but it remains a key part of the discharge strategy.

There is also a role for integrated neighbourhood teams (INTs) who operate across 12 neighbourhoods to support the delivery of care. The teams support a joint approach to delivering care. The INTs work closely with GPs as the main point of access to care, as well as connecting with MLCO and wider health and wellbeing services. The INTs also work with other partners in the neighbourhood including Manchester City Council neighbourhood teams, local housing associations, police and VCS organisations to deliver the best possible care for service users.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Manchester Care and Repair have in house equipment and an adaptation service which ensures that patients are able to receive the adaptions they need quickly to return home.

The Manchester Equipment and Adaptions Partnership (MEAP) has occupational therapists who support disabled residents with equipment and adaptations for their home, or by rehousing them in a more suitable property.

There have been issues when people need an Occupational Therapists as there is a national shortage of therapists, but generally adult social care is able to arrange the appropriate care needs for service users including any adaptions, with social workers able to make rapid decisions to support services users to receive the adaptions that they need.

As part of the assessment of need, a Disabled Facilities Grant will be applied for and used where appropriate to make sure that housing can be fully adapted for the needs of the individual to allow them to continue to live in their own home,

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Community services has a multi diverse workforce which is able to provide support to service users in several different languages. Staff also have access to translation services including phone translation to support people for whom English is not their first language.

By linking in with local neighbourhood teams, engagement activities are undertaken to understand the needs of different communities. The assessment and support process that is in place mean that support is tailored to the needs of the individual including any of their long term health conditions.

An assessment is being taken to ensure that there is equity within service delivery. This is involving a review of the outcomes of acute activity by ethnicity. Disparity in outcomes will then help to identify whether additional support needs to be put in place to support specific groups.

Where patients are released from hospital consideration is made of patient's protected characteristics in order to make sure that the most appropriate care can be provided to service users.

An addressing inequalities action plan has been developed by MHCC to look at how actions to reduce inequalities can be evidenced. As part of this, effort is being made to ensure that there is a systematic review of Equal Impact Assessments to ensure that all programmes fully take the needs of the protected characteristics of service users. The plan is also about ensuring that there is sufficient data to analyse the impact of services on people based on different protected characteristics.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Manchester
Completed by:	Owen Boxx
E-mail:	[redacted]
Contact number:	[redacted]

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Population Health and Wellbeing
Name:	David Regan

Has this plan been signed off by the HWB at the time of submission?	Yes
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (where applicable)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Bev	Craig	cllr.bev.craig@manchester.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Ian	Williamson	[redacted]
	Additional Clinical Commissioning Group(s) Accountable Officers	Mr	Ed	Dyson	[redacted]
	Local Authority Chief Executive	Ms	Joanne	Roney	j.roney@manchester.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Bernie	Enright	bernadette.enright@manchester.gov.uk
	Better Care Fund Lead Official	Mr	David	Regan	d.regan@manchester.gov.uk
	LA Section 151 Officer	Ms	Carol	Culley	carol.culley@manchester.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Manchester

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,482,757	£8,482,757	£0
Minimum CCG Contribution	£47,264,693	£17,103,241	£30,161,452
iBCF	£30,815,774	£30,815,774	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£86,563,224**	**£56,401,772**	**£30,161,452**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£13,431,286
Planned spend	£0 Planned spend is less than the minimum require

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,103,241
Planned spend	£17,103,241

Scheme Types

Assistive Technologies and Equipment	£418,959	(0.7%)
Care Act Implementation Related Duties	£2,002,751	(3.6%)
Carers Services	£0	(0.0%)
Community Based Schemes	£0	(0.0%)
DFG Related Schemes	£8,482,757	(15.0%)
Enablers for Integration	£28,149,724	(49.9%)
High Impact Change Model for Managing Transfer of	£365,000	(0.6%)
Home Care or Domiciliary Care	£3,410,731	(6.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£6,410,595	(11.4%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£1,879,872	(3.3%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£0	(0.0%)
Residential Placements	£5,281,383	(9.4%)
Other	£0	(0.0%)
Total	**£56,401,772**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	739.4	720.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	1.4%	1.3%
	LOS 21+	1.8%	1.7%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	96.2%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	760	1,908

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Manchester

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Manchester	£8,482,757
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£8,482,757**

iBCF Contribution	Contribution
Manchester	£30,815,774
Total iBCF Contribution	**£30,815,774**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Manchester CCG	£47,264,693
Total Minimum CCG Contribution	**£47,264,693**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£47,264,693**	

	2021-22
Total BCF Pooled Budget	**£86,563,224**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Manchester

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£8,482,757	£8,482,757	£0
Minimum CCG Contribution	£47,264,693	£17,103,241	£30,161,452
iBCF	£30,815,774	£30,815,774	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£86,563,224**	**£56,401,772**	**£30,161,452**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend	
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£13,431,286	£0	£13,431,286	Planned spend is less than the minimum required spend
Adult Social Care services spend from the minimum CCG allocations	£17,103,241	£17,103,241	£0	

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

One or more National Conditionals are not met (see second table at top of this sheet)

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	DFG	The DFG is a means-tested capital grant to help meet the costs of	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£8,482,757	Existing
2	Improved Better Care Fund	Address pressures on Adult Social Care budgets - It is well	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	iBCF	£28,149,724	Existing
3	Winter Pressures Grant	Additional social care posts to provide social care capacity for	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	iBCF	£2,196,050	Existing
4	Winter Pressures Grant	Additional funding to support increase in home care packages	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£105,000	Existing
5	Winter Pressures Grant	Additional social care posts to provide social care capacity for	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	iBCF	£365,000	Existing
6	Care Act	Funding to cover changes in the legislation relating to eligibility,	Care Act Implementation Related Duties	Other	Safeguarding, financial assessments,	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,002,751	Existing
7	Social Care	Protection of ASC: variety of spend such as social workers,	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,250,113	Existing

8	Social Care	Protection of ASC: variety of spend such as social workers,	Residential Placements	Nursing home		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,481,000	Existing
9	Social Care	Protection of ASC: variety of spend such as social workers,	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£118,959	Existing
10	Social Care	Protection of ASC: variety of spend such as social workers,	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum CCG Contribution	£300,000	Existing
11	Social Care	Protection of ASC: variety of spend such as social workers,	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,879,872	Existing
12	Social Care	Protection of ASC: variety of spend such as social workers,	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,191,055	Existing
13	Social Care	Protection of ASC: variety of spend such as social workers,	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,447,731	Existing
14	Social Care	Protection of ASC: variety of spend such as social workers,	Residential Placements	Other	Supported Accommodation, Day Care, Adult	Social Care		LA			Local Authority	Minimum CCG Contribution	£550,270	Existing
15	Social Care DTOC	Funding will be used to support existing services or transformation	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,023,490	Existing
16	Social Care - Extra Care	Support for the extension of extra care, to enable people to	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£858,000	New

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Manchester

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		739.4	720.0	Total admissions for 2020/21 - 4088. Population 552858. The crisis response team is embedded across the city. Team includes a nurse, therapist and practitioner who can then call out team to support the person to stay at home. They will then contact reablement within 72 hours to ensure that a full package of care can be put in

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	1.4%	1.3%	Q1 21-22 14 day admissions 725 21 day admissions 903 Total admissions 51293
	Proportion of inpatients resident for 21 days or more	1.8%	1.7%	Q2 21-22 14 day admissions 21 day admissions Total admissions

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.2%	2020/21 Normal place of residence 162996, Population 169484. There are 25 short stay neighbourhood apartments to help people to leave hospital quicker. This allows people to transitition to their own home or into other accommodation including Extracare or residential

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by	Annual Rate	784	809	760	1,908	D2A model pilot has reduced the rates of permanent Residential and Nursing home placements as more

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing

people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Numerator	405	416	392	1,000	people are going home. People who are being discharged into residential care are still assessed and will be stepped down to more appropriate provision if their conditionn approves.	**homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Denominator	51,631	51,441	51,557	52,417		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	61.1%	85.0%	20/21 rate was 63.47% (note includes intermediate care as per the ASCOF 2B definition). For 19/20 the number of people who were at home 90 days after being discharged under a reablement package was over 82%. The lower figure for 18/20 will also reflect the amount of people who are discharged to intermediate care. Going	**Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	824	299	850		
	Denominator	1,030	489	1,000		

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Health and Wellbeing Board

Minutes of the meeting held on 1 September 2021

Present:
Councillor Leese, Leader of the Council – In the Chair
Councillor Midgley, Executive Member for Adults Health and Wellbeing
David Regan, Director of Public Health
Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust
Dr Geeta Wadhwa, GP Member (South) Manchester Health and Care Commissioning
Bernadette Enright, Director of Adult Social Services
Paul Marshall, Strategic Director of Children's Services
Dr Murugesan Raja, Manchester GP Forum
Vicky Szulist, Chair, Healthwatch
Dr Doug Jeffrey, (South) Primary Care Manchester Partnership
Dr Ruth Bromley, Chair Manchester Health and Care Commissioning
Dr Shabbir Ahmad, Manchester GP Forum

Apologies:
Councillor Craig, Deputy Leader of the Council
Councillor Bridges, Executive Member for Children and Schools Services
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Dr Denis Colligan, GP Member (North) Manchester Health and Care Commissioning
Dr Tracey Vell, Primary Care representative - Local Medical Committee
Katy Calvin-Thomas, Manchester Local Care Organisation
Dr Manisha Kumar, Medical Director, MHCC

Also in attendance:
Helen Ibbott, Manchester Local Care Organisation
Kate Proven, Quality Lead, MHCC
Sarah Perkins, Director of Operations, MHCC
James Binks, Director of Policy, Performance and Reform, MCC
Julie Taylor, Director of Strategy, MHCC

HWB/21/19 Minutes

The minutes of the meeting held on 7 July 2021 were submitted for approval.

Decision

To agree as a correct record, the minutes of the meeting of the Health and Wellbeing Board held on 7 July 2021.

HWB/21/20 Public Health Annual Report

The Director of Public Health submitted a report containing the Public Health Annual Report. The Director of Public Health is required to produce an Annual Report on the health of the local population. The Board was informed that the report provides a legacy for future years and documents the City's co-ordinated response to Covid-19 and includes personal reflections of the Public Health Team and partner agencies

represented on the Health and Wellbeing Board. The report also provides a timeline on events since the start of the pandemic and the work undertaken to respond and plan public health provision at a very challenging time. The report referred to the expected continuance of the pandemic and included a recovery phase programme.

The Chair invited questions and comments from Members of the Board.

In welcoming the report Councillor Midgley acknowledged the record of the hard work that has taken place and the decisions that were made during that period that had protected people and saved lives. Thanks were given to everyone involved for ongoing work in tackling covid.

Members of the Board thanked the Director of Public Health for his work, leadership and dedication during the past year as well as paying tribute to all those involved.

In noting the report, the Chair paid tribute to those involved in working to address the pandemic, in particular the leadership shown and the collaboration of agencies across the health and care sectors was recognised. The close working arrangements during this time demonstrated what is possible and gave a vision of what will be achieved moving forward.

Decision

To note the report submitted.

HWB/21/21 COVID-19 Update and the 12 Point Plan

The Director of Public Health and the Medical Director, Manchester Health and Care Commissioning submitted a report presenting an update on Covid 19 and details of the 12 Point Plan.

Following on from Manchester's designation as an 'enhanced response area' that ended on 26 July 2021, Manchester has continued to implement the local enhanced response area action plan throughout August. The Board was informed that it is likely that Manchester and other areas with enduring higher transmission rates will be invited to be part of a longer-term national programme up to April 2022. In anticipation of this the Manchester COVID-19 12 Point Plan has been refreshed and a copy was submitted.

The Director of Public Health provided an update on the 12 Point Plan with the latest data, local and national infection rates, current intelligence and the update on the Citywide Vaccination Programme including the Winter Phase 3 Plans.

The Twelve Point Action Plan will focus on the following aims:

1. Support early years, schools and colleges to remain open and operate as safely as possible, using effective infection control measures, testing, management of outbreaks and vaccination where appropriate. Ensure universities and other higher education settings remain open and operate as safely as possible using effective infection control measures, testing,

management of outbreaks in campuses and student accommodation and vaccination where appropriate.

2. Protect the city's most vulnerable residents by reducing and minimising outbreaks in care homes and other high risk residential settings, including prisons.
3. Support workplaces and businesses to operate as safely as possible, using compliance measures and enforcement powers where necessary. Support work to keep our border safe at Manchester Airport.
4. Facilitate the recovery of the city by supporting the shift from regulatory to voluntary guidance for events, leisure and religious celebrations.
5. Ensure the needs of people and communities that are high risk, clinically vulnerable or marginalised are prioritised and addressed within the broader COVID response.
6. Co-ordinate communications activity to enable Manchester residents to live safely with COVID and make informed decisions, including around vaccination.
7. Deliver targeted community engagement that supports wider aims and objectives, ensuring that appropriate and culturally sensitive approaches are taken.
8. Ensure that decisions in respect of the direct response to COVID-19 and the wider recovery programme are informed consistently by high quality data and intelligence.
9. Continue to deliver the community testing model, with a focus on testing becoming part of 'living with COVID' and on underrepresented and disproportionately impacted Groups.
10. Identify local cases of COVID early and provide a rapid response though effective contact tracing and outbreak management.
11. Ensure residents comply with any legal instruction to self-isolate and have the support to enable them to do so.
12. Work with the NHS locally to drive up vaccination rates among those groups with lower uptake, ensure second vaccinations are administered and support the roll out of booster vaccinations.

Reference was made to arrangements for the return of schools and university students and the contingency plans in place to address increases in infection and the offer of PCR testing to students to help prevent the need for isolation. Work would be ongoing at Manchester Airport with the Border Force for safety checking and quarantine arrangements. Thanks were given for the response from Manchester to help with the Afghan resettlement programme.

The work on events and planning in Manchester, in particular the Manchester Pride festival, had provided important data on the vaccination status of the 40,000 attendees at the event. The rates would be monitored, however the analysis so far had indicated the event to have been well managed.

The Director of Public reported that it was anticipated that the Joint Committee on Vaccination and Immunisation (JCVI) would make a decision on the vaccination of 12-16 year-olds and a booster programme in the near future. A plan would be required for close working with the Local Care Organisation and school nurses. It was reported that this would be a continuing challenge to meet demand with the

resources available. It was yet not clear where the priority would be on based levels of vulnerability, age group or frontline worker cohorts. It was reported that once a decision on priority groups is made it will inform the winter planning process.

The Chair invited questions and comments from Members of the Board.

Dr Bromley welcomed the presentation and noted that a lot of work is being undertaken across the city in preparation for the reopening of schools throughout the summer period. Reference was made to the physical and mental wellbeing of colleagues across all sectors as work on the recovery of the city progresses and importance to be mindful of individuals health.

Helen Ibbot thanked the Director Public Health for the framework the report provided and gave an outline of the work of the LCO moving forward. The board was informed that the LCO would concentrate on work within community services /voluntary sector to engage with communities. The guidance on the 12-16 year old age group was yet to be received, although it was recognised that work was required on the a short term response on immunisation. The importance of the continued work within care homes was also highlighted.

The Chair referred to media reports on the Delta Variant within India that suggested the infection rates of the variant had started to recede and asked the Director of Public Health to respond.

The Director of Public Health reported that there was a view that the Delta Variant may have started the recede in some countries and areas, but the Delta Variant had continued to be prevalent in others. The pandemic was not ending and modelling scenarios were being produced in preparation for the winter period.

The Chair referred to the return of students to the city and the approach being taken to provide a second vaccination to those who have received a first dose.

The meeting was informed that the vaccination would be made available across the city at various locations including pop up clinics and this would be actively promoted towards students.

Dr Jeffrey referred to the level of infection across Greater Manchester and asked if there was belief that there may be a degree of herd immunity taking place.

The Director of Public Health reported that the levels of infection in areas such as Bolton and Blackburn had indicated a levelling out, however it would be difficult to state with a level accuracy on there being herd immunity within sections of the population. This would be an issue for the Chief Medical Officer to provide a statement on.

The Chair commented on the movement of the covid infection across the city which now appeared be not be located in a middle band of wards across the centre of the city and is now moving in all areas. Reference was also made to contain and recover phase and the move towards the process of normalisation, although it was not clear yet how long this may take. With reference to the infection rates in school pupil and

teenagers, it is noted that although teenager infection rates had reduced it is still the highest rate in the city and this may be due to socialisation during the summer which could be repeated following a return to study during the autumn.

The Chair referred to the work of the Manchester partnership agencies for the reception provided for the arrival of Afghan asylum at Manchester Airport. The Chair thanked those involved for their work during this time to provide help and support to those people arriving in the UK under very difficult circumstances. The City of Manchester would work provide permanent accommodation to some of the families after a temporary period of quarantine and placement. The point was made that a large proportion of the Afghans speak English and have high levels of skills that will help them to work and contribute to society, once the Government has put arrangements in place.

Decisions

1. The Board endorsed the refreshed 12 Point Plan.

2. The Board noted the presentation.

HWB/21/22 Health and Social Care Recovery

The Board received a report from Dr Bromley, Chair, Manchester Health and Care Commissioning (MHCC). Dr Bromley introduced the report that provided updates on the current recovery of health and social care services as part of the system's response to the COVID-19 (Covid) pandemic, with a specific focus on Manchester University NHS Foundation Trust (MFT). The report also provided a description of the broader strategic recovery plans of the health and social care system. The Board noted that the MFT continues to experience operational pressures, as a result of the national pandemic that is impacting on delivery of NHS constitutional targets. Safety is being prioritised across emergency, urgent and elective pathways and system-wide improvement programmes are in place to support recovery. It is envisaged that progress will be made in reducing elective backlogs over the coming months, however this will be incremental and in the context of wider pressures. Demand for Mental Health, Community and Primary Care services has also significantly increased and out of hospital services are under equal levels of pressure. COVID-19 has had a much broader impact on the health and wellbeing on the people of Manchester. Some is evident now and some can be anticipated in the future and some may yet emerge. The development of a strategic recovery framework captures the breadth of the health and social care system's response within the recovery phase. The framework covers four themes with associated outcomes metrics. (i. the resumption of services to bring services back to their pre-pandemic levels. ii. addressing the disproportionate impact that Covid has had on some population groups, as well as addressing the long-term health inequalities that would have widened, as a result of the pandemic. iii. meeting the new needs of our population because of Covid, including physical and mental health impacts. iv. the broader contribution the health and social care sector can make to the wider City recovery).

It is important to note that there is an ongoing, significant response, to Covid as well as high levels of demand for urgent care services. There is an interdependency

between the level of demand within the system at a moment in time and implementation of recovery as it calls upon the same capacity and workforce.

The Board was addressed by officers from the agencies involved in the recovery process.

Sarah Perkins Director of Elective Recovery (MFT) addressed the Board on the work to re-engage with patients for a return to hospital services, post covid. Currently staff absence rates are between 9-10%, that presents resource issues to provide care across urgent care, paediatric care, mental health and elective services. The process of engaging patients is under a period of change from non-face to face to in-person attendance. A process of grading patients is in place to deliver care to the most urgent patients and work is ongoing to engage with those patients in lower categories of need. The Board was informed of the process for engaging patients from across different ethnic communities.

Kate Proven, Quality Lead, MHCC addressed the Board on the work of the LCO which has seen higher levels of need. Work is ongoing on the delivery of the vaccination programme, although levels of covid related sickness has impacted on service delivery, plans are in place to help and support staff members. There is a comprehensive recovery and reform work programme with eight priority areas. Work is also ongoing in the integrated neighbourhood team hubs with other support services through various programmes of support and care.

James Binks, Director Policy Performance and Reform addressed the Board on the Strategic Recovery Framework contained in Part 2 of the report. This is linked to four themes:

1. the resumption of services to bring services back to their pre-pandemic levels.
2. addressing the disproportionate impact that Covid has had on some population groups, as well as addressing the long-term health inequalities that would have widened as a result of the pandemic.
3. meeting the new needs of our population because of Covid, including physical and mental health impacts.
4. the broader contribution the health and social care sector can make to the wider City recovery.

Julie Taylor, Director of Strategy (MHCC) reported that the framework is currently under development and the focus is to find a deeper understanding of covid and how it has affected the residents of the city.

The Chair invited questions and comments from Members of the Board.

Dr Murugesan Raja welcomed the report and thanked officers for the work being done and referred to the importance of recognising staff welfare in the delivery of services and the challenge in addressing the increases in public contact being made with care services.

The Chair asked officers what within the programme is there to deal with the longer-term effects of covid and the effects on mental health which may not materialise for

some time such as young people who have lost a period of their developmental growth.

It was reported that there is a mental health services provision is available for university students. Details of other services would be provided in a later report.

Dr Bromley stated that as a GP in a high demand area of the city, there had been a shift over the past 18 months with mental health presentations taking up approximately 90% of work overall. This has included adolescents and younger children. GP's have been able to provide help and referrals to secondary services.

Dr Wadhwa referred to staff wellbeing and the impact on staff health as a result of negative reporting within the media and an increase in levels of abuse towards staff members.

The Chair commented that demand management and preventative approaches is important as part of a whole system care approach to providing early preventative treatment. The Chair acknowledged the importance of data collection to improve the provision of services to address health inequalities within sectors such as the acute services. Reference was also made to the subject of work force and work-load and the responses received through the GM Community covering health services. It was noted that staff shortages in some areas of services were noticeable and others were struggling to meet high levels of demand. Other primary care services were not as visible and the point raised on abuse towards staff due potentially in part to the frustration of patients is not an acceptable reason. It was important to provide a clear picture of the level of pressure the whole health care system is currently operating within and the plans required to ensure that services work differently to get through the challenges of the winter period. In noting the level of challenge this presented the health service, the Chair offered the support of the Health and Wellbeing Board where possible.

Dr Jeffreys thanked the Chair for the support offered and suggested that the opportunity presented itself to blur boundaries between hospital and primary care/community services which appear to oppose to each other. The position has started to change, and it was important for each side to learn to trust the other. This could be developed further through the sharing of IT systems and closer working for hospitals to understand what community services can offer to patients to take care away from the hospital and into the community.

The Chair noted the comments and referred to the Manchester Partnership Board where work had taken place on the discharge of patients with respiratory diseases to receive care in the community. The joint working approach of the LCO during the peak period of the pandemic had proved to be invaluable in keeping hospitals functioning. The interdependency that was highlighted will provide a way forward for a better and more efficient form of working.

Decision

The report was noted.

HWB/21/23 Work Programme

Decision

The Work Programme was received,

Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 3 November 2021

Subject: Winter Planning: COVID-19 and Flu

Report of: Director of Public Health
Medical Director, Manchester Health and Care Commissioning

Summary

The attached slideset describes the planned approach to delivering both the COVID-19 and flu vaccination programmes over the coming months. These programmes sit alongside the winter plans of local NHS Trusts and Adult Social Care and the overarching national Autumn/Winter Plan. An additional update on the latest data and intelligence will be provided at the Board meeting.

Recommendations

The Board is asked to note the report.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The Winter Plans of all organisations represented on the Board relate to most of the priority areas, especially the one health and care system and self-care priorities.
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning around the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

Contact Officers:

Name: David Regan
Position: Director of Public Health
E-mail: david.regan@manchester.gov.uk

Name: Dr Manisha Kumar
Position: Medical Director, Manchester Health and Care Commissioning
Email: manisha.kumar1@nhs.net

Name: Jenny Osborne
Position: Strategic Lead, Population Health Programmes
Email: jenny.osborne4@nhs.net

Background documents (available for public inspection): None

Winter Vaccination Programme Health & Wellbeing Board 3rd November 2021

Dr Manisha Kumar ,Medical Director
Manchester Health & Care Commissioning

Performance Summary

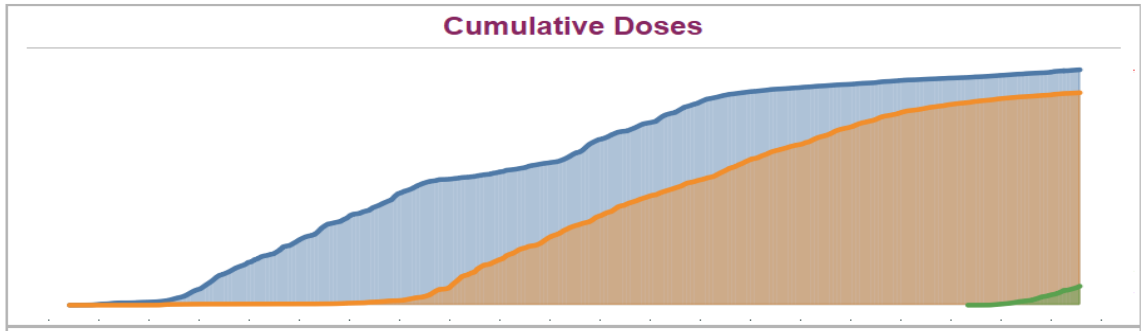
Manchester Health & Care Commissioning
Business Intelligence Team

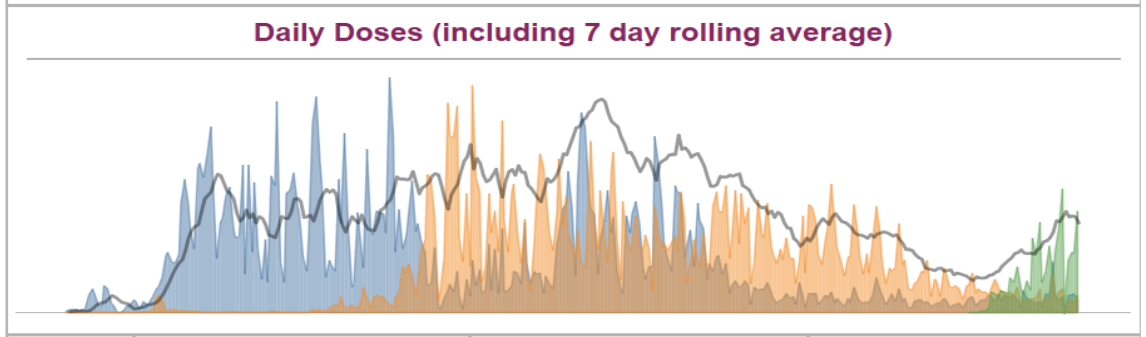
COVID Vaccination Coverage as of 21 October 2021

Data Source: National Immunisation Management System (NIMS)

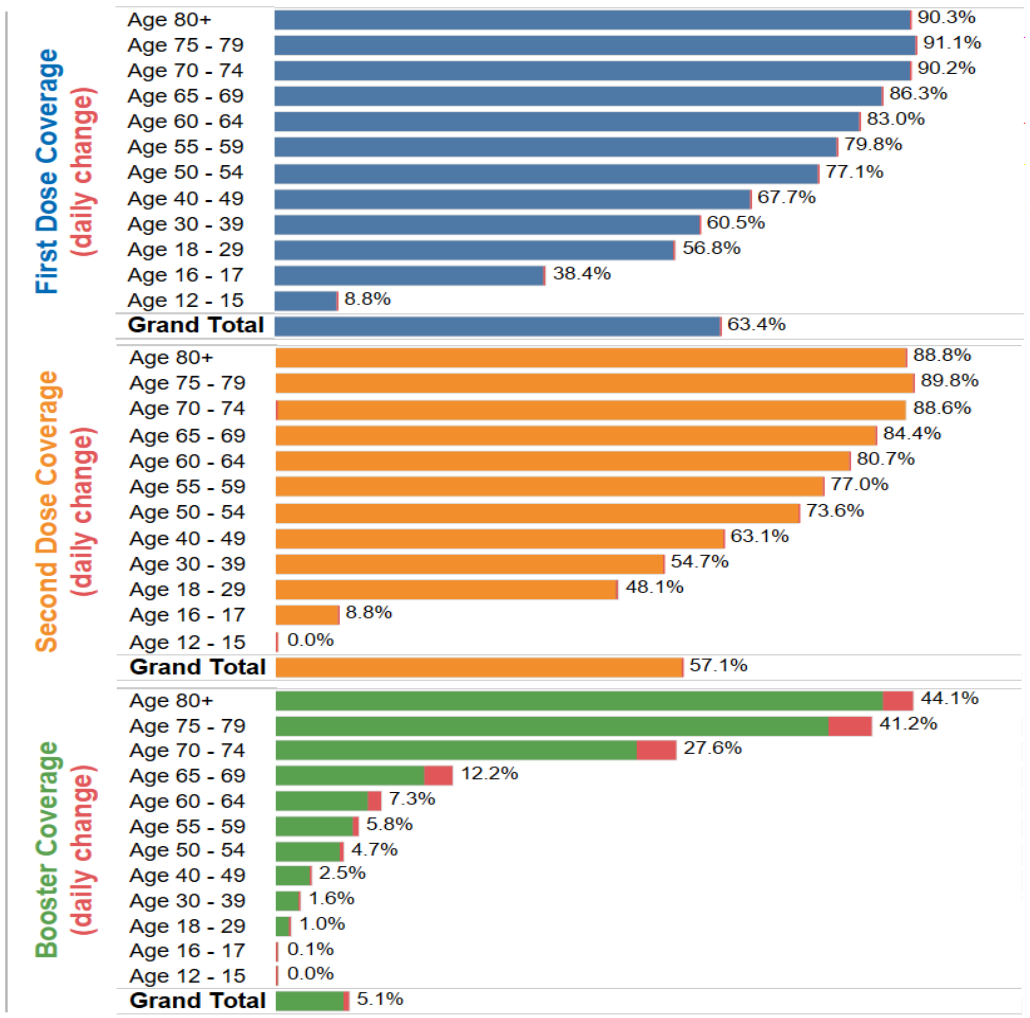
For patients registered with a Manchester GP Practice:

375,158 patients given their first dose	Δ	302
338,587 patients given their second dose	Δ	412
30,195 patients given their booster dose	Δ	2,394



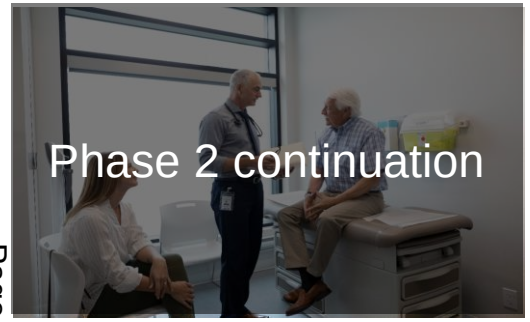


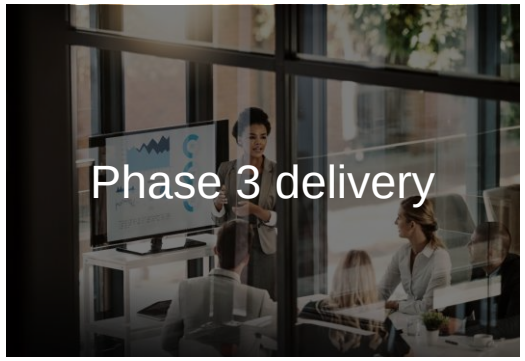
Dose	Coverage for Age 18+ (daily change)	Coverage for Age 16+ (daily change)	Coverage for Age 12+ (daily change)
First	67.5% (0.02%)	66.7% (0.03%)	63.4% (0.03%)
Second	62.1% (0.05%)	60.6% (0.06%)	57.1% (0.06%)
Booster	5.55% (0.44%)	5.40% (0.43%)	5.09% (0.40%)



Winter Vaccination Programme timelines

The timeline below shows the continuation of programmes from Phase 2 and the additional programmes included in Phase 3 - Winter Vaccination Programme.





September	October	November	December	2022
Extended Vaccination Offer (EVO) for JCVI cohorts 1-12 >				
16-17 year olds >				
12-15 year olds that are Clinically Extremely Vulnerable >				
Care home staff 2nd dose 11th ^				
Inequalities - e.g. pregnant women, asylum seekers, homeless >				
13th Flu programme				
13th Immunosuppressed 3rd dose >				
22nd All 12-15 year olds 29th*		All 12-15 yrs complementary offer >		
22nd Booster programme >				

^ Deadline for all 2nd doses to be delivered
** Deadline for all school visits to have taken place*

Manchester's Citywide Vaccination Delivery Model: A **single system approach** focused on 'place' and 'person'

8 Covid Vaccination Sites
Run by 14 Primary Care Networks including bespoke clinics

Flu Vaccination to eligible patients at all GP Practices in the city

15 Covid Vaccination Community Pharmacy sites

Flu Vaccination at citywide Community Pharmacies

Mass Vaccination Centre, Etihad Campus

Aiming to offer Flu in November

3 Hospital Hubs
Manchester Foundation Trust
Manchester Local Care Organisation

Flu & Covid – mixed delivery model

Evening

Weekend

Prebook

Walk in

Frontline health & care staff
School Covid Vaccinations
Pregnant women
Specific patient groups
Surge capacity

GP Practice 'Back to Practice' & Walk In Offers

Mobile offer to Care Homes, Housebound, & Wider Care Settings

Roving Model
Pop Up Clinics
Mobile Vans

In/Out of School offer for Covid Vaccination

This describes the delivery pathways for the 12-15 offer. The primary offer remains through School Aged Immunisation Services delivered in schools with an expanded out-of-schools offer being provided by existing delivery channels to ensure equity and accessibility.

School Aged Immunisation Service led school visits to all schools across GM to ensure the 100% offer

School Aged Immunisation Service led catch up for all immunisations (supplementary offer)

Out-of-school offer for all immunisations (complementary offer commissioned centrally)

Hospital Hubs

Mass Vaccination Centre
Etihad Tennis Centre

PCN-led sites
The Jain
The Vallance

Community Pharmacy Sites
Whalley Range Cricket Club
Everest Pharmacy (Whalley Range)
MMC Pharmacy (Cheetham)

Access is via the National Booking System – PCN sites can vaccinate opportunistically

Integration of Covid and Flu Vaccination Planning & Delivery

There is a mixed delivery model for Covid and Flu vaccination across the city in 2021/2.

- 'Co-administration' – the offer of a Covid and Flu vaccination at the same time is currently limited. This is due to national complexities around which provider is able to vaccinate which person/patient and multiple funding flows.
- The key message is for people to come forward to take up the offer of either vaccination as soon as it is available.

We are integrating our approach in the following areas to ensure cohesion and co-ordination through the winter season:

- Neighbourhood Level Planning
- Vaccine Equity and Inclusion
- Communications and Engagement
- Citywide performance monitoring through Vaccination Programme structures
- We retain a Citywide and weekly flu co-ordination group remains to ensure that we do not lose our focus on Flu

Separate Flu and Covid Vaccination offer

- PCN Local Vaccination Sites are not currently offering co-administration but this may change later in the year
- Mass Vaccination Site aims to offer co-administration later in the year
- Children & Young People eligible for the Flu and Covid Vaccination will not be offered co-administration – it is delivered by different providers

Co-administration offer

- Care Home Residents and Staff
- Housebound Patients
- MFT/MLCO Health and Social Care Workforce
- Community Pharmacy sites may offering flu and Covid jabs together

Strategic Approach to Vaccine Equity

We co-ordinate activity through a Citywide Vaccine Equity Group

We use high quality data to drive our strategic and operational approaches and monitor the impact of activity

We focus on short to mid-term actions - acknowledging that the issues underpinning low coverage are long-standing and building trust with particular groups is an ongoing process

Work takes place at citywide and neighbourhood level on proactive and targeted design of vaccination service offers, supported by high quality communication & community engagement approaches

We work through Covid Health Equity Manchester & Sounding Boards and other community partners to inform our approaches and extend our reach within particular communities

We focus on increasing coverage across three broad groups in response to performance data

- **Ethnicity:** primarily Black African, Black Caribbean and South Asian
- **Disabled People:** particularly people with Learning Disability; Severe Mental Illness
- **Inclusion Groups:** Refugees & Asylum Seekers; Homeless people; sex workers, Gypsy, Roma & Traveller communities

Vaccine Equity: Spotlight on Young People

16 – 17 Year Olds - Engagement
36.9% Vaccinated (5,722), 46.6% At Risk, 33% Not At Risk

In mid September we mapped out the Colleges & Sixth Forms & Independents against our LVS sites and worked with PCN's & community pharmacy on arranging pop-up clinics where appropriate.
We held pop-up clinics at 8 sites from the end of September/early October and vaccinated over 650 pupils.

The Comms team supported this work by creating a Toolkit to share with relevant organisations including education and training settings. This included a poster/social media assets with a QR code which takes people to the MCC website with all clinics across the city listed including Walk-Ins.
A large number of NEET groups have also been contacted and sent the toolkit.

Manchester Young Lives, Skills for Life - Manchester City Council, Manchester Youth Council, Street Style Surgery, Greater Manchester Youth Network, Greater Manchester Centre for Voluntary Organisation,
Young Manchester, 4CT Get Together Club, Manchester Youth Zone, Boys & Girls Clubs of Greater Manchester, North Manchester Scout District 14-18, M13 Youth Project, The Hideaway Youth Project, Norbrook Youth Club, The Powerhouse Youth Zone

An MCC Neighbourhood Project Lead is co-ordinating focus group to look more closely at engagement. The focus will be on young people 16 – 30. They are going to start by doing some asset mapping and our toolkit will form part of this. There may also be a requirement for further pop-up's or perhaps the peripatetic offer could be utilised once up and running.

Young People: Rates Hall October Review

Total vaccinated in October so far over 1,360 (as of Monday 18th October)
September total was 1,616
August total was 1,512

Patient Feedback

- Over **300** students identified.
- People's main reasons to have the vaccine are to keep themselves and others safe and to have the freedom to do things.
- **75%** Work in the city
- **65%** aged 18 – 26
- **32%** 25 to 40
- **8.8%** stated that they wouldn't have bothered finding an alternative vaccine centre if this option wasn't available
- Targeting/reach - Social media **37%,** WOM **25.6%,** Outdoor Advertising **13%**

Next Steps

- Continuing the offer for the month of November
- Regular reviews which give us the opportunity to identify ways to improve the service
- Future pop up's planned and we will have clinics running at Owens Park in early November
- Ensure all local vaccination sites and pharmacies across the city which are listed on the MCC website.

Communications: Manchester's Winter Campaign

Challenge:

- Sheer volume of messages already circulating
- National and regional campaigns
- Challenging context – from promoting one vaccination strand (flu) last year to promoting 5 vaccination strands, lower perceived risk by the public
- Given the return to pre-pandemic social mixing levels – lower uptake levels this year would leave many groups vulnerable

Objectives:

- Raise high awareness about who is eligible and where they can get vaccinated
- Inform audiences of the dangers of flu, particularly combined with COVID-19
- Maximise the intention of take-up of both vaccines amongst eligible groups, by addressing barriers and increasing understanding of the benefits
- Generate high levels of confidence in flu and COVID-19 vaccination - most adults and children will be eligible for a flu jab, Covid-19 booster, or both

Key messages:

Flu and Covid-19 can both be life-threatening and spread more easily in winter, especially with people socialising more and when crowded together inside. Make sure you:

- Have both Covid vaccinations (it's never too late - the offer is always open);
- Have your Covid booster when called;
- And have your flu jab;
- As well as continuing with testing and wearing a mask when needed.

Manchester's Winter Campaign

Communications focus

- Simple messaging in complex times
- Social 'norming' the benefits of vaccinations
- Activity will amplify national and local messages in a targeted way
- Encouraging 'at risk' cohorts and traditionally lower uptake communities to get vaccinated through targeted engagement activity at a neighbourhood level - based on intelligence and insight

'Manchester's winter is coming' - our city's battle

- Campaign launched w/c 18 October
- Game of Thrones lookalike actor became 'Jon Snow' for the campaign – his famous line was 'Winter is coming'
- Filmed him in a variety of ways, including getting vaccinated
- Winter message from David Regan as Manchester's Director of Public Health
- Execution – full channel plan in place – inc media relations, digital screens, radio, mobile phone advertising, potentially GP surgeries, student pubs, website, social media, local publications and so on.
- Vaccination site based assets being developed too

National campaign resources will also be used for public facing messages and where appropriate, specific messaging and resources will be developed for targeted community groups in line with local engagement plans.

Winter Vaccination Programme
Flu Vaccination 2021/22
David Regan
Director of Public Health

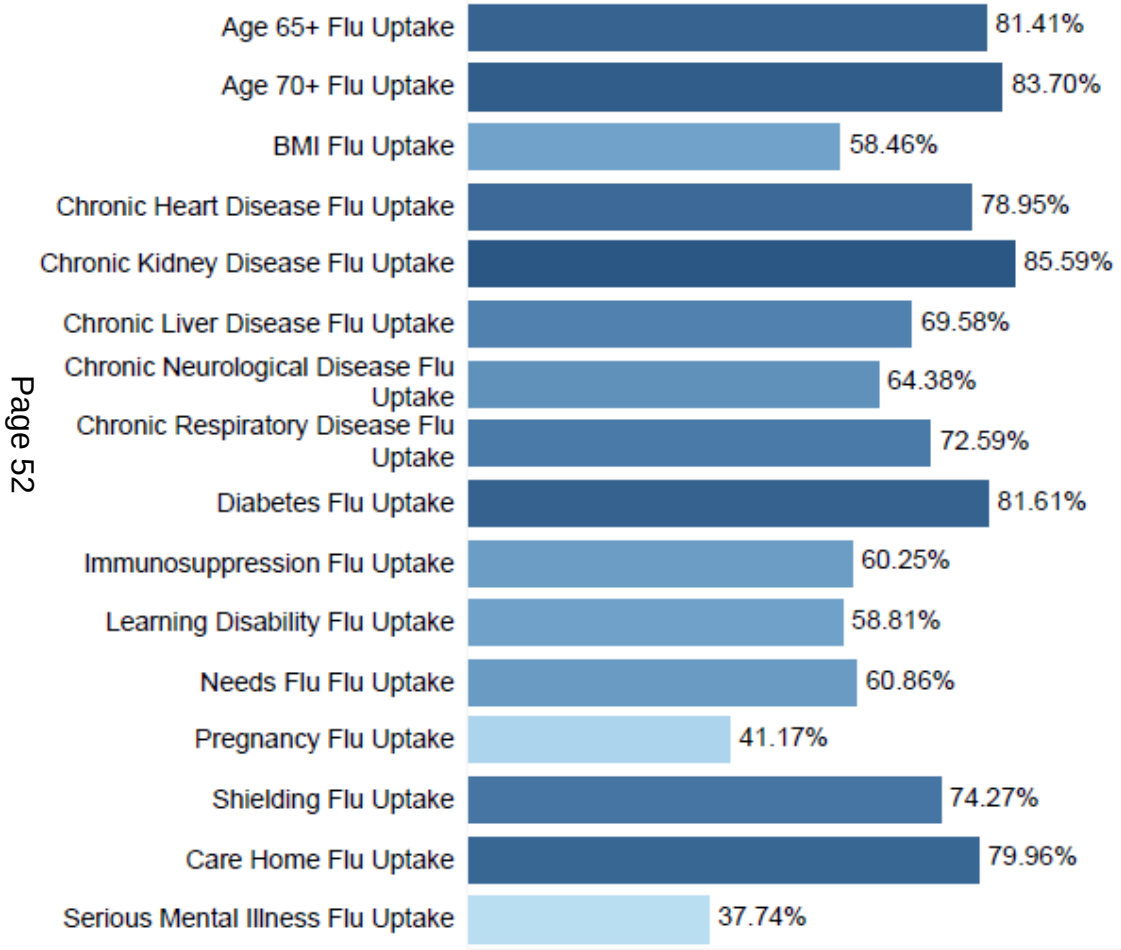
Overview

OBJECTIVES	OUTCOMES
Deliver safe and effective vaccination programmes to JVCI cohorts and to meet national targets	Protect population health and support recovery from the pandemic
Maximise vaccination coverage across the whole population, building on learning from 2020/21	Improved levels of vaccination coverage and an increase in heath equity through greater engagement and targeting of inclusion groups
Effective system coordination across all vaccination programmes and delivery partners	Partners work together to make every contact count and support system resilience
Facilitate and support the design of a sustainable vaccine delivery function	An ability to repeat vaccination programmes safely and cost effectively using mainstream resources

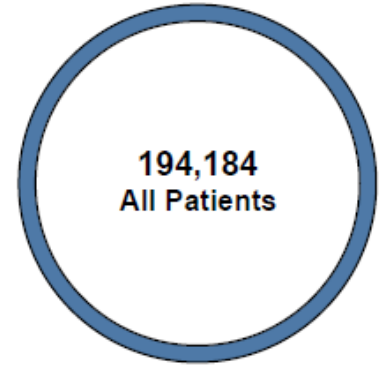
APPROACH TO THE ANNUAL FLU PROGRAMME 2021/2

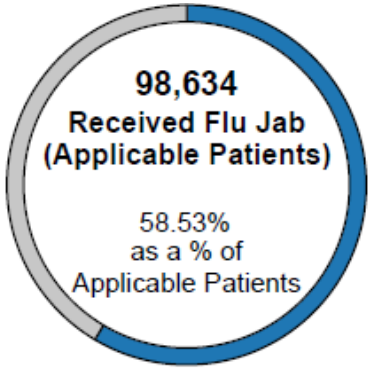
- We are taking an integrated approach to winter vaccination planning this year.
- We have system objectives and outcomes
- Citywide performance monitoring of both flu and covid vaccination programmes will take place through our Vaccination Programme structures
- This plan focuses specifically on our approach to Flu Vaccination and specific activity we will take forward to support flu vaccination coverage for our population
- A Monthly Citywide and weekly Core Flu co-ordination group remains to ensure flu focus

Manchester Flu vaccination Uptake 2020/21

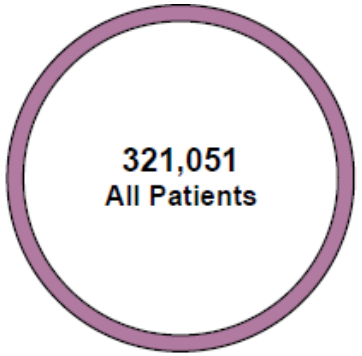


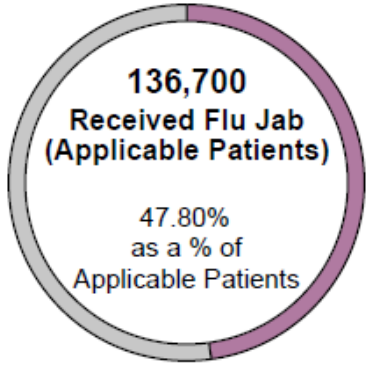
Traditional Cohorts



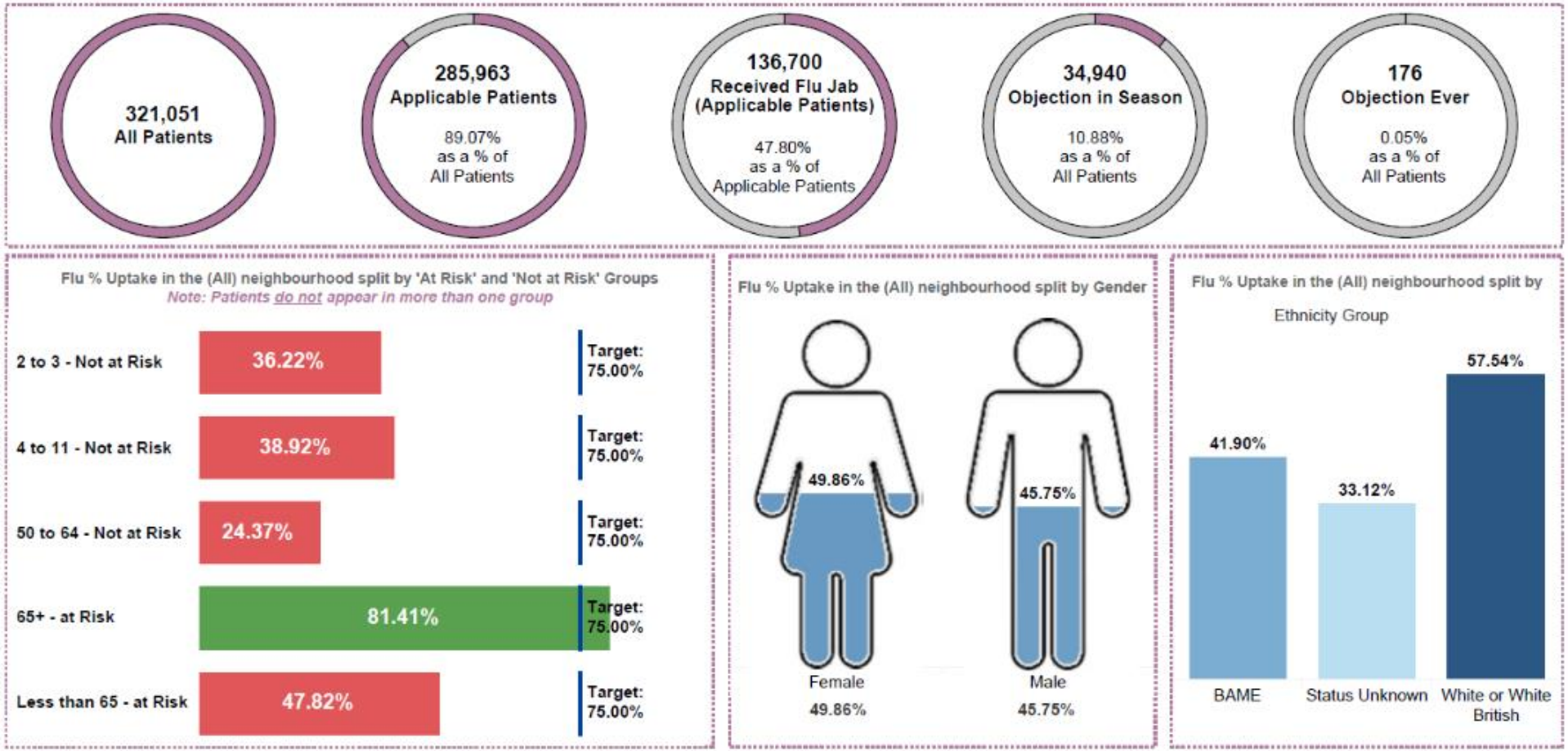


Extended Cohorts





Manchester Flu vaccination coverage 2020/21 (All Eligible Cohorts*)



*Eligibility changed in year

Eligible cohorts for Annual National Flu Programme 2021/22

Flu Vaccine Eligibility Criteria
All children aged 2 to 15 (but not 16 years or older) on 31 August 2021
Those aged 6 months to under 50 years in clinical risk groups
Pregnant woman
Those aged 50 and over
Those in long-stay residential care homes
Carers
Close contacts of immunocompromised individuals
Frontline health and social are staff employed by: • A registered residential care or nursing home • Registered domiciliary care provider • A voluntary managed hospice provider • Direct Payment/Personal Health Budgets, such as Personal Assistants

Total population in scope number = 345,613 (50.39 % of the population)

National Uptake Ambitions 2021/22

Eligible Group	National uptake ambitions
65+	85%
> 65 'at risk & pregnant women	75% + in all clinical risk groups
50-64	75%
Children aged 2 and 3 years	70%
School-age children	70%
Health & Social Care workers	100% offer with 85% ambition
Inequality	No group or community should have uptake more than 5% lower than national average

IIF Target Indicator	Thresholds	Valuation
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT) 86% (UT)	£9.0M/ 40pts
VI-02: Percentage of at-risk patients2 aged 18 to 64 years who received a seasonal influenza vaccination between 1 September and 31 March	57% (LT) 90% (UT)	£19.8m/ 88pts
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT) 82% (UT)	£3.2m/ 14pts

Flu Cohort Planning 2021/2

Children (2 & 3yrs)

Performance 2020/21

- **Coverage increased from 28.07% to 36.22% however remains lower than 75% target**
- **Wide variation across and within neighbourhoods e.g. Moss Side, Hulme & Rusholme overall coverage 17.4% (highest 45% to lowest 1%)**

Key Priorities for 2021/2

- Improve uptake across all practices and localities, reducing variation.
- Feedback regularly to individual practices and PCNs using last year's and live data for this age cohort
- Work with neighbourhood leads and practice nurses to raise community awareness particularly for this age cohort and pregnant women
- Improve access within localities offering out of hours immunisation clinics e.g. early evening and weekends for parents with practices sharing resources

Pregnant Women

Last Years Uptake

- **Coverage has reduced year on year since 2017 (41.07% in 2020/1)**

Key Priorities for 2021/2

- Opportunistic flu vaccination within practices (make every contact matter)
- Optimise the Covid vaccination offer with flu at specific venues such as Central Mosque pop-up and other planned extra clinics
- Identifying flu vaccine supplies to be available at all LVS offering Covid vaccination to pregnant women
- Provide regular feedback to practices on flu and Covid vaccination uptake in their pregnant population

School Age Children

Performance 2020/21

- **39% uptake with large variation between schools**
- **Variation between 2% and 84% uptake**

Key priorities for this year

- Earlier partnership work and sharing of booking schedule, sharing of e-consent uptake data, closer work with neighbourhood engagement & comms and regular sharing of coverage data
- Scale up of delivery in schools to allow for extended cohorts
- Majority of schools will return to paper consent after last year's feedback that e-consent was not first choice for many parents
- IM consent to be offered in conjunction with nasal vaccine to streamline process
- Joint local engagement and comms work
- Joint planning on community clinics linking to Vaccination Site location

Early Years settings for 2-3s- flu vaccine information provided to nurseries and childminder settings, that covers some commonly circulating diseases in children, raising the awareness of the flu vaccine availability and information that can be relayed to parents.

Over 65's and 50-64's

Performance 2020/21

Vaccine coverage:

- **81% over 65's (best year to date)**
- **47% under 65 at risk**
- **24% 50-64 not at risk (added December 2020)**

Key Priorities for 2021/2

- Improve uptake across all practices and localities, reducing variation
- Encourage PCNs to work collaboratively to increase uptake and maximise IIF funding.
- Provide weekly flu data update and create a forum for shared learning across PCNs and Neighbourhoods
- Weekly data review and identification of at risk cohort(s) with low uptake. Facilitate focused communications and campaigns for these cohorts.
- Promote collaboration between practices and community pharmacies to maximise uptake across the Manchester population
- Provide advise and guidance to facilitate co-administration of COVID-19 and influenza vaccination
- Early vaccination of all care home residents across Manchester.
- Ensure adequate vaccine supply across practices and PCNs and support practices to access centrally held national stocks

Flu Vaccination in Care Homes

All 83 Older Care Homes in Manchester will be visited by 1st November 2021.
Co-administration of Flu and Covid Vaccination to reduce footfall into care homes is prioritised for this group

Targeted work with Inclusion Groups

Priorities for 2021/2

Monitor coverage of people with a **Learning Disability** and work with partners to develop bespoke approaches learning from Covid vaccination experience

Monitor coverage of people with **Severe Mental Illness** and work with partners to develop approaches to drive up coverage

Work with GM commissioned services to support delivery to our **homeless** and sex worker population and people accessing **substance misuse** services

Health and Social Care Workforce

Priorities for 2021/2

Co-administration of flu and covid booster jab to care home staff to maximise coverage

Co-administration of flu and covid booster jab to MFT/MLCO staff and affiliates) via Hospital Hubs

Promote the expanded cohorts eligible for a free flu jab – domiciliary care, Direct Payment & Personal Budgets.

Track the outcome of the national consultation on mandatory vaccination of wider health and social care workers for flu in addition to Covid vaccination.

Neighbourhood Partnership Approach

Neighbourhood

- **2020-21 – Wide variations across neighbourhoods with flu vaccination uptake e.g. 47.98% in Moss side and Hulme and 67.3% in Brooklands and Northenden**
- **Mixed picture in terms of increase from the previous year 2019-2020 with some neighbourhoods seeing a decrease in uptake**

Key Priorities for 21/22

- Partnership model with PCNs in each neighbourhood to develop local plans to increase uptake
- Targeted work to increase uptake in BAME communities across neighbourhoods
- Utilise data to drive neighbourhood approach and ensure that information is shared with wider team around the neighbourhood colleagues to build offer
- Build on partnerships with VCSE to increase access to vaccine offer

Primary Care Communications

As well as the wider winter campaign we have also been ensuring practices have all of the communications materials that they need to promote vaccinations to their patients

This includes:

Answerphone message, digital assets and scripts about the vaccinations

Website copy

Social media messages

Specific flu resources include:

- Access to all patient leaflets (including community languages and Easy Read) – specific information for adults, primary, secondary and pregnant women. We have offered to facilitate the printing of relevant leaflets to practices.
- Access to relevant videos including a video about flu vaccinations in our LD population
- Text message copy to send to patients inviting them to be vaccinated
- Flu Q&A (including a specific Q&A for our Muslim communities)

Data Performance and Monitoring

Delivery and Monitoring

- Citywide performance monitoring through Vaccination Programme structures
- Monthly Citywide and weekly Core Flu co-ordination group remains to ensure flu focus
- Monitoring data available through Tableau Dashboard
- Data reviewed weekly by MHCC core flu group

Data and Intelligence

- MHCC weekly Tableau data and interactive dashboard displaying citywide, neighbourhood and practice level data enabled equalities analysis and targeted work with population and inclusion groups
- Sustain this approach which has been developed further for Covid Vaccination and work with MHCC Business Intelligence to refine dashboard for integrated approach with Covid Booster intelligence where possible

Covid and Flu Vaccination Performance Dashboards

20th October 2021

Dr Manisha Kumar

Covid-19 Vaccination: Programme Summary

66.5% have received a first dose
60.2% have received both doses

Total vaccines delivered to Manchester patients
708,538

First doses
372,509

Second doses
336,029

Manchester Health & Care Commissioning
Business Intelligence Team

JCVI Priority Cohort Summary

Data Source: EMIS, Patients Registered with a Manchester GP Practice Only

Priority Cohort		Patients	% Dose 1	% Dose 2
01: Care Home Resident Age 65+ or Care Home Worker	Care Home Resident	1,688	93.1%	89.9%
	Care Home Worker	113	91.2%	87.6%
02: Age 80 and over	Age 80 and over	14,472	88.0%	86.6%
03: Age 75 - 79	Age 75 - 79	11,037	90.8%	89.5%
04: Age 70 - 74 OR Shielding OR QCOVID	Age 70 - 74	16,326	90.1%	88.5%
	QCOVID	14,380	83.5%	78.7%
	Shielding - Age 18+	12,685	87.5%	83.8%
05: Age 65 - 69	Age 65 - 69	17,468	85.6%	83.8%
06: Higher Risk	Higher Risk	69,244	80.6%	75.4%
07: Age 60 - 64	Age 60 - 64	14,188	77.4%	75.2%
08: Age 55 - 59	Age 55 - 59	20,527	75.0%	72.5%
09: Age 50 - 54	Age 50 - 54	26,093	72.7%	69.5%
10: Age 40 - 49	Age 40 - 44	40,676	62.0%	57.2%
	Age 45 - 49	31,389	66.1%	62.0%
11: Age 30 - 39	Age 30 - 34	58,385	56.7%	50.5%
	Age 35 - 39	50,143	59.2%	53.7%
12: Age 18 - 29	Age 17 (18 in <= 3 mo..	1,844	39.8%	11.3%
	Age 18 - 29	142,385	54.7%	46.1%
13: Age 12 - 17 At Risk	Age 12 - 15 At Risk	3,090	12.1%	0.3%
	Age 16 - 17 At Risk	1,409	46.6%	21.9%
14: Age 12 - 17 No Risk	Age 16 - 17 No Risk	12,046	33.0%	4.1%
	Age 12 - 15 No Risk	30,892	6.0%	0.0%

First dose uptake JCVI Cohorts 1 – 4
72,362

First dose uptake JCVI Cohorts 5 - 9
169,609

First dose uptake Ages 18 – 49 (JCVI 10 -12)
230,612

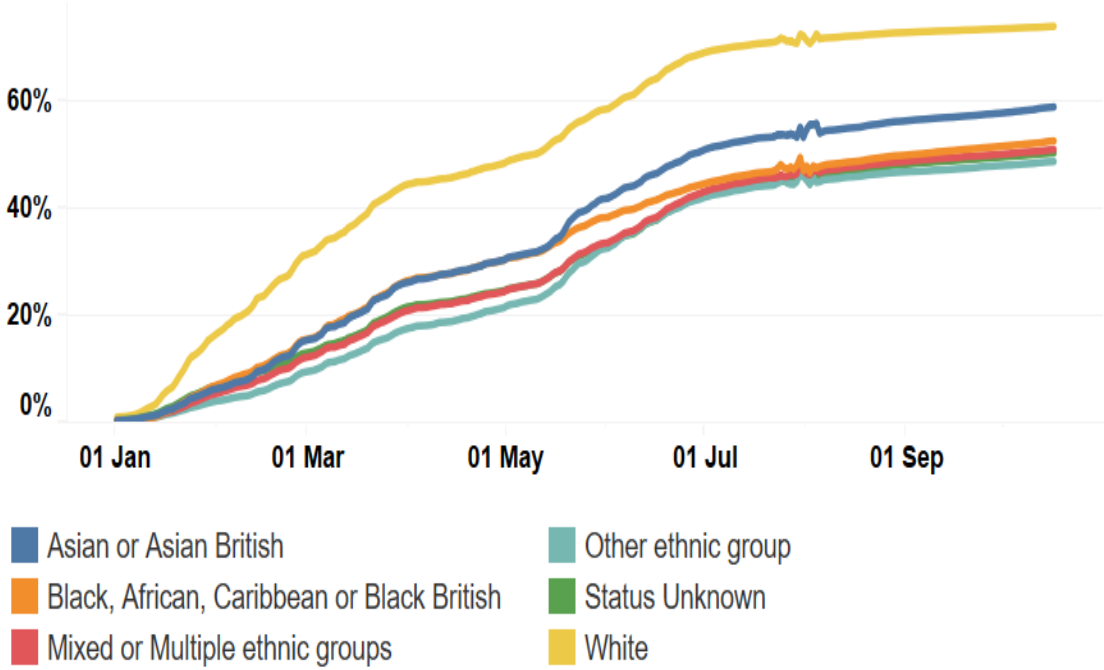
First dose uptake Ages 12 – 17 (JCVI 13 -16)
8,970

First Dose Coverage for Cohorts 1 to 14 by Ethnicity

First Dose Coverage by Ethnicity

Ethnicity		Vaccinated	Eligible	% Coverage (increase from 2 weeks ago)
White	Irish	5,527	7,377	74.9%
	English, Welsh, Scottish..	179,314	228,242	78.6%
	Any other White backgr..	19,505	40,753	47.9%
	Gypsy or Irish Traveller	70	273	25.6%
Asian or Asian British	Bangladeshi	4,282	5,996	71.4%
	Indian	10,186	15,115	67.4%
	Pakistani	33,700	51,625	65.3%
	Any other Asian backgr..	8,567	16,164	53.0%
	Chinese	7,676	20,453	37.5%
Black, African, Caribbean ..	Caribbean	3,979	7,955	50.0%
	African	18,486	33,629	55.0%
	Any other Black, African..	3,956	8,662	45.7%
Mixed or Multiple ethnic groups	White and Asian	1,675	2,749	60.9%
	White and Black African	2,262	4,438	51.0%
	Any other Mixed or Multi..	3,103	6,244	49.7%
	White and Black Caribb..	1,947	4,193	46.4%
Status Unknown	Declined to provide ethn..	4,190	7,853	53.4%
	No record of ethnicity st..	51,450	102,655	50.1%
Other ethnic group	Arab	2,585	4,958	52.1%
	Any other ethnic group	10,127	21,117	48.0%
Grand Total				63.1%

Trend in First Dose Coverage by Ethnicity



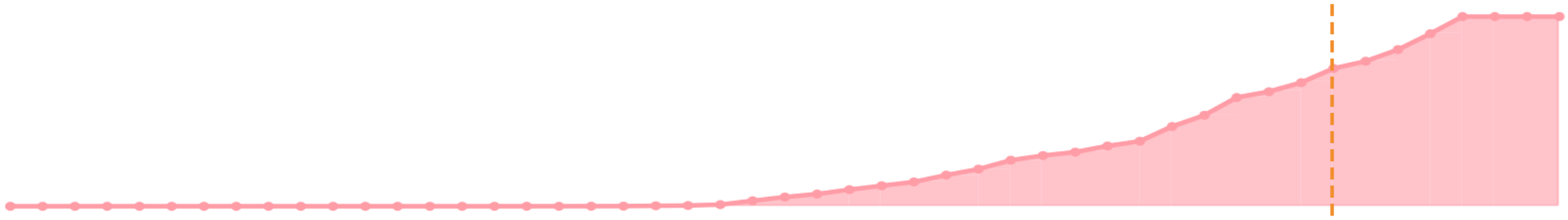
This slide uses patient level data flowing from NIMS to GP Clinical Systems. This means that the data is a few days behind NIMS.

Ethnicity data is based on information stored within GP Practice records only. Approximately 20% of patients do not have their Ethnicity recorded and work is ongoing to reduce this.

Patients receiving Covid Booster – Summary

Overall Delivery: 23,151 Covid booster doses given. This is an increase of 6,336 doses from 1 week ago

Cumulative Doses



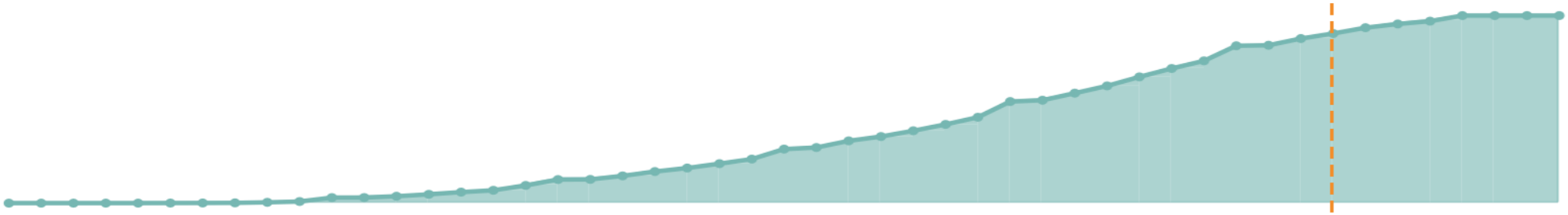
Coverage by Cohort

Booster Cohort		Vaccinated	Patients	% Coverage (change from 1 week ago)
Stage 1	1.1 Immunosuppressed	1,801	15,925	11.3%
	1.2 Resident of Nursing or Residential Care Home	428	1,570	27.3%
	1.3 Aged 70 and over	11,249	39,175	28.7%
	1.4 Clinically Extremely Vulnerable	1,712	23,069	7.4%
Stage 2	2.1 Aged 50 and over	4,060	103,304	3.9%
	2.2 Aged 16 - 49 At Risk	633	33,069	1.9%
	2.3 Contact of Immunosuppressed	3	325	0.9%
Other	Other eligibility, already received booster	3,265	3,265	100.0%
Grand Total				10.5%

Patients receiving Flu - Summary

Overall Delivery: 44,915 Flu doses given. This is an increase of 4,295 doses from 1 week ago

Cumulative Doses



Coverage by Cohort

Booster Cohort		Vaccinated	Patients	% Coverage (change from 1 week ago)
Stage 1	1.1 Immunosuppressed	3,448	15,925	21.7%
	1.2 Resident of Nursing or Residential Care Home	372	1,570	23.7%
	1.3 Aged 70 and over	14,790	39,175	37.8%
	1.4 Clinically Extremely Vulnerable	4,485	23,069	19.4%
Stage 2	2.1 Aged 50 and over	17,522	103,304	17.0%
	2.2 Aged 16 - 49 At Risk	3,086	33,069	9.3%
	2.3 Contact of Immunosuppressed	14	325	4.3%
Other	Other eligibility, already received booster	1,198	3,265	36.7%
Grand Total				20.4%

Patients receiving Flu – Breakdown by Ethnicity

Coverage by Ethnicity

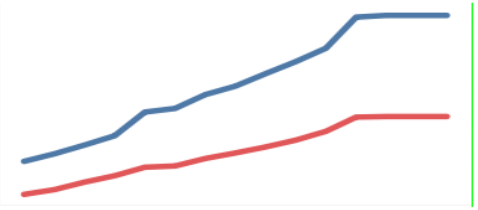
Sorted By Total Coverage

Ethnicity	Vaccinated	Patients	% Coverage (change from 1 week ago)
Irish	1,231	4,103	30.0%
English, Welsh, Scottish, Northern Irish or British	30,161	114,688	26.3%
Chinese	800	3,088	25.9%
Indian	860	3,738	23.0%
Bangladeshi	451	2,166	20.8%
White and Asian	122	679	18.0%
Any other Asian background	618	3,752	16.5%
Declined to provide ethnicity status	318	1,966	16.2%
Any other White background	1,315	8,632	15.2%
Pakistani	2,771	19,292	14.4%
Any other ethnic group	601	4,323	13.9%
Caribbean	640	4,749	13.5%
Any other Mixed or Multiple ethnic background	194	1,450	13.4%
White and Black Caribbean	169	1,408	12.0%
Arab	153	1,289	11.9%
White and Black African	138	1,260	11.0%
African	1,147	10,762	10.7%
No record of ethnicity status	2,967	29,440	10.1%
Gypsy or Irish Traveller	8	88	9.1%
Any other Black, African or Caribbean background	251	2,824	8.9%
Roma	0	5	0.0%
Grand Total			20.4%

Coverage as of 28 Sep
White background: **9.1%**
BAME background: **4.9%**
Difference: **-4.2%**

Coverage as of 05 Oct
White background: **13.5%**
BAME background: **7.2%**
Difference: **-6.3%**

The difference in coverage between patients from a White background and patients from a BAME background has **increased by 2.1 %** in the last 7 days.



Care Homes – vaccination coverage

Care Homes		1st doses	2nd doses	Flu	Booster
	Residents	93%	87%	33%	19%
	Staff	92%	79%	6%	9%
	Total number of Care Homes	Phase 3 visited		Remain Oct	Week 1 Nov
	83	48 (58%)		35 / 40.8%	1 / 1.2%

National guidance is that all eligible care home patients should be offered a booster vaccination by the 1st of November.

We are on track to achieve this target – one clinic has been scheduled for 4th November but this needed to be done with the LD Community team and this was the first available date.

Working closely with care homes and partners to ensure staff have mandated 2nd dose vaccinations by the cut off point – 11th November

Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 3 November 2021

Subject: Manchester Climate Change Framework 2.0

Report of: Director, Manchester Climate Change Agency

Summary

The purpose of the report is to highlight the increasing evidence of a strong correlation between climate vulnerability and health inequalities, to provide an update on the refresh of the city's Climate Change Framework (Framework 2.0) and to seek guidance on the best way to bring expert advice on Health & Wellbeing into the Framework refresh, both in the short and longer term.

Recommendations

The Board is asked to:

1. Note the recent publication of a number of key reports that provide evidence of a strong link between climate vulnerability and health inequality.

2. Provide a view on the most appropriate way to secure expert input from this Board to the Climate Change Framework 2.0 and its ongoing delivery.

3. Provide feedback on the type of indicators that could be adopted to show progress on addressing climate change and health inequalities.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The MCCA objective for 2020-25 is: *To improve the health and wellbeing of everyone in Manchester through actions that also contribute to our objectives for CO_2 reduction and adaption and resilience, with particular focus on those most in need.* This objective provides good alignment with the Board's priorities.
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

Contact Officers:

Name: Samantha Nicholson
Position: Director, Manchester Climate Change Agency
E-mail: samantha.nicholson@manchesterclimate.com

Name: Dr Raja Murugesan
Position: Board Member, Manchester Health & Wellbeing Board
E-mail: murugesan.raja@nhs.net

Background documents (available for public inspection):

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

The Manchester Climate Change Framework 2020-25:
https://www.manchesterclimate.com/sites/default/files/Manchester%20Climate%20Change%20Framework%202020-25.pdf

There are references to published documents throughout the report.

1.0 Introduction

1.1 The Our Manchester Strategy sets out the commitment that *'Manchester will play its full part in limiting the impacts of climate change.'*

1.2 The responsibility for developing and facilitating the delivery of the citywide strategy to fulfil this commitment is devolved to the Manchester Climate Change Partnership (the Partnership, MCCP) and Manchester Climate Change Agency (the Agency, MCCA).

1.3 In February 2020, the Partnership and Agency published Version 1.0 of the Manchester Climate Change Framework 2020-25; it was endorsed by Manchester City Council's Executive in March 2020, formally establishing it as the city's climate change strategy.

1.4 The Framework's aim is:

'Manchester will play its full part in limiting the impacts of climate change and create a healthy, green, socially just city where everyone can thrive.'

1.5 The Framework sets out four headline objectives:

1) Staying within our carbon budgets:
'To ensure that Manchester plays its full part in helping to meet the Paris Agreement objectives by:

- keeping our direct CO_2 emissions within a limited carbon budget,
- taking commensurate action on aviation CO_2 emissions and
- addressing our indirect / consumption-based carbon emissions.'

2) Climate adaptation and resilience
'To adapt the city's buildings, infrastructure and natural environment to the changing climate and to increase the climate resilience of our residents and organisations.'

3) Health and Wellbeing
'To improve the health and wellbeing of everyone in Manchester through actions that also contribute to our objectives for CO_2 reduction and adaption and resilience, with particular focus on those most in need.'

4) Inclusive, Zero Carbon and Climate Resilient Economy
'To ensure that Manchester establishes an inclusive, zero carbon and climate resilient economy where everyone can benefit from playing an active role in decarbonising and adapting the city to the changing climate.'

1.6 The Framework asserted that as well as ensuring that climate action has positive health and wellbeing outcomes, this approach will also ensure that our commitment to social justice remains at the heart of what we do.

1.7 The Health & Wellbeing Board has been represented on the Partnership by Dr Raja Murugesan and the proposals in this paper build on the work carried out to date.

2.0 Background

2.1 There have been a number of reports published over the last year that have emphasised the link between climate vulnerability and health inequality.

UK Health Expert Advisory Group

2.2 The UK Health Expert Advisory Group was formed by the Committee on Climate Change (CCC) in 2020 to advise on developing an approach to assessing the health impacts of setting the sixth carbon budget covering 2033-2037, which will set a new path towards the target date of net-zero carbon emissions by 2050[1].

2.3 The key conclusion is that climate change is already damaging the health of populations in the UK and globally and has the potential to increase health inequalities. Actions to combat climate change, done in the right way, could improve health and health equity. Conversely, actions to improve health and health equity have the potential to reduce greenhouse gas (GHG) emissions.

2.4 Direct impacts on health of climate change are created by changing exposure to heat and cold, increased exposure to UV radiation, air pollution, pollen, emerging infections, flooding and associated water-borne diseases, and the impacts of extreme weather events such as storms and floods, notably on mental health. Indirect impacts will also occur as a result of climate change's impacts on the livelihoods of individuals, on prices for food, water and domestic energy; on utilities and supply chains that are at risk from extreme weather events, on global security - and on the increasingly complex interactions between these factors.

2.5 The group identified four key areas in which action would bring benefits to public health and reduction of health inequalities whilst contributing to the mitigation of, and adaptation to, climate change: transport, buildings, diets, and sustainable economic and employment models that better support health and well- being. A further theme that ran through all of these was air pollution.

2.6 In summary the overarching actions proposed are:

- Support a just energy transition that minimises air pollution from all sources
- Design and retrofit homes to be energy efficient, climate resilient and healthy
- Build a sustainable, resilient and healthy food system

[1] Sustaining Health Equity: Achieving a Net-Zero UK - https://www.theccc.org.uk/publication/ucl-sustainable-health-equity-achieving-a-net-zero-uk/

- Develop a transport system that promotes Active Travel and Road Safety which minimises pollution.

All of these actions form part of the Manchester Climate Change Partnership's (MCCP's) priorities for activity in 2021/22.

WHO – Health & Climate Change

2.7 Climate change has the ability to seriously alter public health and has already begun to do so with the World Health Organization (WHO)[2] estimating that between 2030 and 2050, 250 000 people will die annually as a direct result of climate change. The WHO reports that they expect at-risk population groups such as infants and the elderly to be particularly affected, but that if climate change continues unabated, other population groups will also be affected.

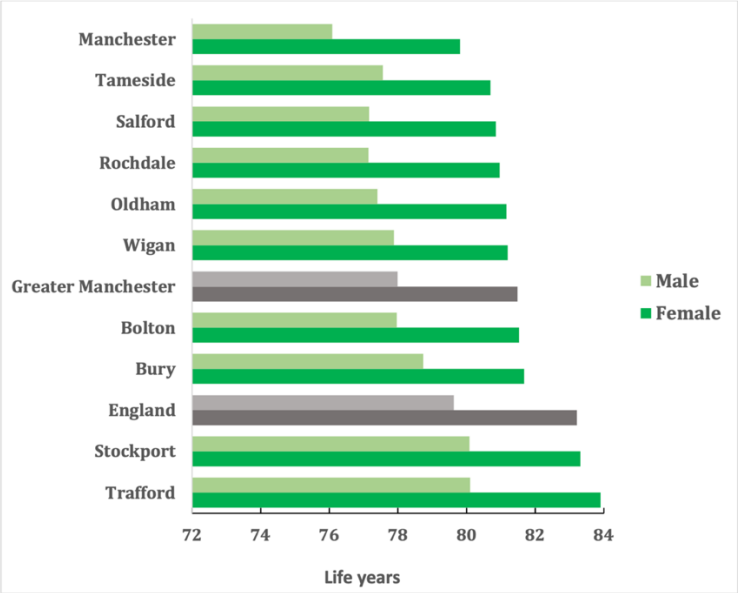
2.8 Although global warming may bring some localized benefits, such as fewer winter deaths in temperate climates and increased food production in certain areas, the overall health effects of a changing climate are overwhelmingly negative. Climate change affects many of the social and environmental determinants of health – clean air, safe drinking water, sufficient food and secure shelter.

2.9 All populations will be affected by climate change, but some are more vulnerable than others. Children, in particular children living in poorer communities, are among the most vulnerable to the resulting health risks and will be exposed longer to the health consequences. The health effects are also expected to be more severe for elderly people and people with infirmities or pre-existing medical conditions. The incidence will include but not limited to: Heat Stress, Flooding, Food insecurity, Air pollution and Disease prevalence because of global warming.

Greater Manchester: A Marmot City Region

2.10 The Marmot 10 years on review found that differences in life expectancy at birth between the least and most deprived deciles have persisted, the difference is 9.5 years for males and 7.7 years for females in 2016-18. Greater Manchester had lower life expectancies for men and women than England in 2016-18: the differences were 1.6 years less for males, and 1.7 years less for females. For Manchester itself, this gap in life expectancy almost doubled for males and females to around 3 years, see illustrative bar chart below.

[2] Climate Change and Health, WHO - https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health



Source: ONS, 2018 (6).

Figure 1 Life Expectancy at Birth

2.11 The Marmot Review 10 years on report describes selected outcomes for five of the six Marmot priority areas for health inequalities, as set out in the original 2010 Review. These five areas are the causes of health inequalities related to: early child development; education; good working conditions; people having enough money to live healthily on; and creating safe and healthy environments[3].

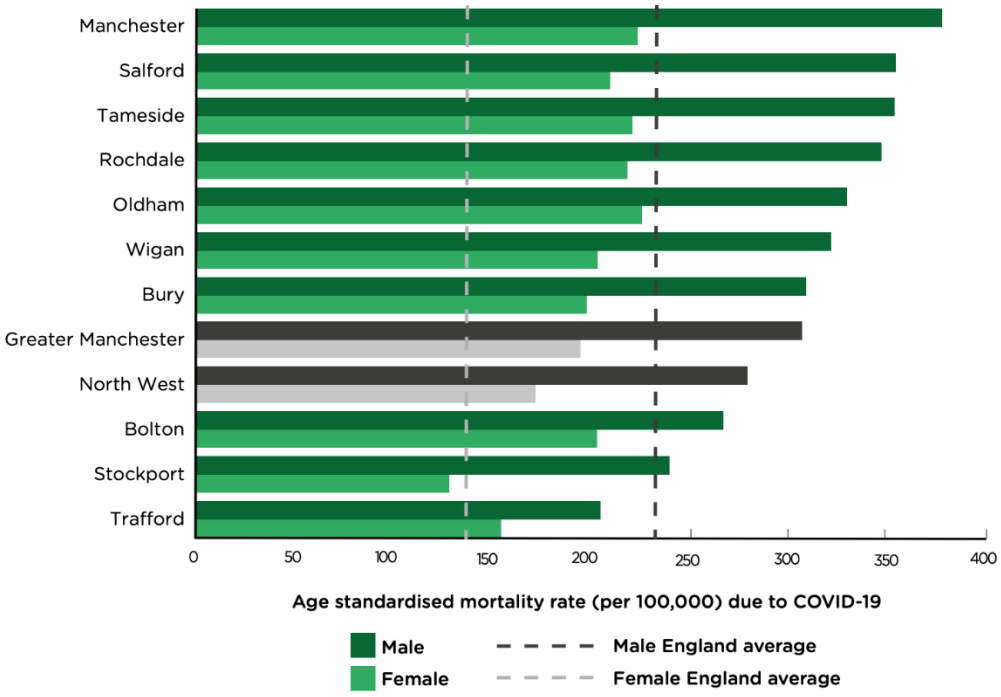
2.12 Reflecting the view of the UK Health Expert Advisory Group, the Marmot Review confirmed that efforts to mitigate impacts of climate change and reduce greenhouse gas emission are positive for health and health inequalities.

The Impact of Covid

2.13 The social inequity around health outcomes was sharply illustrated during the Covid-19 pandemic. In a report commissioned by the Greater Manchester Health and Social Care Partnership from Sir Michael Marmot, it was revealed that the coronavirus death rate in Greater Manchester was 25% higher than the England average during the year to March 2021, leading to "jaw-dropping" falls in life expectancy and widening social and health inequalities across the region over the past year.

2.14 Covid-19 mortality rates varied within the region from around 400 males per 100,000 in the poorer boroughs to fewer than 250 per 100,000 in more affluent areas. As the bar chart indicates, Manchester's Covid mortality was the worst across Greater Manchester.

[3] Health Impact in Greater Manchester: The Marmot Review 10 Years On - https://www.instituteofhealthequity.org/resources-reports/greater-manchester-evaluation-2020



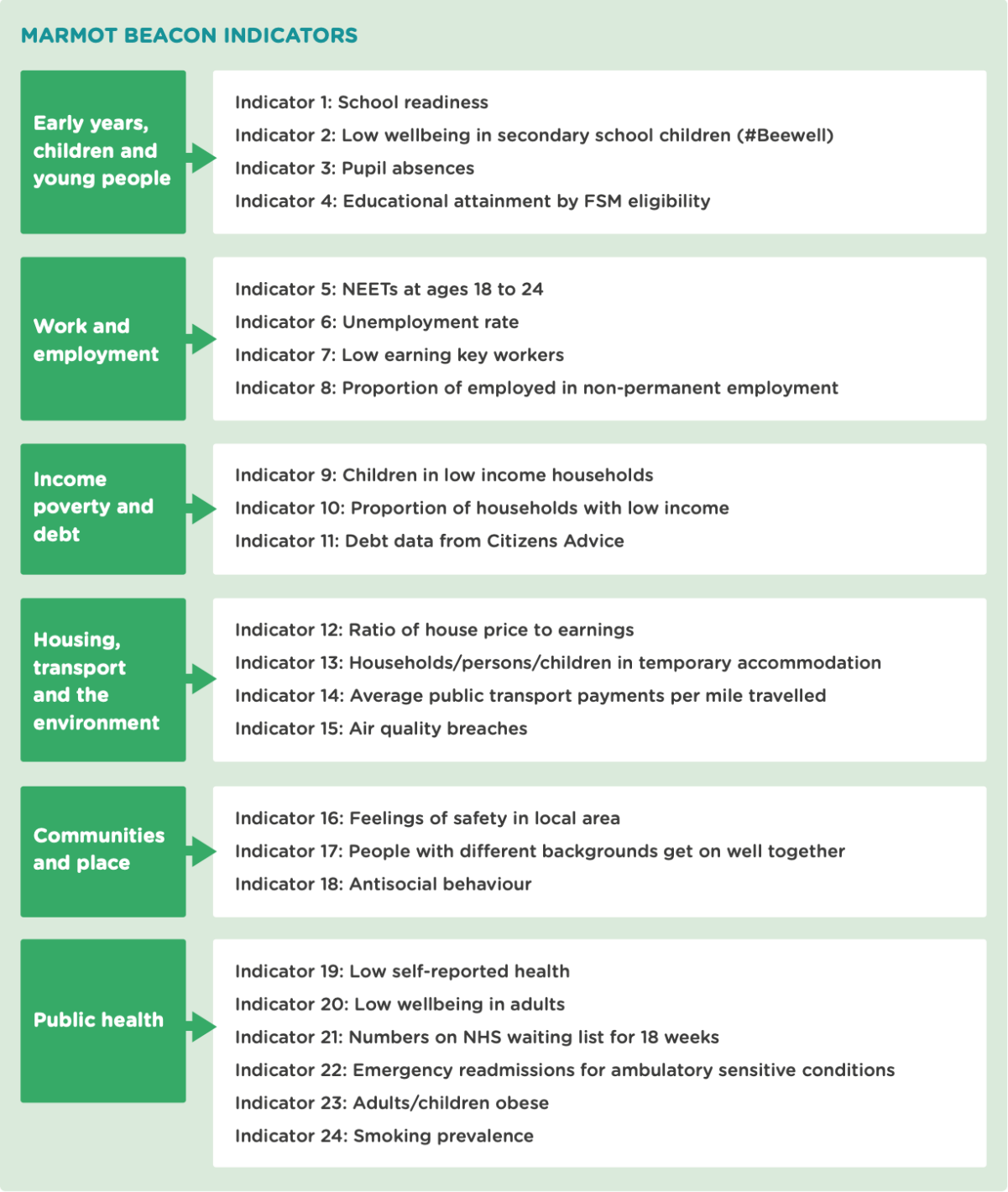
Note: *Deaths 'due to COVID-19' only include deaths where COVID-19 was the underlying (main) cause.*

Source: *ONS. Age-standardised rates from COVID-19, People, Local Authorities and Regions in England and Wales, deaths registered between March 2020 and March 2021 (15).*

Figure 1 Age Standardised Covid-19 Mortality for Greater Manchester (March 2020 – April 2021

2.15 The report is entitled Build Back Fairer in Greater Manchester: Health Equality and Dignified Lives[4] and it also detailed a series of 'beacon indicators' to monitor the improvement in health outcomes should further investment be made available (see below).

[4] https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives



3.0 Manchester's Climate Change Framework (Version 2.0)

3.1 Building on Version 1.0 of the Framework, Version 2.0 is being produced during 2021 and will include a new Implementation Plan to detail what needs to be achieved by when, i.e. quantifying the scale and pace of change required.

3.2 Framework 2.0 will retain the original four headline objectives: CO_2 reduction, climate adaptation and resilience, **health & wellbeing**, and inclusive and sustainable economy. And the original six thematic areas: buildings,

renewable energy, transport, food, things we buy and throw away, green infrastructure and nature-based solutions.

3.3 Consultations with residents and businesses are being carried out at two points in the process to support development of 'key actions for residents and businesses' and an understanding of the barriers that are preventing further action.

3.4 The Agency and Partnership are working with a range of experts on Framework 2.0 to update the case for change and to set targets for action wherever possible. For example, Anthesis, an environmental consultancy, have been procured to provide the technical evidence base around direct emissions reductions (first headline objective); Manchester Metropolitan University is working on adaptation and resilience (second headline objective); and a steering group lead by the Chamber of Commerce is supporting work on sustainable economy (fourth headline objective).

3.5 Input is also being provided by the existing independent Advisory Groups including the Zero Carbon group and the Adaptation and Resilience group. Going forwards, these groups will provide ongoing technical advice will track and report progress against the objectives and targets in Framework 2.0.

4.0 Support Requested

4.1 We are seeking support from the Health & Well Being Board with the third headline objective on **health and wellbeing,** both in terms of setting the right objectives and targets, and in tracking progress with their implementation**.**

4.2 Given the correlation between climate action and improved health outcomes, it is vitally important that organisations represented on the Board are able to contribute to this work.

4.3 The way in which the Framework, Partnership and Agency currently channel independent advice from the city's experts is via **dedicated Advisory Groups**.

4.4 Two proposals are presented for consideration, but other options may be available:

a) The Health & Well Being Board itself acts as the independent Advisory Group for the Climate Change Framework's third headline objective.
b) The Health & Well Being Board create a new sub-group of appropriate level members to be the independent Advisory group, which is then overseen by the Board.

4.5 The role of the Advisory Group would be, in the first instance, to ensure the **narrative** around climate, health and wellbeing is up to date in Framework 2.0 and to propose a **set of indicators** that will enable Manchester to track its progress against these shared objectives. This work would need to be

completed relatively quickly, e.g. draft in December 2021 and finalised in January 2022.

4.6 Suggested indicators for consideration include (but are not limited to):

- Marmot beacon indicator 15: air quality breaches
- Deaths from heat stress or cold spells
- People living in fuel poverty
- Asthma cases

4.7 The Advisory Group would also be called on to provide **ongoing support**. Using the Terms of Reference adopted by the other Advisory Groups as a template, this could include:

- Reviewing progress against the chosen indicators - at least once per year for the Annual Report;
- Reporting periodically to the Climate Change Partnership on activities underway in the city of relevance to the objective;
- Providing independent and objective advice to the Partnership and Agency, for example on the need to update objectives in the light of changing policy or underlying data.
- Considering the recommendation of the UK Health Expert Advisory Group to carry out health equity impact assessments.

4.8 The Advisory Group would be expected to meet four to six times per year, depending on the work programme established by the Health & Wellbeing Board and the Climate Change Partnership, and would be able to input to the specific Terms of Reference once established.

Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 3 November 2021

Subject: 'Our Year' 2022

Report of: Strategic Director of Children and Education Services

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Summary

Since the 23rd March 2020 the country has been subject to various guidance, regulation and a series of 'lockdowns' to manage and control the spread of Covid19, which is widely reported to have had a detrimental impact on the UK's economy and population and amplifying the determinants of social and health inequalities.

Manchester prides itself on being a warm and inviting city with something to offer for everyone. Our communities pulled together in the face of the adversity and inequality that Covid brought.

As it stands Covid has brought some key concerns that we must address before they become entrenched and hinder, or even prevent the progress of our children and young people:

Education and Learning– during the pandemic the gap between those children who are considered to be disadvantaged and their peers has grown significantly.
We also know that learning time, language acquisition and other social experiences have been affected;

Wellbeing – We know there are higher levels of children and young people with anxiety and other mental health issues, compounded by limited contact with friends and peers during lockdowns

Fewer Opportunities – There are fewer opportunities for young people leaving school or college and that's likely to lead to more unemployment

Financial Hardship – we have increased issues linked to deprivation, loneliness and mental health issues from the pandemic including reduce access to support groups

Those are just some of the issues which is why we need a citywide approach to listening to what children and young people need; and then harness our collective resources, support and communities to bring more opportunities, training and experiences for the next generation.

'Our Year' 2022 will see us listening and acting together to create an offer of activities, opportunities and experiences.

However, the next 12 months will just be a kick-start. The project will be a movement and a change in behaviour, rather than a time limited campaign, to make sure

children and young people are at the heart of everything we do in Manchester. We want this commitment to be long-lasting and one more thing that sets Manchester apart.

Manchester will be submitting an expression of interest to become part of UNICEF's Child Friendly City and Communities programme.

The attached slide set provides more information for the Board

Recommendations

The Board is asked to:

1. Endorse and promote 'Our Year 2022'. A year to celebrate the successes of Manchester's children and young people and supporting their recovery from the impact of Covid19.

2. Endorse and support Manchester submitting an expression of interest to become part of UNICEF's Child Friendly City and Communities programme

3. Promote initiatives/programmes within areas of responsibility that create activities, opportunities and celebrate the success of Manchester's children and young people

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Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	It is universally recognised the first 1000 days are critical for a child's physical, emotional and neurological development. We know that limited opportunities for them to play and interact with others will most likely have had a detrimental impact on their overall development. Therefore a co-ordinated and inclusive offer of opportunities to the younger age range will contribute to our youngest children getting the start they need in life.
Improving people's mental health and wellbeing	A range of activities, opportunities and campaigns that support the mental health of children and young people. Creating a city where no young person feels that they cant ask for help.
Bringing people into employment and ensuring good work for all	Increase the number of quality work experience placements and mentoring opportunities. Widening the 'Skills for life' agenda and providing opportunities for young people to develop the skills they need to enter adulthood successfully.

Enabling people to keep well and live independently as they grow older	Through the skills for Life programme, developing young people's self-management skills
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

Contact Officers:

Name: Ruth Denton
Position: Our Year Lead
E-mail: ruth.denton@manchester.gov.uk

Background documents (available for public inspection):

None

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‘Our Year 2022’

A whole-city approach, creating an offer of activities, experiences and opportunities to build a safe, happy, healthy and successful future for all children and young people





UNICEF Child Friendly City – 2024

- Putting Children's Rights into Practice
- Have a meaningful say in, and truly benefit from, the local decisions, services and spaces that shape their lives.





What is important to you as a young person living in Manchester?

- Family and Friends
- Education
- Environment
- Healthy Lives
- Having fun stuff to do
- Feeling included

Themes

Safe and Secure

Voice and Participation

Enjoyment

Health

Equal and included

Education

Climate Change

We asked young people, what should be included as part of 2022?

- Free sport tickets
- Climate change events
- Outdoor cinemas
- Free food
- Discount cards
- Take over days
- Development opportunities
- Local festivals
- Play streets
- Free transport
- Concerts
- Youth Markets
- Fun stuff!
- Work experience
- Celebrating culturally diversity

‘Our Year 2022’
Will see a programme of events / Key activities linked to the themes