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MANCHESTER
CITY COUNCIL

Health Scrutiny Committee

Date: Wednesday, 7 February 2024
Time: 2.00 pm
Venue: Council Antechamber, Level 2, Town Hall Extension

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Membership of the Health Scrutiny Committee

Councillors - Green (Chair), Bayunu, Cooley, Curley, Hilal, Karney, Muse, Reeves, Riasat and Wilson

Agenda

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

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

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

4. [2.00-2.05] Minutes 5 - 12
To approve as a correct record the minutes of the meeting held on 10 January 2024.

4a. [2.00-2.05] Minutes 13 - 18
To receive the minutes of the Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Task and Finish Group meeting held 23 January 2024.

5. [2.05-2.30] Budget 2024/25

5a. Revenue Budget Update 2024/25 - To Follow

5b. Public Health Budget 2024/27 - To Follow

5c. Adults Social Care Budget 2024/27 - To Follow

6. [2.30-3.00] Progress Update on Winter 2023/24 19 - 30
Report of the Deputy Place Based Lead and the Executive Director Adult Social Services

In September 2023, the Manchester Health Scrutiny Committee and the Council Executive was presented with a forward view of the plans for this winter. The following paper describes the current progress in implementation of winter plans, and summary of pressures within the urgent care system.

7. **[3.00-3.50] Palliative and End of Life Care in Manchester** 31 - 52
Report of the Manchester Deputy Place Lead and Marie Curie Lead

This report provides critical research from the *Better End of Life programme,* conducted in collaboration between Marie Curie, King's College London Cicely Saunders Institute, Hull York Medical School, the University of Hull and the University of Cambridge, in relation to experiences of palliative and end of life care, as well as identifying policies and resources that will help to make a positive difference to the lives of people affected by dying, death and bereavement. Marie Curie have asked all localities to respond to an audit questionnaire and the findings from this are discussed in the body of this report and will inform locality developments.

In order to give a rounded perspective of issues and challenges across Manchester as well as the GM Integrated Care Board, contributions have also been collected from the GM Quality Improvement Programme Manager, Palliative & End of Life Care, who describes the developments and ambitions of the GM Palliative and End of Life Care Programme, and the Manchester Locality Team, (Primary Care as well as Quality), where the issues and challenges in relation to transformation are discussed.

8. **[3.50-4.00] Overview Report** 53 - 62
Report of the Governance and Scrutiny Support Unit

The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission.

Information about the Committee

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

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

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

Further Information

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

Lee Walker
Tel: 0161 234 3376
Email: lee.walker@manchester.gov.uk

This agenda was issued on **Tuesday, 30 January 2024** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 2, Town Hall Extension (Library Walk Elevation), Manchester M60 2LA

Health Scrutiny Committee

Minutes of the meeting held on 10 January 2024

Present:
Councillor Green – in the Chair
Councillors Bayunu, Cooley, Curley, Hilal, Karney, Muse, Reeves and Wilson

Also present:
Councillor T. Robinson, Executive Member for Healthy Manchester and Adult Social Care
Councillor Chambers, Deputy Executive Member for Healthy Manchester and Adult Social Care
Councillor White, Executive Member for Housing and Development
Tom Hinchcliffe, Deputy Place Based Lead for Health and Social Care Integration, NHS Greater Manchester Integrated Care
Sam Bradbury, Deputy Director of Integrated Commissioning, Manchester Local Care Organisation
Julie Taylor, Locality Director of Strategy/Provider Collaboration (Manchester) NHS Greater Manchester
Dr Sohail Munshi, Chief Medical Officer, Manchester Local Care Organisation
Coral Higgins, Cancer Reform Manager, NHS Greater Manchester
Graham Mellors, Strategic Lead for Population Health Management, Manchester Local Care Organisation

HSC/24/01 Minutes

Decision

1. To approve the minutes of the meeting held on 6 December 2023.

2. To receive the minutes of the Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Task and Finish Group meeting held on 19 December 2023.

HSC/24/02 Support For People With Complex Needs And The Role Of Social Workers & Tackling Alcohol Harm in Manchester

The Committee considered the two-part report of the Executive Director of Adult Social Services and the Director of Public Health. The first report provided a full description of the services provided by the Manchester social work teams, who supported adults with complex needs; the second report focused on efforts to tackle alcohol harm in Manchester and Greater Manchester.

Key points and themes in the report included:

- Information relating to the Substance Misuse Teams, including a description of their key areas of work;
- Information relating to the work of the Entrenched Rough Sleepers Social Work Team;

- Discussion of the approach to the continuous development of services, noting the commitment to research and evidence-based practice;
- Discussion of the meaning of alcohol harm;
- Consideration of alcohol harm and inequalities, noting that increased levels of deprivation were associated with increased levels of alcohol related harm;
- Data relating to the levels of alcohol harm in Manchester;
- Current activities to tackle alcohol harm in Manchester; and
- Next steps both at a Manchester and Greater Manchester level.

Some of the key points that arose from the Committee's discussions were:

- Noting the proliferation of 24/7 alcohol delivery services and the detrimental impact this had on health outcomes;
- Noting increased levels of alcohol consumption during the pandemic;
- A Member described her personal family experience of alcohol harm;
- In a similar way that the tobacco industry was challenged, Manchester needed to tackle the alcohol industry to reduce alcohol-related harm;
- What was the process for a family member or carer to access support as a carer;
- Recognising the need to not demonise or curtail people for enjoying alcohol responsibly;
- A Member commented that in his ward every application for any new off-licence was vigorously opposed;
- Public Health should be formally recognised as a licensing objective;
- Welcoming the reported Family Centred rehabilitation initiative and requesting that a report on this be submitted to the relevant scrutiny committee at an appropriate time;
- Noting the impact of foetal alcohol spectrum disorder (FASD) and noting the motion on this specific issue at the meeting of Council held 29 November 2023, and requesting that a report on this be submitted to the relevant scrutiny committee at an appropriate time;
- Noting the challenge presented by grant funding of services; and
- Requestion an update on the impact of the "Communities in Charge of Alcohol" pilot that had been launched in Miles Platting and Newton Heath in 2017.

The Director of Public Health welcomed the comments from the Committee and stated that the views expressed in regard to the alcohol industry and the 24/7 availability of alcohol were shared by the Association of Directors of Public Health.

The Registrar in Public Health described the multi-agency approach to consider all licensing applications submitted and where appropriate submit objections for consideration by Licensing Panels. She made reference to conditions and modifications to licences as a result of this approach.

The Director of Public Health stated that a round table discussion would be convened in February 2024 with practitioners and experts participating to develop actions to progress the work on FASD, noting the motion that had been passed by Council.

The Executive Director of Adult Social Services informed the Committee that anyone could refer themselves for an assessment under the Care Act. She acknowledged that consideration needed to be given to promote this more widely.

The Service Manager (Complex Needs), Adult Social Care commented that the Family Centred rehabilitation model had been developed by the staff working within the Alcohol Team. She said that this model utilised a number of therapies, including Trauma Informed Therapy, to best meet the needs of the individual. She commented that the intention was to build upon this model and work with Children's Services, adding that an update on this work could be provided to the relevant scrutiny committee at the appropriate time.

The Director of Public Health said that NHS England funding for Alcohol Care Teams was due to end in March 2024 and discussions were currently underway to look at transitional funding arrangements so the services could be sustained in 2024/25. He added that Wythenshawe Hospital had mainstreamed this service and options to adopt a similar approach would be explored at the other two hospital sites, noting that this changed its funding status and arrangements.

The Director of Public Health said that the formal evaluation of the Communities in Charge of Alcohol pilot had not been undertaken due to the pandemic, however the lessons learnt from this pilot would be used, along with the underlying principles to roll this programme out more widely.

The Executive Member for Healthy Manchester and Adult Social Care stated that despite the failure of government to tackle the issue of alcohol harm it remained a priority for Manchester. He paid tribute to the staff working in the Substance Misuse Team. He further commented that FASD was considered by the Children and Young People Scrutiny Committee.

Decision

The Committee recommends that the Executive Member for Healthy Manchester and Adult Social Care and the Chair of the Health Scrutiny Committee engage with the Mayor of Greater Manchester with the view to establishing a Manchester Manifesto to tackle the alcohol industry on the issue of alcohol-related harm.

HSC/24/03 Cancer Screening Update

The Committee considered the report of the Director of Public Health and the Chief Medical Officer, Manchester Local Care Organisation that provided the latest position in relation to cancer screening programmes for the population of Manchester.

Key points and themes in the report included:

- The latest available screening uptake figures for Manchester in relation to the national cancer screening programmes, noting that there were currently three screening programmes for the prevention or early detection of cancer, namely Breast, Bowel and Cervical screening;
- The role of the Manchester Population Health Management Board within the Manchester Local Care Organisation;
- Information on the actions that were being taken across Manchester to address low uptake and coverage, with a greater focus on health inequalities; and

- Describing the Greater Manchester targeted lung health check programme, and the plan for Manchester.

Some of the key points that arose from the Committee's discussions were:

- Stating that the key message was that screening saved lives;
- What was the process for following up on bowel cancer testing kits that were not returned;
- What was the current advice in relation to prostate cancer;
- More information was requested in relation to the Equality Impact Assessments undertaken in relation to cancer screening;
- What were the ages of people accessing screening services;
- Welcoming the mobile mammogram unit at North Manchester General Hospital; and
- Noting the reported issues and limitations to gynae services at Manchester University NHS Foundation Trust (MFT) as a result of staff shortages, recruitment processes and training for new staff.

The Chief Medical Officer, Manchester Local Care Organisation addressed the discussions in relation to the data presented in the report and stated that it was important to differentiate between the rates of screening rather and incidents of cancer diagnosis. He made reference to the Health Development Coordinators and the Manchester Population Health Management Board (PHM). He said that PHM plans were built on their work in communities, building positive relationships with local communities and local partners in the VCSE and, importantly, primary care. He commented that all this work was data led and evidence based. In terms of the age of cohorts and screening he commented that this was in accordance with national clinical guidance.

The Chief Medical Officer, Manchester Local Care Organisation discussed the need to consider health literacy adding that this could be a barrier to people accessing screening services, making reference to his own experience when receiving a testing kit. He commented that consideration needed to be given to the language used to ensure it was appropriate. He commented on the issue of trust amongst some communities and health services and the need to work to tackle these barriers to screening and health services more generally, noting that it was recognised that a 'one size fits all' approach was not appropriate.

The Chief Medical Officer, Manchester Local Care Organisation said that the national advice in relation to prostate cancer was to contact your GP if you experienced any change when passing urine and/or noticed blood in your urine. The Cancer Reform Manager (Manchester), NHS Greater Manchester made reference to the 2023 'This Van Can' prostate cancer awareness roadshow. The roadshow had visited sites across Greater Manchester between May and October 2023 as part of an NHS pilot. It was targeted at black men aged over 45 who were at greater risk of getting prostate cancer.

The Chief Medical Officer, Manchester Local Care Organisation advised that the issues reported at MFT in relation to gynae services were being addressed, noting that the issue of staff recruitment and retention was a national issue. He added that

the impact of the pandemic on NHS backlogs of work remained an issue. The Cancer Reform Manager (Manchester), NHS Greater Manchester informed the Committee that MFT had established a cervical screening facility for their staff in an attempt to increase the take up rates of screening.

The Cancer Reform Manager (Manchester), NHS Greater Manchester said that if a bowel testing kit was not returned, a second kit was issued. If this was not returned the patient was classed as a non-responder. She said that an individual could request a kit at any time if they had missed the initial invitation. With regard to the question asked in relation to the Equality Impact Assessments she advised that these were undertaken by commissioners and that Health Equality Audits were also undertaken.

The Executive Member for Healthy Manchester and Adult Social Care welcomed the report and paid tribute to the collaborative approach of the cancer alliance. He further recognised the important work of the Population Health Management Board, chaired by the Chief Medical Officer, Manchester Local Care Organisation, noting this was responsive to address the needs of residents. He further made reference to the good practice demonstrated by the exercise undertaken by the Miles Platting, Newton Heath and Moston Primary Care Network, who between June and early December 2023 had called more than 400 eligible patients who had not returned their screening kits to discuss the importance of screening and identify any barriers, noting that as a result, 220 screening kits were reissued.

Decisions

The Committee recommend;

1. That the Director of Public Health, in consultation with relevant partners review the letters issued with bowel screening kits to ensure the language and terminology used is appropriate.

2. That the Director of Public Health, in consultation with relevant partners, give consideration to the use of videos as a visual medium to promote the importance of cancer screening.

HSC/24/04 Enabling Independence Accommodation Strategy Update

The Committee considered the report of the Executive Director of Adult Social Services & Strategic Director (Growth and Development) that provided an update on the delivery of the Enabling Independence Accommodation Strategy for Manchester (2022-2032) which was considered and supported by the Committee on 12 October 2022, prior to its approval at Executive in November 2022.

Key points and themes in the report included:

- Noting that the key aim of the strategy was to improve housing with care and support options to meet people's needs and better enable their independence;

- Describing that it was a partnership strategy, developed between Adults, Children's, Homelessness, Strategic Housing, Property Development, and the Manchester Housing Providers Partnership;
- Reporting progress to date, noting the progress made in the first year of this 10-year strategy;
- Describing the four key objectives of the strategy;
- Reporting the key stages of delivery of the strategy;
- Discussion of the assessment of current provision;
- Discussion of future demand and how this need would be addressed;
- Consideration of the building upon our care and support at home services;
- Case studies; and
- Next steps.

Some of the key points that arose from the Committee's discussions were:

- Welcoming the report and recognising the importance of supporting people to remain living safely in their communities, close to their families and support network;
- Recognising that this important work was integral and important for individuals and communities;
- Welcoming the scale of work delivered by the Manchester Equipment and Adaptations Partnership and Community Alarm and Technology Enabled Care service;
- Recognising the importance of adaptations to support people to remain living safely in their own homes;
- The need to promote widely the positive and important initiatives described within the report;
- Welcoming the inclusion of the case studies;
- Did the work and ambitions described meet the needs of the population;
- Noting the Disabled Facilities Grant (DFG) funding was not sufficient to keep up with increased demand and construction cost and calling for adequate funding from government; and
- Commenting that investment in these initiatives saved money in the longer term as individuals were not accessing costly acute or care settings.

The Commissioning Manager Strategic Housing stated that the service was continually exploring all opportunities to deliver future schemes. She commented that the Housing Needs Assessment would inform future commissioning considerations, noting that future schemes would consider the housing needs of young disabled people.

The Executive Director of Adult Social Services acknowledged the discussion relating to the DFG, adding that it was not sufficient to meet the demand. She described that despite the challenges the service remained committed to being innovative and suggested that Members undertake a visit to the Smart Suite, a new facility that had opened in Manchester that allowed people to see and try out the equipment and adaptations that could keep them independent at home. The Members welcomed this invitation.

The Assistant Director Adult Social Services (Commissioning) welcomed the recognition of the work of the Manchester Equipment and Adaptations Partnership and Community Alarm and Technology Enabled Care service, adding that it was important to record and report these activities as it supported independent living and helped support the case for an increase in the DFG. She further paid tribute to the partnership work and positive relationship established with housing providers to deliver these interventions to support residents.

The Executive Member for Housing and Development paid tribute to the partnership approach to deliver the strategy. He commented that the relationship between housing and health outcomes was understood and the ongoing stated commitment to partnership working would help deliver the best outcomes for Manchester residents.

The Executive Member for Healthy Manchester and Adult Social Care stated that he welcomed the many positive comments from the Committee adding that the report clearly articulated the ambitions for the city. He stated that the strategy recognised the nature and importance of place. He said that despite the government's failure to adequately fund and acknowledge the importance of this work, Manchester had taken the lead nationally on this issue.

The Chair in concluding this item of business paid tribute to the work described and requested that an update report be provided to the Committee at an appropriate time.

Decision

To note the report and that a visit to the Smart Suite be arranged for Members.

HSC/24/05 Community Health Transformation Programme: Community Podiatry Service Change

The Committee considered the report of the Deputy Director of Integrated Commissioning, Community Health that provided the recommendations made by Manchester Local Care Organisation Executive to reduce variation in community health podiatry services as part of the Community Health Transformation Programme.

The Committee was asked to note the Manchester Local Care Organisation recommendation to remove the variation in the community health service podiatry offer; and to endorse the view that this action did not constitute a substantial variation.

Key points and themes in the report included:

- Describing the context and rationale to standardise provision for podiatry services across Manchester;
- To amend the service offer to ensure consistent access criteria; and
- To align budgets to the size and need of people in the neighbourhoods.

Some of the key points that arose from the Committee's discussions were:

- A Member described his personal experience of accessing this service and stated that the service he had received had been very positive; and
- What was the criteria used for patients to access the service.

Officers in attendance stated that a risk matrix was used to assess the criteria for accessing the podiatry service, adding that if a person did not meet the criteria they would be signposted to alternative offers. She added that the majority of appointments were delivered in local health centres. Officers also commented that it was the intention to deliver training to staff working in residential and care homes so they could assist individuals with nail cutting.

Decision

To note the report.

HSC/24/06 Overview Report

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

Decision

The Committee notes the report and agrees the work programme.

Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Task and Finish Group

Minutes of the meeting held on 23 January 2024

Present:
Councillor Green – In the Chair
Councillor Curley and Wilson

Apologies: Councillor Bayunu

Also present:
Councillor T. Robinson, Executive Member for Healthy Manchester and Adult Social Care
Jan Ditheridge, Chief Executive, Greater Manchester Mental Health NHS Foundation Trust
Andrew Maloney, Deputy Chief Executive and Chief People Officer, Greater Manchester Mental Health NHS Foundation Trust
John Foley, Chief Operating Officer, Greater Manchester Mental Health NHS Foundation Trust
Bridget Hughes, Associate Director of Operations, Greater Manchester Mental Health NHS Foundation Trust

GMMHIP/24/01 Minutes

In moving the minutes, the Chair requested that the information requested in relation to the 'Freedom to Speak Up' anonymised case studies and associated and analysis of trends be circulated to the Members of the Group at the earliest opportunity.

Decision

To approve the minutes of Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Task and Finish Group meeting held on 19 December 2023 as a correct record, noting the above comment.

GMMHIP/24/02 Update on GMMH Improvement Plans on People and Culture

The Task and Finish Group considered the report and accompanying presentation of the Interim Associate Director of Operations, Associate Director of Health Professionals and the Quality and Associate Medical Director Manchester Care Group that provided an update regarding the progress to date on the Greater Manchester Mental Health NHS Foundation Trust (GMMH) Improvement Programme, with specific reference to People and Culture.

Key points and themes in the report included:

- Noting that the Trust were working to create a safe and supportive working environment for all staff (clinical and non-clinical);

- Describing that The People workstream was supporting the Trust to create open communication, to set a clear direction and enable staff to play a vital part in improving both the service they work in and the Trust as a whole; and
- Describing that the Trust were working to become a collaborative, inclusive and compassionate organisation that actively engages with service users and carers, staff, the public and other stakeholders to build a more positive future.

The accompanying presentation discussed the identified challenges, discussion of the organisation-wide improvements, the joint working between the Trust and the Council, and next steps.

Some of the key points that arose from the Task and Finish Group's discussions were:

- Requesting that an organisational plan on a page be circulated to the Group;
- Noting the importance of correct staffing levels, equipped with the correct values to deliver care and to ensure patients were safe and treated compassionately at all times;
- The importance of staff retention;
- Did the Trust inherit bad practice and a poor culture when it had taken over Manchester service from the previous metal health Trust;
- Seeking an assurance that the cruel practices exposed in the Panorama programme no longer existed;
- How was the voice of the service user and carers captured to inform the work described to drive improvements;
- Information was sought as to the composition and role of the Board of Directors; and
- Were all staff at the Trust trained in Trauma Informed Practice.

The Deputy Chief Executive and Chief People Officer, GMMH stated that the Improvement Plan was heavily focused on the issue of people and this theme ran across all the workstreams. He added that by delivering the improvements would result in attracting quality staff to the organisation and contribute to staff retention. He said that this was beginning to be realised already, commenting that this reflected the improvements realised to date. He stated that the recruitment process was designed to explore and test a candidate's values, adding that service users were included on recruitment panels. He advised the Group that a number of recruitment events had been delivered and these provided an opportunity for clinicians to meet and link with potential candidates. He described that the process to appoint the new Board Chair at the Trust had involved extensive stakeholder conversations and service user representation on the interview panel. In response to a specific question regarding the recognition that the Trust was a Living Wage Foundation Accredited employer he said that this applied to all staff directly employed by the Trust and those NHS contracted staff.

The Deputy Chief Executive and Chief People Officer, GMMH made reference to the positive relationship and partnership working with the Council, with particular reference to the shared targeted recruitment campaign in development aimed at social care professionals and social workers. He also reiterated the Trust's ongoing commitment to develop and strengthen service user support and engagement.

The Deputy Chief Executive and Chief People Officer, GMMH said that the data from the ‘Freedom To Seak Up’ programme was reported to the Bord and these reports could be shared with the Group for information. He commented that the number of these referrals had risen from approximately 35 to 75 incidents, adding that this was regarded as a positive development as it reflected staff confidence to raise issues and concerns. He said that Staff Champions existed across the different teams, and these would support staff to raise concerns.

The Deputy Chief Executive and Chief People Officer, GMMH addressed the discussion in relation to the growth of the organisation when it took over Manchester services. He acknowledged the points raised in relation to the risks of inheriting bad practice and entrenched poor culture. He said that this was an issue that was being considered and the learning would be reflected upon as an organisation. The Chief Executive GMMH acknowledged that the governance arrangements at the time of the acquisition were not robust enough at that time and that measures had been taken to address this.

The Chief Executive GMMH said that staff recruitment and retention in mental health services was a national issue and not unique to Manchester. She discussed the historical issues in relation to staff recruitment and retention and the consequences of this, noting that this had contributed to the poor practice witnessed and reported. In response to this she described that this had resulted in an improved approach to the recruitment process to ensure that the correct people, with the correct values and skills were recruited to the organisation. She added that the recruitment of the correct staff, at the correct and safe levels, combined with the correct competencies and values was key to delivering the Improvement Plan. She said that staff also received appropriate training and refresher training accompanied by appropriate levels of supervision. She said in addition to this correct clinical and managerial leadership was being introduced to support staff; further support the delivery of high-quality care and support and drive improvements in the culture of the organisation. She added that systems were now established across the Trust for staff to discuss areas of concern, and where necessary escalate these with managers and senior leaders and referred the Group to the section of the presentation that discussed the roll out the leadership development programmes across all Manchester services. She reiterated that there was never an excuse for bad practice and stated that the Trust recognised the need to ensure the correct calibre of staff were employed, across all levels and services, reiterating the previous reference made to value based recruitment process; that staff were provided with the correct levels of support and learning, and good practice was reflected upon and continued to be shared to drive improvements across the organisation.

The Chief Executive GMMH commented that the deployment of Matrons and Heads of Nursing who worked alongside Ward Managers helped drive improvements and provide an additional level of assurance against poor practice. She commented that Quality Leads had also helped with the development and support for staff, noting the improvements that had been reported to the Board in relation to the use of restrictive practice when working with patients.

The Chief Executive GMMH informed the Group of the improved governance arrangements that had been established across the Trust. She said that senior leaders and Board members routinely visited teams and staff, both formally and informally to provide a level of assurance by having ‘eyes and ears on the ground’. She provided an example of an occasion when a staff member had raised a concern with a senior leader and how this had been responded to and dealt with appropriately. She commented that this reflected the increased confidence amongst staff that they could raise issues with senior leaders, and this would be responded to and acted upon.

The Chief Executive GMMH made reference to the issue of Out of Area Placements and acknowledged that this was an area of activity that needed to improve, especially in relation to patient flow across the system into more appropriate care settings. She discussed the importance of this from a patient perspective by adding that the risk was that failure to improve this could result in a person becoming institutionalised.

The Chief Executive GMMH discussed the importance of the service user voice and patient advocacy. She advised of the different forums, spaces and opportunities that existed for this to be articulated and captured. These included the ‘You Said We Did’ programme; the improved complaints process; and that the voice of staff and service user experience was articulated at every Board meeting and other formal meetings. In relation the discussion of the Board, she stated that the non-Executive Board Members were drawn from a variety of backgrounds and brought a wealth of experience and knowledge to the organisation. She added that these non-Executive Board Members also undertook visits to teams and met with service users. She said that this fostering of a culture of ‘natural curiosity’ across the Board supported the improvements across the governance arrangements at the Trust.

The Chief Executive GMMH advised the Group that the Board regularly received performance reports that collated the various sources of data. She informed the Group that there were distinct and detailed project plans that informed the Improvement Plan and reported progress against each workstream, adding that the delivery date for the Improvement Plan was March 2025. The Chair asked that the most current RAG ratings against the delivery of the various workstreams that had previously been provided be circulated to the Group for information.

The Associate Director of Operations informed the Group of the many different forums and opportunities to hear and capture the voice of the patient and carers. These included ‘Our Care Matters’ monthly meetings; service user and area meetings, noting the active group in North Manchester; the voice of the service users were present at Team meetings, adding that this provided an opportunity to raise areas of concern and discuss solutions; the strengthening of the complaints procedure, noting that this had resulted in improvements in the communication between patients and care coordinators. She informed the Group that service users and carers had suggested that a satisfaction survey should be undertaken, and this would be piloted in response to this request. The Chief Operating Officer added that service users had spoken at the Trust’s recent Annual General Meeting where they also heard from the forensic teams, noting that service users had been actively engaged in the co-production and development of this service area. Members of the Group were invited to undertake a visit to a selection of services and forums.

In response to the specific question asked in regard to Trauma Informed Practice and training, the Deputy Chief Executive and Chief People Officer, GMMH said that the Trust was committed to this and data in relation to the numbers of staff who had undertaken this training would be provided following the meeting.

In response to the specific question from the Chair who sought an assurance that cruel practice and treatment of patients had been eliminated, the Chief Executive GMMH commented that it was important to consider that you should never rule out the possibility that it could never happen again, however she reiterated the previous points discussed throughout the course of the meeting regarding staffing and governance arrangements to raise practice standards and expectations and mitigate against any cases of cruel treatment of patients. She said there had been no reports of serious incidents, adding that the environment, culture, and experience at the Edenfield Centre was completely transformed for the better.

In concluding this item of business, the Chair stated that a future meeting of the Health Scrutiny Committee would be dedicated to hearing from a range of different service users and patient groups who would be invited to share their experience of the impact of the Trusts Improvement Plan.

Decision

1. The Group request that the Trust circulate the following items for information:

   i) An organisational plan on a page.
   ii) The most current RAG rating for each Improvement Plan work stream.
   iii) Data relating to the numbers and grades of staff who had undertaken the Trauma Informed Practice training.
   iv) 'Freedom to Speak Up' anonymised case studies and associated and analysis of trends.

2. The Group recommend that a meeting of the Health Scrutiny Committee in the new municipal year be dedicated to hearing from a range of a range of different service users and patient groups who would be invited to share their experience of the impact of the Trusts Improvement Plan.

GMMHIP/24/03 Oral Update from the Executive Member for Healthy Manchester and Adult Social Care

In addressing the Group, the Executive Member for Healthy Manchester and Adult Social Care introduced his comments by stating that they needed to be considered in the context of his role as the elected representative to hold the Trust to political account on behalf of Manchester residents. He also stated that he recognised the positive contribution John Foley, Chief Operating Officer, GMMH and Bridget Hughes, Associate Director of Operations, GMMH had made to meetings of the Provider Collaborative Board.

The Executive Member for Healthy Manchester and Adult Social Care said that he had seen various reiterations of the presentation that had been submitted to the

Group over previous months, however he still had concerns regarding the governance arrangements that existed at the Trust due to the number of interim senior posts. He stated that this instability at the senior level was not conducive to implementing the change and scale of improvements required. He said that he had articulated this concern both in public meetings and in private conversations with the Trust. He said that to date he had not had the opportunity to meet with the new Chair of Board.

He further made reference to the number of complaints and correspondence he continued to receive from constituents regarding the Trust that supported his opinion in the Trust. He said that waiting lists; staff recruitment and retention; out of area placements continued to remain an area of concern. He also commented on the delays experienced when requesting information from the Trust. He concluded by stating that he did not believe the Trust was acting with the appropriate sense of urgency and as a result he was not confident that he could say to residents that the correct level and scale of improvement had been made to date.

Decision

To note the update from the Executive Member for Healthy Manchester and Adult Social Care.

GMMHIP/24/04 Work Programme of the Task and Finish Group

The Task and Finish Group considered the terms of reference and future work programme and were invited to make any amendments.

Decision

To note and approve the work programme.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 7 February 2024

Subject: Progress Update On Winter 2023/24

Report of: Deputy Place Based Lead
Executive Director Adult Social Services

Summary

In September 2023, the Manchester Health Scrutiny Committee and the Council Executive was presented with a forward view of the plans for this winter. The following paper describes the current progress in implementation of winter plans, and summary of pressures within the urgent care system.

Partners will attend the Committee to answer questions relating to their respective organisations.

Recommendations

The Health Scrutiny Committee is asked to note the report.

Wards Affected: All

Environmental Impact Assessment - **the impact of the decisions proposed in this report on achieving the zero-carbon target for the city**
In terms of service delivery all NHS partner organisations in Greater Manchester are expected to adhere to the GM NHS Green Plan and Council directorates and teams are aware of their responsibilities in contributing to the city's net zero carbon target.

Our Manchester Strategy outcomes	Contribution to the strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Health and social care are an important part of the city's economy including creating significant economic value, jobs, health innovation and supporting regeneration efforts
A highly skilled city: world class and home grown talent sustaining the city's economic success	Health and social care supports significant jobs and skills development in Manchester

A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Progressive and equitable is central to the Our Healthier Manchester Locality Plan and the Making Manchester Fairer Plan now provides an effective framework for tackling health inequalities in the city
A liveable and low carbon city: a destination of choice to live, visit, work	There are strong links between health partners and housing providers in the city and health partners also have an important role in working towards net zero
A connected city: world class infrastructure and connectivity to drive growth	Transport infrastructure and digital connectivity are critical to providing effective health care for Manchester residents

Full details are in the body of the report, along with any implications for

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences – Revenue

Each year various grants are made available to social care, primary care, NHS Trusts to support the response to dealing with winter pressures

Financial Consequences – Capital

None

Contact Officers:

Name: Tom Hinchcliffe
Position: Deputy Place Based Lead
E-mail: tom.hinchcliffe@nhs.net

Name: Bernadette Enright
Position: Executive Director of Adult Social Services
E-mail: bernadette.enright@manchester.gov.uk

Background documents (available for public inspection): None

1.0 Introduction

1.1 This paper gives an update on the delivery of winter plans, and key areas of urgent care pressure within the system.

2.0 Delivering operational resilience across the NHS this winter

2.1 NHS England's national letter to systems on winter planning states four key areas of focus to help local systems prepare for winter. The core objectives are:

- Continuing to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place.
- Completing operational and surge planning to prepare for different winter scenarios.
- ICBs ensuring effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.
- Supporting our workforce to deliver over winter.

2.2 Urgent and Emergency Care Recovery Funds

2.2.1 In March 2023, NHS Greater Manchester (NHS GM) informed localities of recovery/winter funding available for 2023/24 to help plan in a more coordinated way. This funding allocation brought together several separate workstreams and was designed to support virtual wards, help discharge from hospital and secure additional capacity across the system.

2.2.2 System partners worked together over the summer to determine how best to use this funding to complement existing capacity and investment within the system. The funding ultimately available was reduced ahead of winter plans being mobilised. The Manchester Provider Collaborative and Manchester Partnership Board considered how best to deploy the available funding, agreeing a final list of schemes in October that met the revised envelope and making clear that these could be scaled up should further funding become available. This was a whole system approach, which provided additional capacity for primary care, the acute hospitals and the mental health system, prioritising those schemes that were best able to mitigate system pressures.

2.2.3 Monitoring of schemes is underway, with a particular focus on the system's performance against key urgent care metrics such as four hour A&E performance and ambulance handover times. Along with these outcome metrics, system partners have been tracking utilisation of additional capacity. Utilisation of Hospital at Home capacity has been high at over 80%, as has utilisation of additional primary care capacity. As we move out of winter, the Manchester Urgent Care Board will evaluate the performance of the system over winter, and how well targeted our additional capacity was. This will be used to inform winter planning for next year. We do not yet have confirmation of the funding that will be available to support the system next winter. Further

data on the performance of the system over winter is set out later in this report.

2.3 Industrial Action

2.3.1 Effective winter planning also helped the system to mitigate the impact of two periods of industrial action across December and January. Industrial action by junior doctors took place pre-Christmas (from 7am on 20th December until 7am on 23rd December 2023) and in the New Year (from 7am on 3rd January until 7am on 9th January 2024). Planning focussed on maintaining key services and ensuring safe rosters with consultant cover.

2.3.2 A co-ordinated approach has been key to planning for the industrial action, with very close co-operation with partners across the health and social care system. Twice-daily executive-led meetings were held with the leadership teams of all our hospitals, clinical managed services and the LCOs to ensure that any issues can quickly be escalated and resolved.

2.3.3 In addition, a process was established with Manchester University NHS Foundation Trust (MFT) for alerting elected members to system pressures which included a written update that was circulated earlier in January. This was complemented by a daily GM-level system SCC Leadership Group meetings throughout the period of industrial action, attended by Manchester's Deputy Place Based lead as the system's representative.

2.4 Urgent Care Pressures

2.4.1 Throughout Winter all MFT hospital sites have experienced high numbers of attendances, with demand and patient acuity being significant. Growing winter pressures from respiratory illnesses, sickness bugs and other seasonal illnesses tend to rise during January, impacting the demand for care and hospital beds.

2.4.2 The Operational Pressures Escalation Levels (OPEL) Framework supports organisational and system response to the pressures. The framework looks at key metrics to score the system in a consistent way. There are four levels of OPEL – Level 1 where services are operating within normal parameters up to level 4 where pressure in the local health and care system continues to escalate leaving organisations unable to deliver comprehensive care.

2.4.3 Manchester Foundation Trust has reported OPEL scores of level 2 and, at times, level 3 through the winter period. Scoring can fluctuate throughout the day as scoring is updated and recalculated, based on real time information.

2.4.4 Greater Manchester Mental Health also provide a daily mental health escalation level to the GM System Control Centre (GM SCC) using agreed parameters and thresholds reflecting principles of the OPEL framework. This escalation level contributes to the overall system pressures dashboard.

2.5 Urgent Care Performance

2.5.1 Recognising that we are still in winter, to date winter 2023/24 has shown improvement in key metrics when compared to the winter 2022/23. At the time of writing, unvalidated data for 4-hour A&E performance shows improvement for December and January (to date) when comparing to the same month last year. Ambulance handover performance at site level has seen sustained or improved performance overall, with some daily variation.

2.6 GM Integrated Care Board - System Control Centre (GM SCC)

2.6.1 The Greater Manchester System Control Centre (GM SCC) was established in December 2022 and it brought together existing functions, such as the Greater Manchester Urgent and Emergency Care Operational Hub (GM UEC Operational Hub), the Greater Manchester System Operational Response Task Group (GM SORT), and the existing Emergency Preparedness, Resilience and Response (EPRR), as well as the many data feeds to ensure a consistent and collective approach to managing system demand and capacity as well as mitigation of risks.

2.6.2 The System Coordination Centre Leadership Group (SCC LG) has been established to support the wider GM system with winter pressures. The group enables senior oversight and situational awareness of clinical and operational pressures and risks in the Greater Manchester health and social care system. Its role is to coordinate decisions at times of escalation, over and above escalation in individual localities or providers.

2.6.3 The frequency of SCC LG meetings may also be stepped up to provide additional support during incidents. The SCG LG met daily throughout the two periods of Industrial Action. This has provided additional assurance against locality OPEL and support and mutual aid on OPEL actions from the wider GM footprint as and when necessary.

2.6.4 Each week throughout the whole winter period, written updates about the key highlights from SCC LG meetings have been provided by the Deputy Place-Based lead to the Executive Member for Healthy Manchester and Social Care. Member briefings have also been prepared on key issues as the winter has progressed.

3.0 Organisational Winter Deliverables, by Organisation

3.1 This section of the report sets out organisational progress made against the winter plans and priorities as set out in September. The plans considered lessons learned from last winter, aligning with the system’s urgent care recovery goals and with the core principle of working together as partners to keep people well at home. Each of the organisations have provided the narrative and information for their sections.

3.2 Manchester Foundation Trust (MFT)

3.2.1 Across our acute adult and paediatric hospitals, we implemented the nationally recognised high-impact interventions, with the Hospital at Home programme spearheading our local plans to enhance and expand our virtual ward capacity. Objectives throughout are to ensure that when patients attend our departments, we promptly directed them to the appropriate care. Interventions have been accelerated to improve our resilience over winter.

3.2.2 Whilst MFT has seen a 4% drop in performance in the three months leading up to December we have seen a better performance compared to the same period last year despite an increase in attendances and periods of industrial action. Both have placed increasing pressures on an already challenged system with our priority to ensure patient safety is maintained throughout.

3.2.3 MFT has an on-going improvement programme working with NWAS developing pathways for ambulances to take patients straight to Same Day Emergency Care services and avoid A&E admission. Performance relating to the 30-minute ambulance turnaround time has improved significantly this year. North Manchester General Hospital recorded the best ambulance turnaround times in the country during November and in December both North Manchester and Manchester Royal Infirmary had the best performance on handovers over 15 mins, ranking first and second across the North West.

3.2.4 Streaming suitable patients to Same Day Emergency Care services is a core part of MFT's winter plans, with hospitals identifying local targets to divert a proportion of suitable attendances to help avoid pressure building in A&E. Throughout October to December there has been an additional 1000 patients streamed through this pathway.

3.2.5 A key element of our winter plans is the clinically led expansion of our Hospital at Home service which supports increased use of virtual ward capacity. Throughout November and December there were 678 patients supported through Hospital at Home provision, patients who would otherwise have been in a hospital bed. At the end of December the number of new mobilised beds provided by the Hospital at Home service increased capacity by 122 beds per day. Plans are in place to increase occupancy again throughout January to March with further expansion of the service planned for 24/25.

3.2.6 The new national Operational Pressures Escalation Levels (OPEL) framework was implemented in October and is well established across our Hospitals. This framework measures the level of pressure across our Hospitals and ensure rapid response across the Group can be enacted to provide support. MFTs escalation and flow policy was updated to ensure effective decision making and system responsiveness to pressures.

3.2.7 During Winter 2022 we saw flu return at scale and MFT had robust plans in place to roll out and deliver its frontline vaccination programme to protect the public and staff over this winter, beginning early October. Currently 47% of

MFT's frontline staff have been vaccinated for flu. This is the highest performance across all Greater Manchester acute providers.

3.2.8 A new ready date of discharge metric was introduced nationally, which measures the time from when a patient is medically fit to leave an acute hospital bed to when they are actually discharged. In December 88.3% of patients were discharged on their discharge ready date, this is above the national average of 86.2%. All of which has been supported through the interventions on improving discharge in place.

3.3 Manchester Local Care Organisation (LCO)

3.3.1 **Hospital at Home / Admission Avoidance** - There is a delivery plan in place to roll out a Hospital at Home offer in full across the city of Manchester by March 2024. Hospital at Home Has rolled out across North and Central Manchester, with South Manchester community offer going live in March 2024. Between 65-80 people are supported on the pathway every single day. The target is to support 165 patients on the pathway by the end of March 2024. This target is based on work by operational and clinical leaders to design a safe and robust roll out plan.

3.3.2 **Manchester Community Response (MCR)** - Manchester Community Response (MCR) consists of health and social care integrated services that keep people well in their own homes through preventive measures or support timely flow out of our acute hospital sites. Follow a period of assessment and intervention MCR handover to our neighbourhood teams for continuation of support in the community. Manchester CRISIS team manage deflections from NWAS, primary and community services and ED. The national standard is for CRISIS to see patients within 2 hours of referral. In December 2023 performance was 90% against a target of 70%.

3.3.3 **Improving acute inpatient flow and length of stay** - to support improvement in acute flow, a recovery trajectory and plan has been agreed with system partners to reduce the number of patients with No Criteria to Reside (NCTR). The December average is 341 against target of 240. Actions continue to maintain operational grip based on a strengths-based approach to discharge, themed on 1) Early Planning Discharge 2) Streamlined Referral and Discharge Actions 3) Safe and Effective Discharges.

3.3.4 **Transfer of Care Hub** - The Transfer of Care Hub (ToCH) is a virtual network focused on supporting discharge and system communication. ToCH supports mutual aid, system escalation, locality and regional assurance, and improvements in discharge processes. This virtual network has added to the systems resilience during points of pressure, for example, during Industrial Action.

3.3.5 **Home First Discharge Policy Review** – The policy is currently in final ratification stages. The implementation of the policy will be supported by a resource library to support staff to deliver the hone first ethos.

3.4 Adult Social Care

3.4.1 **Home from Hospital – Voluntary, Community and Social Enterprise (VCSE) Collaborative** - to support people who have low or no social care needs, leaving on pathway 0 to enable them to settle in and prevent readmission or being discharged on pathway 1.

3.4.2 **Improving flow through Discharge to Assess beds –** a specialist Social Work team has been created to manage and support the flow through these beds increasing capacity and maximising opportunities to support people to return home from the Discharge to Assess beds. Through the winter period we have reduced the number of individual purchased beds and maximised the utilisation of our Discharge to assess beds.

3.4.3 **Increasing the capacity in Pathway 1 -** A review of the process and placing Reablement Flow Co-ordinators in the Integrated Discharge team to pull more people into reablement and reducing over prescription of care on discharge from hospital.

3.4.4 **Increasing the Social Work presence in the hospital -** To support the hospitals to improve the numbers of people with a 'Home First' approach and increase the flow into pathway 1 maximising opportunities and introducing a 'single handed transfer of care' prototype for people identified as needed two people to support in their care arrangements.

3.4.5 **Increasing flow in reablement –** additional flow co-ordinators have been put in place to increase capacity within reablement supporting discharge from hospital and stepping up from community to support admission avoidance. We have also continued to develop the reablement services to provide every person appropriate the opportunity to go through reablement.

3.4.6 **Supporting flow in Intermediate care units –** continued funding of Senior Social Worker to monitor and maintain flow in the intermediate care units, reducing delays due to social care and support, through working with the integrated teams we support people to return home.

3.4.7 **Integrated Control Room –** Additional resources invested into the Control room to maintain oversight of flow from the acute hospitals, and commissioning provision and care finding to support discharge in a timely manner.

3.4.8 **Social Care support to Greater Manchester Mental Health NHS Foundation Trust (GMMH) –** developing an urgent action plan to support flow in acute and mental health beds to free up capacity and reduce delays in these beds. These plans are continuing to be implemented, and there has been a focus on building the relationships with GMMH to support flow and discharge from hospital.

3.5 Greater Manchester Mental Health NHS Foundation Trust (GMMH)

3.5.1 **Winter Discharge Schemes** - GMMH have been allocated funds from the capacity funds which has contributed towards the maintenance of vital discharge, UEC and previous winter schemes. No additional schemes were mobilised in winter 23/24. A full evaluation of all winter, urgent and emergency care and discharge schemes are underway to ensure they remain fit for purpose and cost effective. Previous evaluations have evidenced the positive impact on flow.

3.5.2 **Mental health inpatient discharge and flow** – the Trust has developed a patient flow and discharge recovery plan that will be overseen by the unscheduled care programme board. GMMH with system partners have established a 3 tier multi-agency discharge event (MADE) to ensure effective flow and focus on reducing the patients clinically ready for discharge (CRFD) with focussed events planned for February 2024. The Trust continues to have oversight of all patients placed out of area via the North West Bed Bureau and community care coordinators are working with the ICB on quality contract monitoring.

3.5.3 **Implementation of the Crisis pathway model** - the Trust continues to work with Greater Manchester Police (GMP) and North West Ambulance Service (NWAS) to consider the response to right care right person and mobilisation of 111 press 2 for mental health in April 2024. Mobilisation of the mental health ambulance is scheduled for early spring in collaboration with NWAS and Pennine Care Foundation Trust.

3.5.4 **Accessing help in a Mental Health Emergency** – we are working to ensure appropriate use of our Health Based Places of Safety (HBPOS) and have made improvements in the number of patients admitted to these areas, rather than presenting to A&E.

3.5.5 **Access and community services** - the Trust has commissioned a full review of access to community service and continues to work in collaboration with Manchester City Council**.**

3.5.6 **Clear escalation processes for A&E** - the Trust continues to work closely with the SCC strengthening the escalation processes for A and E.

3.5.7 **Ensure mental health professionals are embedded in all emergency operation centres ahead of winter -** an embedded model of mental health clinicians into its Emergency Operations Centre (EOC) in Manchester continues to operate as a pilot scheme as an extension of the GMMH crisis line. A business case has been developed to develop this pilot into a substantive service as per the Long Term Plan requirements.

3.6 Manchester Primary Care

3.6.1 **Manchester Acute Respiratory Infection Service (MARIS)** - additional capacity for same-day respiratory appointments for children and adults. An

additional 14,000 appointments are being delivered during the winter period and national data indicates that 50% of these appointments would usually be undertaken in A&E.

3.6.2 **Additional Primary Care Resilience Same Day Access** - additional clinical and non-clinical sessions and GP surge hubs for adults and children. This is providing 21,000 additional clinician time face to face, telephone or virtual over the winter period.

3.6.3 **GP Federation Resilience Hubs** - 8,777 additional appointments in local hubs, these appointments can be booked by all practices. These appointments are operating at high utilisation rates.

3.6.4 **Improving access to General Practice** - implementation of a modern model of general practice. These plans include objectives around working towards improving online access, including website improvement, use of the NHS App and supporting patients to become more digitally enabled. Manchester saw a 14% increase in the number of appointments delivered in primary care between November 2022 and November 2023 (309,000 appointments during the November 2023 compared to 270,000 a year before). Manchester also saw a 12% increase in GP face to face appointments being delivered across the city.

3.6.5 **Personalised Care** - work to shift the focus of healthcare delivery from a reactive, episodic model to a proactive preventive approach. The focus is on three high impact cohorts: dementia, frailty and patients who regularly attend A&E (usually more than five times a year).

3.6.6 **Increasing support for self-directed care** - funding has been secured from the GM ‘Access and Inclusion’ resource for winter vaccination. This includes ‘English for Health’ which has a strong focus on vaccination and self-care.

3.7 North West Ambulance Service (NWAS)

3.7.1 In 2022-23, in common with all national emergency ambulance services, NWAS underperformed significantly against its response time standards. GM performs proportionately well, given its urban environment and relatively compact geography, however GM has suffered the same delays and long response times, that have been widely reported in the media. 999 call demand this year is about 40,000 calls lower than 22/23, but the number of incidents attended is about 10,000 higher. Last year NWAS frequently dealt with multiple calls for the same incident, due to long response times.

3.7.2 NWAS has been awarded a proportion of a national fund to support UEC recovery, specifically to improve the delivery of ambulance response times. NWAS has been able to focus on improving front line responding capacity, through recruitment of 80 new operational staff, as well as a further investment in our Clinical Hub, to improve our ability to redirect patients at the time of call, to the best place of care. By the end of Q1 23/24 GM will have an extra 11 emergency ambulances operational during peak demand hours. Additionally,

work is still underway to mobilise 2 rapid response mental health vehicles, as a joint endeavour between NWAS and the Mental Health providers.

3.7.3 During Q1&2, ambulance handover was very good across GM, and was a positive outlier both regionally and nationally. Industrial action in hospitals has not directly affected NWAS, however the recovery periods after industrial action have been very difficult for urgent and emergency care services, as elective surgery restarts, and beds are comparatively few.

3.7.4 As a year-on-year comparison, 23/24 has been better for patient response times and reliability of the 999 service, however the pressures in the wider health system around us during winter have been very challenging. NWAS is likely to achieve the interim 30 minute response standard for Category 2 calls in GM this year, but there are concerning signs that the sustainability of performance, linked entirely to hospital handover is not guaranteed.

3.8 Manchester Public Health

3.8.1 **Covid-19 vaccination** - General access to a Covid-19 vaccination was offered via six Primary Care Networks and 32 Community Pharmacies across the city. Access to timely, accurate coverage data has been restricted due to GM Integrated Care Board Tableau reconfiguration. Overall recorded uptake for Manchester was 34.1% at 21st January 2024, against 45.3% at the same point in 2023. This is reflective of the annual drop in uptake nationally since the Covid vaccination programme was launched in December 2020 and similar to the overall drop across Greater Manchester. Manchester had strong coverage within its care home population, coverage at 21st January 2024 was 72.7% compared to 70.9% at the same point in 2022. Housebound coverage continues with 73% of eligible patients as of 14th January 2024 receiving the vaccine which is similar to 22/23.

3.8.2 **Seasonal Influenza** - Access to flu vaccination is widespread through General Practice, Community Pharmacies with some hospital and third-party provision. Timely access to flu coverage data has been severely limited this year due to the current limitations of GM ICB Tableau referenced above. At 29th January 2024 flu coverage for over 65's was 66.6% and for under 65's at risk 35.5%.

3.8.3 **Reducing health inequalities** - The system approach to health equity through the provision of mobile vaccination van 'pop up' clinics has continued and expanded this winter, with 58 individual outreach clinics delivered as at 21st January 2024. These clinics commenced on 1st October to reach underserved populations and continued beyond the main programme closure date of 15th December through to 31st January 2024. Delivery was at a range of community venues, supermarket car parks, religious venues and across neighbourhoods citywide. This approach has delivered 2927 Covid Vaccinations as of 21st January 2024. In a new development for this year partnering with Community Pharmacy enabled 240 flu vaccinations to be co-delivered at pop-up clinics in an approach to integrated delivery to build on in future years.

3.8.4 Targeted and bespoke approaches have been delivered to the population via:

- Designated “calm clinics” offering both flu and covid vaccination to adults and children with Learning Disability, with clinics at Ross Place, Heathfield and Hall Lane Day Centres also providing an offer for people with mental illness and other complex needs.
- Clinics delivered by St Mary’s and MFT for pregnant women.
- Clinics delivered by Urban Village Medical Practice for homeless people.
- A partnership with George House Trust to deliver vaccinations to the eligible LGBT+ community.

4.0 Summary

4.1 In addition to the usual winter planning, there has been a lot of hard work over recent weeks preparing and managing the two bouts of industrial action, and this hard work continues as we move back into recovery.

4.2 Although undeniably extremely busy, working collaboratively as a system has meant getting through what is always the busiest few weeks of the year for the NHS. Moving forward, the system will continue to learn and reflect on its experiences from winter this year in preparation for next year.

4.3 Monitoring of the collaborative system working (the Provider Collaborative Board and the Manchester Partnership Board, with constant input from senior members of MFT, elected members and all stakeholders) will continue to ensure this extends beyond the winter period and is a year-round effort.

5.0 Recommendations

5.1 The Health Scrutiny Committee is asked to note the report.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 7 February 2024

Subject: Palliative and End of Life Care in Manchester

Report of: Manchester Deputy Place Lead and Marie Curie Lead

Summary

This report provides critical research from the *Better End of Life programme,* conducted in collaboration between Marie Curie*,* King's College London Cicely Saunders Institute, Hull York Medical School, the University of Hull and the University of Cambridge, in relation to experiences of palliative and end of life care, as well as identifying policies and resources that will help to make a positive difference to the lives of people affected by dying, death and bereavement. Marie Curie have asked all localities to respond to an audit questionnaire and the findings from this are discussed in the body of this report and will inform locality developments.

In order to give a rounded perspective of issues and challenges across Manchester as well as the GM Integrated Care Board, contributions have also been collected from the GM Quality Improvement Programme Manager, Palliative & End of Life Care, who describes the developments and ambitions of the GM Palliative and End of Life Care Programme, and the Manchester Locality Team, (Primary Care as well as Quality), where the issues and challenges in relation to transformation are discussed.

Recommendations

The Committee is asked to consider and comment on the report and in particular the findings from Marie Curie in section eight and the next steps for Manchester partners, which are set out in section nine.

Wards Affected: All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city	Supporting people to die in their own homes and in their communities of choice, supports the zero-carbon agenda for the city. In addition, the provision of high-quality, targeted and accessible information to unpaid carers through a streamlined network ensures sustainability and support for carers of people who are in receipt of palliative and end of life care
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector	There is still unwarranted variation for people with life limiting illness in accessing coordinated and streamlined palliative and end of life care, and in

Equality Duty and broader equality commitments	many cases, much earlier in the progression of disease or illness. Additionally, there are variations in experience for those with protected characteristics. The ambitions of the GM Palliative and End of Life Care programme as well as the Manchester Palliative and End of Life Care Partnership is to reduce health inequalities through collaboration, system co-production, understanding the needs of all communities and promoting an inclusive approach. All locality partners aim to engage with and involve patients/the public on the commissioning of a service and design of pathways to ensure that services meet the needs of Manchester people and align with other programmes of work such as Making Manchester Fairer and the Anti-Poverty Strategy as well as Community Health Equity Manchester, Manchester's Patient and Public Advisory Group and the Manchester Disability Collaborative.

Manchester Strategy outcomes	Summary of how this report aligns to the Our Manchester Strategy/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Carers of people who are in palliative and end of life stage are often disadvantaged in employment opportunities, with many carers ending employment opportunities when their caring responsibilities increase. By supporting Carers to maintain employment through care and support interventions is positive for the city's economy and positive for Carers.
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Access to co-ordinated, quality palliative and end of life care in a person's chosen environment should be a basic human right. This is a value of a progressive society and a key aspiration of the national Ambitions, and GM Commitments to establish a gold standard in ensuring that all people and their carers feel they are being listened to, and their views are taken into account at all points in their journey.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Full details are in the body of the report, along with any implications for:

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences – Revenue

There may be financial consequences for the revenue budget dependant on the acceptance of recommended changes.

Financial Consequences – Capital

There are no financial consequences for the capital budget.

Contact Officers:

Name: Carolina Ciliento
Position: Associate Director of Safety, Quality and Nursing, Manchester (locality)
Telephone: 07779 546663
E-mail: carolina.ciliento@nhs.net

Name: Morgan Tarr
Position: Local Public Affairs Officer, North West, Marie Curie
E-mail: morgan.tarr@mariecurie.org.uk

Name: Elaine Parkin
Position: Quality Improvement Programme Manager , Palliative & End of Life Care, NHS GM
Telephone: 07876 851865
E-mail: elaine.parkin1@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.

End of Life Care Strategy (publishing.service.gov.uk)

CQC_A Different Ending_3.pdf

Palliative and End of Life Care in Integrated Care Systems – Marie Curie

Better End of Life - Marie Curie

Taking the Temperature of NG6 - Marie Curie & National Energy Action

Seventy years of end of life care in the community: how much has changed since 1952? - Marie Curie

Bereavement is everyone's business – UK Commission on Bereavement

NHS England: Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

Greater Manchester Commitments: Approach for Palliative and End of Life Care (gmintegratedcare.org.uk)

1.0 Introduction

1.1 Marie Curie is a national charity that works to support dying people and their families. The organisation offers expert care across the UK in people's own homes and in Marie Curie's nine hospices. During 2023, Marie Curie supported more than 50,000 people across the UK at the end of their lives. Currently in Manchester Marie Curie provides hospice care at home and offers free information and services which give guidance and support to families. Marie Curie is also the largest charitable funder of palliative and end of life care research in the UK and campaigns for the policy changes needed to deliver the best possible end of life experience for all.

1.2 The World Health Organisation defines palliative care as the 'prevention and relief of suffering of adult and paediatric patients and their families facing the problems associated with life-threatening illness. These problems include physical, psychological, social and spiritual suffering of patients and psychological, social and spiritual suffering of family members.

1.3 Using this definition quality palliative care should:

- ensure early identification, assessment and treatment.
- enhance quality of life, promote dignity and comfort, and may also positively influence the course of illness.
- be integrated with and complement prevention, early diagnosis and treatment of serious or life-limiting health conditions.
- support bereaved family members after the patient's death.
- seek to mitigate the pathogenic effects of poverty on patients and families and to protect them from suffering financial hardship due to illness or disability.
- not intentionally hasten death, but provide whatever treatment is necessary to achieve an adequate level of comfort for the patient in the context of the patient's own values and spiritual beliefs.
- be applied by health care workers at all levels of health care systems, including primary care providers, generalists and specialists in many disciplines and with various levels of palliative care training and skill, from basic to intermediate to specialist care
- encourage active involvement by communities and community members
- be accessible at all levels of health care systems and within patients' homes.
- improve continuity of care through strengthened health and social care systems.

2.0 Background

2.1 Individuals that experience a life limiting illness should be supported to live as well as possible before they die. They should be empowered to make decisions about their own care, with their wishes and preferences at the centre of all care planning and clinical decisions. All individuals should be treated with dignity and respect, with appropriate culturally sensitive care available for those who need it. The reality is that for too many people report experiences

that fall short of what we all hope for and should expect at this stage of our lives. Currently there is significant unmet need for palliative and end of life care. The most recent estimates suggest that in England up to 25% of those who need palliative care are not receiving it. Applying national estimates this would equate to a minimum of around 830 people in Manchester going without the care they need each year.

2.2 The Health and Care Act 2022 directed that Integrated Care Boards (ICBs) have a legal responsibility to commission health services that meet their populations needs. The Act specifies all age palliative and end of life care services as a statutory responsibility of the ICB. The inclusion of palliative and end of life care is a welcome addition to the Health and Care Act given the rising numbers in the ageing population who are living longer, many with multiple co-morbidities and the advances in medicine supporting many adults and children to live longer with complex care needs.

2.3 In November 2023 Marie Curie published findings from a survey conducted with ICBs to see how they were responding to this new legal duty. The survey findings provide some grounds for optimism, as ICB respondents feel they are performing strongly in delivery of services, collaboration and engagement across providers, governance and accountability, and use of data to drive improvements.

2.4 However, the survey findings also point to areas requiring further work to ensure improved outcomes for people at the end of life. Only a minority of ICB respondents feel they have properly understood population need, and a majority report significant challenges in addressing inequalities in palliative and end of life care. Workforce and funding are seen as key barriers to improving services and ICBs also report significant gaps in some of the core components of commissioned palliative and end of life care services in the national Ambitions framework. Despite the legal duty being in place for over a year, current evidence indicates that nationally there is still an insufficient focus on palliative and end of life care both in needs analysis, commissioning and reduction of unwarranted variation.

2.5 The Covid-19 pandemic highlighted how hard it is for some groups of people with a terminal illness and their families to get the care and support they need, including people who are living in poverty, alone, or with dementia, or life limiting conditions not associated with malignancy (Cancer), as well as people with learning disabilities, those experiencing homelessness or who are in prison, ethnic minority groups, and LGBTQ+ people. The cost of living crisis is compounding this situation with poverty affecting more than 90,000 people each year at the end of their lives across the UK, including more than 1,100 in Manchester. 34% of people who die in Manchester are dying in poverty.

2.6 This is a key moment for action to improve palliative and end of life care. As a result of our ageing population, by 2043 it is estimated that 147,000 more people will require palliative care each year across the UK (a 25% increase). New models for delivering care in the community will be needed to reduce pressures on the NHS, local government and social care and, where it is the patient’s preference, for people to receive support to be cared for at home at

the end of their lives. Larger numbers of families and carers will also require support through the process of dying, death and bereavement.

2.7 Integrated Care Systems and Councils have a critical role to play in helping people to die well. Many of the core services that local authorities provide, such as social care, are important components of a high-quality approach to end of life care. Councils are also an important source of information and advice for residents, and can help to play a convening role locally, working in partnership with Integrated Care Systems, healthcare providers, other agencies, and the wider voluntary and community sector.

3.0 Marie Curie- 'Better End of Life Programme'

3.1 Health & Wellbeing

Good quality palliative and end of life care improves outcomes for individual patients, their carers and families however acute pressures on GPs and district nursing services, as well as workforce challenges in health and social care, within complex referral systems are making it extremely difficult for people to access the joined-up and local services they need. Research from Marie Curie's 'Better End of Life' programme indicates significant current challenges for people in accessing palliative and end of life care services in community settings, particularly outside of traditional office hours. Many struggle to access community nursing services and find it very difficult to access the palliative care medication they urgently require during nights and weekends.
(Note: The Better End of Life programme is a collaboration between Marie Curie, King's College London Cicely Saunders Institute, Hull York Medical School, the University of Hull and the University of Cambridge)

3.2 Palliative care also delivers cost savings by reducing pressures on the wider health and care system. Emergency admissions to hospital for people in the last 12 months of life cost in excess of £1.2 billion in 2018/2019. In Manchester 7% of deaths are preceded by at least three emergency admissions in the last three months of life (in line with the national average). People who receive palliative care in community settings are less likely to be admitted to hospital, less likely to attend A&E, and spend less time in hospital if they are admitted.

3.3 Financial Security

More than a third (34%) of people who die in Manchester do so in poverty. Many people experience poverty throughout their lives and continue to experience it as they reach the end of life. For many others however, the often devastating financial impact of terminal illness is what drives them into poverty even if they were previously financially stable as a result of a combination of income loss and additional costs after a terminal illness diagnosis. Working age parents with children are particularly vulnerable to moving into poverty after a diagnosis of terminal illness. In Manchester, 42% of working age people who die are below the poverty line in their last year of life.

Table 6. Number and proportion of working age people dying in poverty, 2019 (top 20 UK local authorities)

Local Authority	Region	Number died in poverty	% died in poverty
Tower Hamlets	London	102	44.0%
Newham	London	163	43.5%
Hackney	London	128	42.0%
Manchester	North West	314	41.5%
Birmingham	West Midlands	645	41.5%

Table 7. Number and proportion of pensioners dying in poverty, 2019 (top 20 UK local authorities)

Local Authority	Region	Number died in poverty	% died in poverty
Manchester	North West	822	32.0%
Tower Hamlets	London	201	27.3%
Newham	London	251	26.9%
Hackney	London	198	26.0%
Liverpool	North West	922	25.9%

The table above shows how Manchester ranks amongst other UK local authorities with regards to working age people and pensioners who die in poverty. Of all top-tier councils in England, Manchester currently ranks 4th highest for the proportion of working age people who die in poverty, and 1st for the proportion of pensioners who die in poverty.

3.4 Nobody should die in poverty. While much social security policy is outside the control of local government, there are important steps that local authorities can take to support local residents who are experiencing poverty or who are at risk of falling below the poverty line, including ensuring that people with a terminal illness are eligible for benefits that councils distribute. This is very much what the Manchester Anti-Poverty Strategy aims to address.

3.5 Inequality & Inequity

Profound and persistent inequalities exist in access to, and experiences of, care and support for people affected by dying, death and bereavement. Given the unique position and local insights they hold at place-level, local authorities have a key role to play in tackling inequity at the end of life. Groups and communities experiencing wider societal disadvantage, often at multiple intersections, are disproportionately represented among those without access to quality palliative and end of life care. These include, but are not limited to:

- People with conditions other than cancer
- The oldest old, i.e., people aged 85 years or over
- Racialised, minoritised ethnic communities
- People living in more deprived areas
- People with learning disabilities
- Imprisoned people
- LGBTQ+ communities

3.6 Support for carers

Around 38,200 people in Manchester care for a family member, friend or neighbour because they have long-term physical or mental health conditions, illnesses, or problems related to old age. Carers play a pivotal role in providing vital unpaid support to a family member or friend with a terminal illness, often doing so through to the end of that person’s life. This caring role is extensive, varied and in many cases around-the-clock.

3.7 Carers of people with a terminal illness are often older and have to manage the physical demands that caring places on their own health, at the same time as the impact of ageing. The demands of caring can have a significant impact on a carer's physical health, leaving them at increased risk of illness and injury. Looking after someone with a terminal illness can be a mental and emotional rollercoaster. Receiving news of a terminal illness diagnosis can be devastating and carers can experience feelings of fear, anxiety, and uncertainty about the future.

3.8 Despite the critical role that carers play and their huge contribution in supporting our social care system, the support available to them often falls short of what is needed. Under the Care Act 2014, carers are eligible for a formal assessment of their needs by their local authority, but only around a third of carers of a person with palliative care needs report having had an assessment done or reviewed in the past 12 months. The quality of assessments is also variable, with vital issues such as respite care and support with their own needs often not addressed.

3.9 Bereavement support

More than 18,000 people are bereaved in Manchester every year. Bereavement can be an exceptionally isolating and lonely experience, however almost everyone will experience a bereavement at some point in their life. While most people can be adequately supported by their friends, families and wider communities through a bereavement, some adults, children, and young people will also need more formal emotional support, whether from a peer support group, a volunteer, or a professional counsellor/therapist. But across the UK, over 40% of adults who want formal bereavement support don't receive any, while half of bereaved children said they didn't get the support they needed from their schools and colleges.

4.0 UK Commission on Bereavement

4.1 In 2022, the UK Commission on Bereavement carried out one of the largest ever consultations on bereavement support. It found that bereavement support needs to be more accessible; a lack of guidance and difficulty finding the right information about what to do after someone dies means that many bereaved people feel unsupported and lost. Furthermore, there is no legal right to take paid time off for bereavement, except parental bereavement leave for a person whose child has died, and many employers offer little or no additional bereavement support.

4.2 The Commission also highlighted that families can wait a long time for a funeral in some localities. Delays to funerals can be particularly upsetting for those bereaved families whose faith requires a swift burial. Out of hours systems to enable the rapid processing of death paperwork necessary for burials to happen quickly, which are available in some but not all local authority areas, can help.

4.3 The high cost of funerals, cremation and burials is another concern. The Commission also heard of difficulties some people experience in attempting to access public health funerals, in addition to some instances of stigma and hostility towards bereaved people seeking to access them. Public health funerals are provided by local authorities for people who have died when no one else is making the necessary arrangements for a funeral. There is a statutory duty on local authorities to arrange for a burial or cremation where no suitable alternative arrangements are being made, however, there is considerable variation in how these funerals are delivered across the country.

4.4 The Commission also found that for people living in social housing, a bereavement can also bring the profound worry and disruption of an immediate eviction notice. Some grieving people living in social housing receive an eviction notice and face the strain of having to find somewhere to live, or even the threat of homelessness, through no fault of their own. This is most common with adult children living with their parents. Having to leave the family home, with all its memories, can compound feelings of distress – especially so soon after the death.

4.5 Ensuring individuals and families are properly supported through bereavement also depends on tackling taboos and encouraging more open conversations about death and dying, helping to enable communities to adopt a compassionate approach to supporting bereaved people of all ages. Local Authorities can harness the resources and compassion of local people by embedding Compassionate Communities in their local areas. Compassionate Communities is a social movement where local people support others who are affected by dying, death and bereavement. They are networks of volunteers that work alongside formal services. (For example, a local person might volunteer to do food shopping for a neighbour who can't leave the house, or provide companionship to someone living alone with a terminal illness.) This support can make a huge difference to the person who receives it, while complementing the work of formal palliative care services.

5.0 GM Developments

5.1 The Greater Manchester Palliative and End of Life Care Programme was established in 2013 as part of the Greater Manchester and Eastern Cheshire Strategic Clinical Networks and now embedded with NHS Greater Manchester ICB. The programme reports into the NHS GM ICB Medical Directorate under the SRO Chief Medical Officer and is clinically led by a Consultant in Palliative Medicine and a GP from the GM system, supported by a Programme and a Project Manager.

5.2 Following the 2008 national End of life Care Strategy there has been several national publications which have supported the development of the 'Greater Manchester Commitments to Palliative Care individuals approaching or in the last year of life'. The GM Commitments outline a pledge to the citizens of GM and give clear direction of programme deliverables required, in preparation to meet a future need.

5.3 The Greater Manchester Commitments to palliative care individuals

approaching or in the last year of life, align to the National Ambitions for Palliative and End of Life Care which were refreshed in 2021. In direct response to the outlined statutory requirement in the Health and Care Act NHS Greater Manchester ICB Board agreed to a Greater Manchester all age programme in September 2023 to address the unwarranted variation in palliative and end of life care across Greater Manchester.

5.4 **Table 1:** The 10 outlined deliverables were agreed as:

1) Increase the **identification** of individuals in the last year of life and understand the prevalence of palliative care for babies' children and young people.
2) Increase the opportunity for personalised care conversations and **future care planning.**
3) Increase **digital sharing** of palliative and end of life care information for all ages through the GM Care Record.
4) Improve **data and intelligence** to support effective commissioning of palliative and end of life care across the system.
5) Address **workforce planning** to ensure an available workforce with the right skills to support the delivery of 24 hours 7-day services in palliative and end of life care for all ages
6) Grow **compassionate communities**.
7) **Address unwarranted variation** and inequalities in palliative and end of life care provision.
8) Professionals providing care for babies, children and adults with life-limiting illnesses should receive specific **training and education** in palliative and end of life care and in communication skills.
9) Every family shall have timely access to practical support, including clinical equipment, **financial grants, and benefits**.
10) To ensure **commissioning arrangements** to support palliative and end of life care provision are in place to are provide a seamless provision of care

5.5 The GM programme provides leadership, strategic direction and collaboration to support localities progressing against the GM commitments. The GM programme works across the GM Integrated partnership managing and supporting several groups to drive forward the work in relation to the 10 outlined deliverables. The GM programme has made significant progress in developing and supporting the implementation of an EARLY identification tool for primary care, which incorporates personalised approaches to advance care planning.

5.6 The programme is working with the GM system to support the use of the electronic palliative care coordination system (EPaCCS) as part of the Greater Manchester Care Record (GMCR) to enable the sharing of electronic records and advance timely decisions for people approaching end of life. The programme has undertaken scoping against the speciality palliative care nursing workforce and a service mapping to identify gaps in 24/7 provision and continue to work with the system to identify workforce solutions. The

programme support discussion for all sectors in sustaining specialist palliative care services to support the population of Greater Manchester.

5.7 A number of dashboards are in development to support a population view and system wide map of activity including the hospice sector. Work is just beginning in one locality to address a joint strategic needs assessment (JSNA) and the programme team are exploring how this could be applied to provide a GM view.

5.8 The ICB and Partnership are committed to addressing unwarranted variation and inequalities in palliative and end of life care. The GM Programme have completed an Equality Quality impact assessment which will be monitored through the governance of the programme. The CQC report ‘A Different Ending (2016)’ highlighted 10 communities who receive less than adequate provision or services for palliative and end of life care.

a. People with conditions other than cancer
b. Older people
c. People with dementia
d. People from black, or minority ethnic (BME) groups
e. Lesbian, gay, bisexual, and transgender people (LGBT)
f. People with a learning disability
g. People with a mental health condition
h. People who are homeless
i. People who are in secure or detained settings
j. Gypsies or travellers

Since this report another emerging group of people who are dying in poverty and deprivation is also of concern to the programme.

5.9 In Table 1, deliverable number six (Grow compassionate communities) and deliverable number seven (address unwarranted variation and inequalities in palliative and end of life care provision) of the GM programme are a direct response to focus on the aspect of inclusion. The programme has delivered several quality improvement initiatives to support the outlined groups who have been identified as receiving less than adequate palliative and end of life care.

5.10 Challenges

The current financial constraints of the health and care system impact on the speed in which the programme can make whole system transformational change. The programme continues to work with the ICB and ICP to seek opportunities for funding and collaboration to support the palliative and end of life care programmme of work.

6.0 Manchester Developments

6.1 Carers

Manchester Local Care Organisation in 2023 published the Manchester Carers Commissioning Strategy 2023 -2025. This was developed in partnership with Carers Manchester Network in order to provide access to support for unpaid carers. The strategy sets out the vision and priorities of 'Carers Manchester', shared by Manchester Local Care Organisation and statutory services (Manchester City Council, NHS). Support for Carers is now embedded within the welfare benefits system and the health service through the NHS Commitment to Carers, whilst the Care Act 2014 makes explicit provision for the statutory assessment of Carer wellbeing and support needs, providing parity with the needs of the cared-for citizen.

6.1.1 Whilst the carers of those in receipt of palliative and end of life care are not explicitly referred to, the focus areas of the strategy will have a direct impact such as Carers Champions and Carers Registers in all GP practices, improved links with Mental Health Assessors and teams, access to learning and development opportunities and carer respite (break) offers.

6.1.2 MFT Carers Strategy 2023 - 2026 sets out five key commitments including identification and recognition of carers, communicating with carers, partnership with health, social care and third sector services to best coordinate care, developing carers awareness across all areas of the organisation and to develop training for staff and ensuring reasonable adjustments.

6.1.3 The strategy cross references to MFT's Adult Supportive Palliative and End of Life Care Strategy 2021-2026. In the commitment entitled Identification and Recognition one of the key actions is "Ask carers 'What Matters' to them about the care of their significant other / loved one at all times, and particularly during Palliative Care of their loved one". Quotes from carers appear throughout the strategy and against the five commitments which highlight the reality of carers experiences.

6.2 Primary Care

For most individuals, care in the last year of life will be provided in their usual place of care, led and/or coordinated by the GP. GPs aim to identify patients at the end of life early so that there is time for care planning conversations to take place with the individual and family/carers and advanced care plans can be developed.

6.2.1 The Enhanced Health in Care Homes (EHCH) Service is a primary care service that supports some of our most frail and complex individuals living in older people's care homes. Within 7 days of moving into a care home an individual will receive a comprehensive geriatric assessment (CGA), which is a holistic physical/psychological/social assessment in partnership with the patient and family/carers. As part of this, advanced care planning discussions will be offered including priorities for future care and a focus on what matters to them.

6.2.2 This is an iterative process and plans are updated regularly as needed. GPs work closely with community teams, especially district nurses, to support patients to die in their preferred place of care. This includes prescription of

anticipatory medications. For more complex patients GPs will contact the community palliative care team for advice and referral.

6.2.3 Challenges

Clinical leadership: Historically Manchester has had a GP Clinical Lead for Palliative and End of Life Care to work with locality clinical leads, colleagues and system partners in driving forward transformation programmes and improvements in outcomes for patients at the end of life. Manchester Locality is in the process of identifying clinical (Medical) leadership resource to sit on the Manchester Palliative and End of Life Care Partnership Group to support the locality nursing leadership in the delivery of the ambitions of the GM Palliative and End of Life Care Programme.

6.2.4 *Care pathways*: Available data clearly indicates that hospital is still the most common place of death. This occurs for a number of reasons including lack of support for individuals and families, lack of care planning, care plans not followed, lack of knowledge and training for staff, lack of information sharing, individuals with complex conditions, often with difficult to manage symptoms. A system approach is needed to provide better joined up care with information sharing across organisational boundaries and more information and support for individuals and family/carers.

6.2.5 *Early identification* of individuals in the last year of life enables planned and coordinated care planning conversations. Late recognition can affect the opportunity for patient centred decision making, choice of preferred place of care and lead to unnecessary admissions to hospital. This can be difficult especially in individuals with chronic illness where the disease trajectory can be uncertain. Alongside training and education, tools that sit within the clinical scope can support clinicians in identifying patients in the last year of life who would then be clinically validated and appropriate treatment and support action taken.

6.2.6 *Information sharing* is vital to ensure that professionals involved in the care of individuals at end of life can see advanced care plans and have the most up to date information to make decisions and recommendations. Multiple partners are often involved in the individuals care and use different clinical systems that do not integrate or enable information sharing. Without this mechanism, care is not coordinated, communication is impeded and there is a risk that the individuals wishes and preferences will not be understood or followed.

6.2.7 *The Electronic Palliative Care Coordination System (EPaCCS*) is a national system that supports the electronic transfer of information, there is an ambition to roll this out across GM. It will take a whole system approach to embed this and issues such as information governance, data sharing, consent, interoperability, digital maturity, engagement and system programme management will need to be addressed and overcome at locality level.

6.3 Manchester Palliative and End of Life Care Partnership

6.3.1 A number of tools and information sources have been used to gain a better understanding of areas of care in Manchester that work well, where pathways and approaches can be improved, where there are clear gaps and where patient experience indicates inequity. These include the Regional Ambitions Self-Assessment Tool (completed in 2021- summary of outputs of this exercise in Table 2 below) and the Macmillan Evaluation of the Implementation of a new City Wide Community Service Delivery Model (completed in 2022, focus on Manchester Macmillan Supportive and Palliative Care Service). All individual services work to a vision for their patient group however feedback from patients and carers over a period of time has made clear that for more patients to access palliative and end of life care and to reduce inequity, all parts of the system must work together in an aligned way to achieve those shared improvements.

Table 2:

Summary of outputs from Manchester's self- assessment		
What works well	**What could be improved**	**What is a gap**
Recognised approach to personalised care and support planning for children and adults	Training strategy for developing communications skills across all health and care staff and evidence of access by staff group and grade	Use of data sharing across all service providers e.g. Electronic Palliative care Co-ordinating Systems (EPaCCS)
Identification of those at end of life across all care settings	Implementation of patient focused outcomes tool (Integrated Palliative Care Outcome Scale) across Manchester and Palliative Care Registers	Multi-lateral contract arrangements that support integrated care.
Local Population Health based needs assessment for individual service planning (e.g., non-malignant conditions)	Central all age directory of services and clear statement about level of service that can be expected	Local Population Health based needs assessment to influence integrated EOLC pathways across the system
Use of Equality Impact assessments to measure and demonstrate equity	Routine use of performance indicators and data to inform system quality improvement	Access to training in simple procedures/processes as well as bereavement support for carers – anticipatory grief counselling as well as post-bereavement, and 24/7 helpline support
Skilled assessment and symptom management	Level of training access and competence for staff in nursing homes	Holding providers to account for person centred outcomes and fair access to care
Emergent integrated system education strategy	Responsive services addressing all forms of distress	Inclusion of a Palliative and End of Life Care system delivery strategy (integrated

		care) in the Manchester Target Operating Model
Help to support patients and carers in self-managing and improving quality of life	Levelling up and consistency of attainment of ambitions across North, South & Central	A named all age system Clinical (Medical) Lead with oversight of hospital, community and primary care pathways.
Community engagement representing different faith & cultural groups is embedded	Use of volunteers	Access to equipment out of hours and on weekends
Access to bereavement counselling	Understanding of impact of anticipatory grief on carers and families	Access to 24/7 helpline and counselling

6.3.2 As a result of informal discussions with a range of agencies and organisations, the Manchester Palliative and End of Life Care Partnership came into being as a *quality improvement programme* reporting into the Manchester System Quality Group. This multi-agency partnership group is made up of representatives from Primary Care, MLCO Community Services, MFT Palliative and End of Life Care leads, GMMH, Medicines Optimisation Team, Locality Quality Improvement, Cancer leads, service user representatives, Manchester Macmillan Palliative Care Supportive Service and St. Ann's Hospice (please see section 7.3. System Structure: Interdependencies across system elements)

6.3.3 The purpose of the partnership is two-fold, firstly, to become the strategic lever for the quality improvement of palliative and end of life care, ultimately by establishing an agreed, standards-based system model of care for Manchester. This is not intended to take the place of individual provider strategies but as a collective ambition for Manchester as a system, and to provide the ICB with assurance of a system-wide collaboration for improvement and quality in specialist and non-specialist palliative and end of life care for the Manchester population (Adults & Children)

6.3.4 The ambitions of the Partnership are to:

- Deliver the GM Palliative and End of Life Care programme in Manchester.
- Ensure that care is available to all those who need it, prioritising quality of life, living and dying well.
- Reduce inappropriate admissions to hospitals.
- Increase individuals dying in their preferred place of care.
- Increase identification of people with palliative and end of life care needs across the Manchester system regardless of diagnosis, condition, and disability.
- Increase use of the Electronic Palliative Care Coordinating System (EPaCCS) across Manchester.

6.4.5 Priorities identified by both Greater Manchester and Manchester locality to achieve these ambitions include:

a) *Improving earlier identification in Primary Care*: this is linked to improving registered patients being placed on GP Palliative Care Registers at the earliest point to signal they have specific needs now or in the future in this area. Being placed on this register will trigger advance care planning discussions with GPs, Social Care and other professionals involved.

b) *Improving Advance Care Planning:* Advance care planning' (ACP) is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care. Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. It enables people to discuss and record their future health and care wishes and also to appoint someone as an advocate or surrogate, thus making the likelihood of these wishes being known and respected at the end of life.

c) *Improving Anticipatory Care:* Many people often equate Palliative and End of Life Care to cancer, however, there are many life limiting conditions and diagnoses where post-diagnostic planning and better monitoring could be initiated at a much earlier stage and consistently, but this is not always the case e.g dementia. Anticipatory care is often a consideration when a person is becoming visibly unwell or less mobile, whereas the actual purpose of this approach is to ensure that people are kept mobile and can enjoy their optimum independence for as long as possible. Good quality and pro-active care (system-wide and integrated) could avoid incidence of deconditioning, crisis management (crisis hospital admissions) as well as the opportunity to broaden offers of regular health checks for people with cancer as well as non-malignant diagnoses promoting a better quality of life.

d) *Improving access to anticipatory and post-bereavement support:* Many carers and families in the knowledge that their loved one is on a journey to end of life, experience anticipatory grief. For many, this can be as catastrophic as post bereavement grief. For some it provides a platform for preparation and planning, for others it can be a trigger for anxiety, loneliness and isolation. This phenomenon is often experienced as a "roller coaster" because feelings of distress can shift back and forth over a period of time. These experiences can apply both to the person dying as well as their carers and loved ones. Carers in particular have stated that access to counselling and support on a 24/7 basis would help to alleviate some of this distress.

e) *Improving the hospital to community discharge pathway:* Anecdotal feedback as well as incident reports tell us that the mechanisms for discharging patients from hospital back to their homes (or permanent setting) do not always operate efficiently, and communication is sometimes compromised. Work to improve this is already underway through various routes including the Resilient Discharge Programme, Primary/Secondary Care Interface meetings, Care Home Clinical

Subgroup. The Partnership brings together lead practitioners through which system issues can be addressed with a feedback loop into quality assurance mechanisms.

f) *General/Specialist skills:* While the Manchester Macmillan service provides excellent specialist support in managing plans for patients and carers, there is scope for further collaboration and integration with frontline services that deliver care to patients in-hours and out of hours. For example, where patients with a palliative diagnosis are flagged to North West Ambulance Service, Manchester Crisis Response and/or the IV service that have not previously been referred to the palliative care team (conditions including dementia, heart failure, respiratory disease). There is an opportunity to explore the confidence, competence and upskilling required for frontline services to provide reactive (generalist), palliative and end of life care/support, across disease groups and settings, for patients experiencing crisis, particularly late in the evening to avoid unwanted hospital admission. Investment in accredited training for appropriate staff and clinical supervision should be considered to strengthen and sustain good , consistent palliative and EOL care.

g) *The Electronic Palliative Care Coordination System (EPaCCS*) as stated in point 6.2.7, is a national as well as GM an ambition to roll this out across GM which will come under the oversight of the Partnership Group.

h) *Co-production/lived experience:* As part of the Manchester Macmillan Supportive and Palliative Care Service (MMSPCS) Programme a large and active service user group was in place for 3 years supported by a funded coordinator. This arrangement came to an end when the Macmillan service became embedded as part of MFT. The Partnership group has sought to maintain contact and involvement with a small number of service users and carers. Their voice and experiences are vital in ensuring quality of experience and in reducing inequalities. This will be further scoped by the group.

i) *Inequalities:* The Partnership is one of a number of points in the system where inequalities is a key focus. Reduction of unwarranted variation in patient experience should be a core activity. Various data sources indicates that there is an under representation of those identifying as ‘other than white’ on the Palliative Care Registers (PCRs) compared to the general population. Potentially people from minoritised communities may be coming to the attention of crisis services at very late stages of their conditions. In addition while cancer is the most prevalent long-term condition for those on both the Palliative Care Register and service users within the Manchester Macmillan Palliative Care service, it ranks 8th overall for the Manchester adult population with just 2.3% of the population on the GP Cancer Register. The recognition of the need for, and access to, palliative care for those living with non-malignant disease (e.g. Dementia, Heart Failure, etc) needs to be improved.

6.5 Challenges

6.5.1 *Programme coordination*: As a result of the ICB restructure, all ICB and Locality Teams are working in a much leaner way. System transformation requires overall programme management and coordination, at the present time these resources are unavailable. Consequently, all members of the Manchester Palliative and End of Life Care Partnership are working together within the parameters of their existing roles. This means that change will be slower and some resources (such as for the system roll out and implementation of EPaCCS) are not currently visible. This will directly impact on achievement of the ambitions overall.

6.5.2 *Locality priority*: Whilst Palliative Care is one of the nine health priorities as advised by NHS GM for Locality Delivery Portfolios, the definition “Inpatient palliative care related diagnosis and specialty admissions” narrows the perspective to Hospice care, and a relatively smaller population than those who die at home or in hospital. Commissioning of hospices is now within the remit of the GM Sustainable Services Programme Board. The definition above does not bring into focus community pathway redesign as this is not directly commissioned, as well as being a narrower reflection of the reality of many patients and families’ experiences. Locality Boards may opt not to include Palliative and End of Life Care as one of their commissioning priorities.

6.5.3 *Generalist Training*: Availability of recurrent resources to be able to work with the various sectors in establishing a meaningful anticipatory and post bereavement service for carers and their families, as well as establishing specifically skilled staff to provide competence based training to care homes, primary care, generalist staff across neighbourhood teams, community services, etc, This needs to be a system wide programme within an agreed model of training in order to ensure the required standards. Appropriate resources are not currently available within the system.

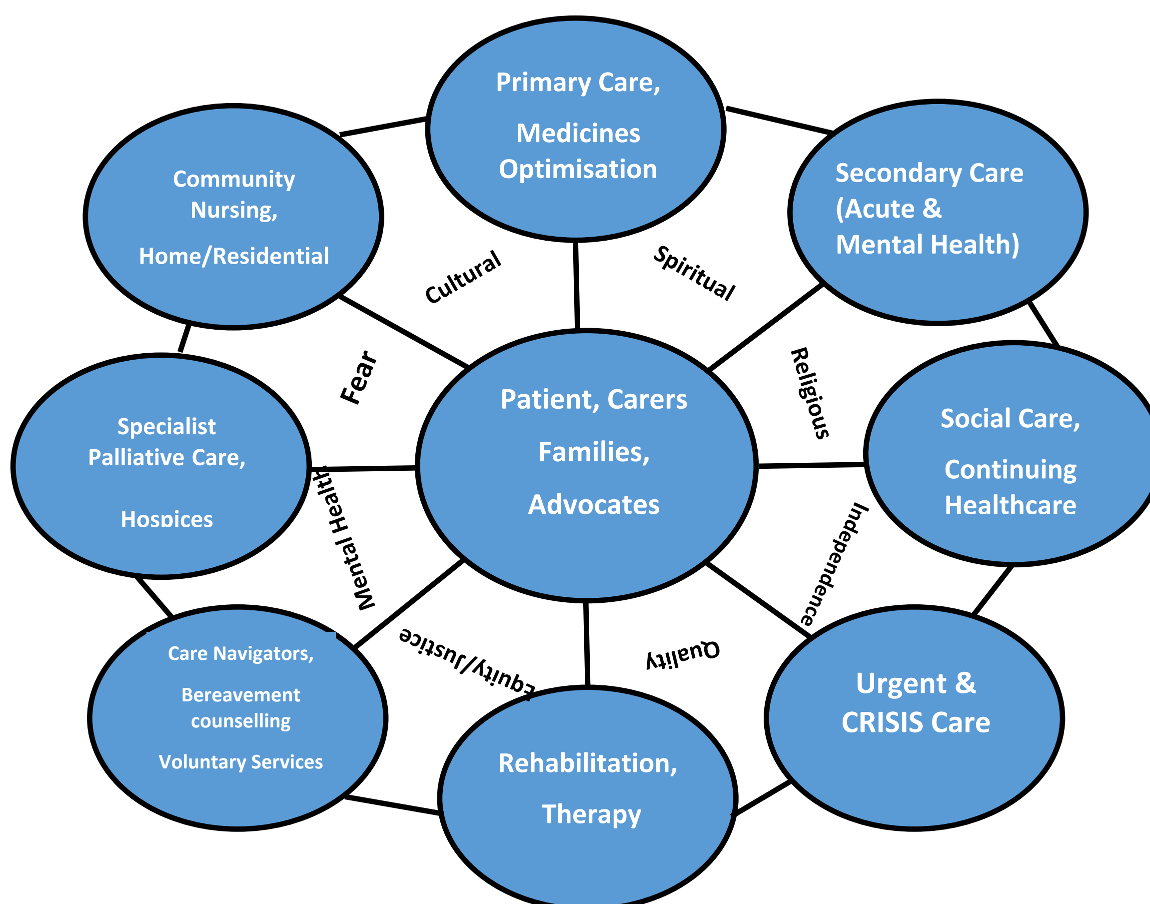
6.5.4 *Quality Standards*: Whilst there is commitment to achieving the standards laid out by the national ambitions demonstrated by Macmillan and “specialist” elements of MLCO and MFT (through its strategic statement), there is still significant work to be done to establish an agreed strategic approach that is owned by Manchester across the system. The involvement of all system stakeholders is critical in developing and agreeing a Manchester system model for palliative and end of life care that can be considered a seamless standards-based offer, providing early identification and timely intervention for all patients where appropriate, regardless of condition and symptomology as well as a full support offer for carers.

7.0 Summary

7.1 Personal experience of palliative and end of life care will only happen once in any person’s life, there are many touchpoints in the system that can work together in a more seamless way to ensure access, quality and as close to a positive experience as possible for patients, their carers and families.

7.2 This report has raised a number of issues regarding equitable access across conditions and minoritised communities. However, the needs of less visible communities such as people with learning disabilities, those who are homeless, people from travelling communities, those in prison, those with mental illness and detained under the Mental Health Act, and those with substance misuse problems with life limiting physical conditions also need consideration.

7.3 System Structure: Interdependencies across system elements



8.0 Marie Curie Findings

As a result of the *Better End of Life Programme* research, other policy/guidance as well as patient experience, Marie Curie is asking all Integrated Care Partnerships, Councils, providers and partners to discuss and consider the following:

8.1 To help improve the health and wellbeing of those living with a terminal illness:

- Ensure that all partners are meeting their statutory duties relating to palliative and end of life care and that services are culturally competent to meet the needs of our diverse communities. Services will need to address the inequalities of access and experience outlined in the Marie Curie report linked to protected characteristics and poverty.

- Ensure a fully accessible 24/7 palliative and end of life care advice line is in place so that local people, as well as health and care professionals, know where to turn for specialist palliative care advice when they need advice and support.
- Undertake and publish a Joint Strategic Needs Assessment specifically for palliative and end of life care to identify the current and future needs of the local population, which would give commissioners an accurate picture of local demand for services.

8.2 To help alleviate financial pressure on people living with a terminal illness:

- Review eligibility criteria for Council Tax Support to ensure that people living with a terminal illness and their family and carers are eligible, irrespective of age or savings.
- Prioritise people living with a terminal illness when allocating Discretionary Housing Payments.
- Consider the outgoings, as well as the income and assets, of applicants for Disabled Facilities Grants and fast-track the process and payment of grants.
- Use leadership roles on Health and Wellbeing Boards to ensure compliance with the National Institute for Health and Care Excellence's NG6 guidelines around excess winter deaths, illness and the health risks associated with cold homes.

8.3 To address health inequalities and inequities:

- Use their influence in supporting Integrated Care Boards to meet its new statutory duties relating to addressing and tackling health inequalities over the whole life course, including at the end of life.
- Ensure that an inequalities lens is embedded while conducting Joint Strategic Needs Assessments, providing commissioners with an understanding of the local unmet healthcare need for disadvantaged groups over the whole life course, including at the end of life.

8.4 In order to better help support carers:

- Ensure that every carer of someone with a terminal illness is offered a carer's assessment at least annually and that recommendations are acted upon promptly and fully.
- Ensures that Council's Carers' Strategies includes a specific focus on carers of people with a terminal illness and support through bereavement.

8.5 To help support all those who have experienced a bereavement:

- Reviews policies and procedures relating to public funerals to ensure that all people accessing such funerals are able to do so in a dignified manner.
- In its role of social landlord, allow a six-month grace period for evictions after a bereavement.

- Encourage schools and local employers to adopt a bereavement policy to ensure that people are supported through bereavement at school and at work.
- Embed a Compassionate Communities approach to complement the work of formal bereavement services.
- Ensure out of hours systems are in place to enable rapid processing of death paperwork and registrations so that quick burials can take place for people whose religion requires this.

9.0 Next steps for the Manchester system

9.1 It is proposed that Marie Curie and relevant officers from MCC and partners, meet again to discuss and consider the above findings and also the best approach for ongoing member engagement and involvement in this area of work.

9.2 The Manchester Palliative and End of Life Care Partnership will be supported to ensure that Palliative and End of life Care becomes a priority for system improvement through the new integrated arrangements relating to the Provider Collaborative Board (PCB) and Manchester Partnership Board (MPB).

9.3 The Manchester Palliative and End of Life Care Partnership will then be able to work through the PCB and MPB and bring back a report on progress to the Manchester Health Scrutiny Committee in the new municipal year.

9.4 Finally, Manchester partners have welcomed the excellent work of Marie Curie and their audit questionnaire has been completed by MCC officers and partners. This has helped to inform the content of this report and the next steps.

10.0 Recommendations

10.1 The Committee is asked to consider and comment on the report and in particular the findings from Marie Curie in section eight and the next steps for Manchester partners, which are set out in section nine.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 7 February 2024

Subject: Overview Report

Report of: Governance and Scrutiny Support Unit

Summary

This report provides the following information:

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

Recommendation

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

Wards Affected: All

Contact Officers:

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

Background document (available for public inspection): None

1. Monitoring Previous Recommendations

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

Date	Item	Recommendation	Action	Contact Officer
11 October 2023	HSC/23/43 Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027	1. All Council strategies and policies are to be framed and prominently articulated with the Marmot Themes and Making Manchester Fairer. 2. All Ward Plans should be framed and structured using the key themes of Making Manchester Fairer. 3. That officers provide a briefing note that described the methodology used to identify those areas with the highest need. 4. That officers provide a briefing note that details the location of temporary accommodation across the city and how that relates to the MMF methodology set out in (3) above.	1. This recommendation has been forwarded for consideration. A response to this recommendation will be circulated to Members when available. 2. This recommendation has been forwarded for consideration. A response to this recommendation will be circulated to Members when available. 3. This recommendation has been forwarded. A response to this recommendation will be circulated to Members when available. 4. This recommendation has been forwarded. A response to this recommendation will be circulated to Members when available.	Lee Walker Scrutiny Support Officer
10 January	HSC/24/02 Support For	The Committee recommends that the Executive Member for	A response to this recommendation will be circulated to Members when	Lee Walker Scrutiny Support

Date	Item	Recommendation	Action	Contact Officer
2024	People With Complex Needs And The Role Of Social Workers & Tackling Alcohol Harm in Manchester	Healthy Manchester and Adult Social Care and the Chair of the Health Scrutiny Committee engage with the Mayor of Greater Manchester with the view to establishing a Manchester Manifesto to tackle the alcohol industry on the issue of alcohol-related harm.	available.	Officer
10 January 2024	HSC/24/04 Enabling Independence Accommodation Strategy Update	That a visit to the Smart Suite be arranged for Members.	Dates for this proposed visit were circulated to Members 25 January 2024.	Lee Walker Scrutiny Support Officer

2. Key Decisions

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

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

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

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

An extract of the most recent Register of Key Decisions, published on **29 January 2024,** containing details of the decisions under the Committee's remit is included below. This is to keep members informed of what decisions are being taken and, where appropriate, include in the work programme of the Committee.

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

There are no Key Decisions currently listed within the remit of this Committee.

3. Items for Information

Care Quality Commission Reports

The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England.

Key to Inspection Ratings

Services are rated by the CQC according to how safe, effective, caring, responsive and well-led they are, using four levels:

- **Outstanding** – The service is performing exceptionally well.
- **Good** – The service is performing well and meeting expectations.
- **Requires improvement** – The service isn't performing as well as it should and the CQC have told the service how it must improve.
- **Inadequate** – The service is performing badly and the CQC have taken enforcement action against the provider of the service.
- **No rating/under appeal/rating suspended** – There are some services which the CQC can't rate, while some might be under appeal from the provider. Suspended ratings are being reviewed by the CQC and will be published soon.

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

Provider	**Address**	**Link to CQC report**	**Report Published**	**Type of Service**	**Rating**
Creative Support Ltd	Creative Support - South Manchester Womens Service 65 Longley Lane Manchester M22 4JD	https://www.cqc.org.uk/location/1-2648400357	19 December 2023	Homecare Service	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Engage Care Services Ltd	Engage Care Services - Main Office Unit 58, Cariocca Business Park Sawley Road Miles Platting Manchester M40 8BB	https://www.cqc.org.uk/location/1-9933944079	12 January 2024	Homecare Service	**Overall: Inadequate** Safe: Inadequate Effective: Requires improvement Caring: Inadequate Responsive: Requires improvement Well-led: Inadequate
Greater Manchester Oral Surgery and Restorative Group Ltd	The Lodge Dental 6 North Road Manchester M11 4WE	https://www.cqc.org.uk/location/1-9749539563	12 January 2024	Dentist	**No Action Required**
Beacon Medical Centre	Beacon Medical Centre 156 Victoria Avenue Manchester M9 0FN	https://www.cqc.org.uk/location/1-1962115815	9 January 2024		**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Requires improvement Well-led: Good

Mrs Ala Vitkuniene	Withington Dental Care 240 Mauldeth Road West Withington Manchester M20 1BE	https://www.cqc.org.uk/location/1-296997219	15 January 2024	Dentist	**Overall:** Safe: No action Effective: No action Caring: No action Responsive: No action Well-led: Improvements required

Health Scrutiny Committee
Work Programme – February 2024

Wednesday 7 February 2024, 2pm (Report deadline Friday 26 January 2024)

Item	Purpose	Lead Executive Member	Lead Officer	Comments
Budget Proposals for Adult Social Care And Public Health	To receive the final set of budget proposals for Adult Social Care and Public Health prior to the Executive and Full Council.	Councillor T. Robinson	Bernie Enright, David Regan	
Implementation Of The 2023/24 Winter Plans	Following on from the report presented in September and reflecting the format of the extraordinary meeting held in February 2023, system partners will attend to report back on how effective winter plans were.	Councillor T. Robinson	Tom Hinchcliffe, Bernie Enright, David Regan	
End of Life Care	To receive a report on end-of-life care (palliative care). The scope of this report is to be agreed.	Councillor T. Robinson	Tom Hinchcliffe, Bernie Enright, David Regan	
Overview Report	The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission.	-	Lee Walker	

Wednesday 6 March 2024, 2pm (Report deadline Friday 23 February 2024)

Item	Purpose	Lead Executive Member	Lead Officer	Comments
Carers Strategy	Following the presentation of the Carers Strategy to the Committee in March 2023, an update on strategy implementation will be provided to the Committee.	Councillor T. Robinson	Bernie Enright	Invitations will be extended to frontline service providers and people with lived experience.
Manchester Public Health Annual Report	To receive the 2023/24 Public Health Annual Report which will focus on sexual health and HIV.	Councillor T. Robinson	David Regan	Invitations will be extended to frontline service providers and people with lived experience.
Update On Health Infrastructure Projects	Following the visit by members of the Health Scrutiny Committee to North Manchester General Hospital in March 2023, the Committee will receive an update report on the new hospital programme and progress in north Manchester.	Councillor T. Robinson	David Regan Tom Hinchcliffe	This item was previously considered at the 11 January 2023 meeting.
Final Report and Recommendations of the Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Task and Finish Group	To receive a report which presents the findings of the detailed investigation undertaken by the Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Task and Finish Group.	-	Lee Walker	TBC – Subject to approval of the Final Report and Recommendations.
Overview Report	The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of	-	Lee Walker	

	those organisations that have been inspected by the Care Quality Commission.			

Items to be Scheduled				
Item	Purpose	Executive Member	Strategic Director/ Lead Officer	Comments
Findings From CQC Reports into Manchester Based Services and The Publication Of The GMMH Independent Review by Professor Shanley	To receive a report that describes the findings from CQC reports into Manchester based services and the publication of the GMMH Independent Review by Professor Oliver Shanley OBE.	Councillor T. Robinson	David Regan, Bernie Enright	
An Update on Health Protection Outbreaks as They Arise	To receive an update on health protection outbreaks.	Councillor T. Robinson	David Regan	
Greater Manchester Mental Health NHS Foundation Trust: Improvement Plan Update	Further to the meeting of 24 May 2023 to consider a report from the Greater Manchester Mental Health NHS Foundation Trust that provides an update on the Trust's Improvement Plan.	Councillor T. Robinson	Chief Executive of GMMH	
Access to NHS Primary Care – GP, Dentistry and Pharmacy	To receive a suite of reports that provide an update on the provision and access to primary care services across the city.	Councillor T. Robinson	Tom Hinchcliffe	Previously considered 8 February 2023.
2022/2023 Manchester Safeguarding Partnership Annual	To receive the annual report of the Manchester Safeguarding Partnership with a focus on Adults.	Councillor T. Robinson	Bernie Enright	

Report				