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MANCHESTER CITY COUNCIL

Manchester Integrated Care Partnership

Manchester Partnership Board

Date: Friday, 10 November 2023
Time: 3.00 pm
Venue: Council Antechamber, Level 2, Town Hall Extension

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Membership of the Manchester Partnership Board

Councillor Craig, Leader of Manchester City Council (Chair)
Councillor T Robinson, Executive Member for Member for Healthy Manchester and Adult Social Care (MCC)
Joanne Roney, Chief Executive Manchester City Council (Manchester Place Based Lead)
Julia Bridgewater, Deputy Chief Executive NHS Manchester Foundation Trust
Katy Calvin-Thomas, Chief Executive Manchester Local Care Organisation
Mark Cubbon, Chief Executive NHS Manchester Foundation Trust
Tom Hinchcliffe, Deputy Place Based Lead
Manisha Kumar, NHS GM Integrated Care Board Exec Representative
Vish Mehra, Chair Manchester GP Board
Sohail Munshi, Chair of Clinical Professional Group
David Regan, Strategic Director - Population Health (MCC)
Simone Spray, VCSE Representative
Neil Thwaite, Chief Executive, Greater Manchester Mental Health Trust

Agenda

1.	**Welcome, Introductions and Apologies**	
2.	**Declarations of Interest**	
3.	**Minutes of the previous meeting** To agree as a correct record the minutes held on 15 September 2023	7 - 10
4.	**Matters arising (if any)**	
5.	**Any Other Business (if any)**	
6.	**ICB/ICP Updates**	
7.	**Strategic Financial Framework** Report of the Chief Officer – Strategy & Innovation, NHS Greater Manchester attached	11 - 16
8.	**Admissions Avoidance** Report of the Chief Executive, Manchester Local Care Organisation (MLCO), Chief Medical Officer (MLCO) and Deputy Place Based Lead attached	17 - 24
9.	**Strengthening our approach to Patient & Public Engagement in Manchester** Report of the Chief Executive and and Placed Based Lead attached	25 - 32
10.	**System Finance Update** Report atached	33 - 40
11.	**Date of next public meeting** To note that the date of the next public meeting of the MPB will be 23 January 2024 at 11:00am	

Reports for Noting (comments by exception)

12.	**Manchester Provider Collaborative Board** Report of the Chair of Manchester Provider Collaborative Board and Executive Member for Healthy Manchester and Social Care attached	41 - 46
13.	**GP Board Update** Report of the Chai of Manchester GP Board attached	47 - 50
14.	**Clinical Professional Advisory Group** Report of the Chief Medical Officer (MLCO) attached	51 - 54

Information about the Board

The Manchester Partnership Board is a Committee or Sub-Committee of the NHS GM Integrated Care Board (ICB), and brings together the senior leaders of the City Council, NHS (primary, secondary and community and mental health services) and the VCSE from across the city to exercise those functions delegated to it by NHS GM. Its role is to focus on shared priorities; those areas where, by working together, we can improve the health and well-being of the people of Manchester.

The purpose of Manchester Partnership Board (MPB) is to:

- Agree the shared priorities and strategic direction for health and care and public health in Manchester.
- Ensure integrated and aligned delivery across health and care and public health.
- Agree any resource allocation within the scope of responsibility delegated to it by another party.
- Ensure that all elements of Council and NHS services are aligned with the agreed strategic direction.
- Act as an interface with the GM Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

The responsibilities for MPB will cover the same geographical area as Manchester City Council., These are:-

- To develop a plan that captures and quantifies the activities that require partners to come together to improve the health and well-being of the local people. This will include:
- Any necessary response to the Joint Strategic Needs Assessment
- Plans to address unwarranted variation and meet agreed standards
- To monitor delivery of the agreed plan and ensure that it delivers the expected improvements to health and well-being of residents.
- To be cognisant of, and work with, other localities when necessary and appropriate.
- To act as the forum to consider and agree the use of any discretionary/delegated funds that are related to the stated purpose of the Board.
- To review City Council and NHS strategic plans to ensure that they are aligned with the agreed strategic direction.
- To agree appropriate representation at ICS fora and to agree the Manchester position (or where there is not an agreed position to reflect the varying views of the Board).

Meetings will ordinarily be scheduled on a monthly basis and may alternate between public meetings for transacting formal business, and private meetings for non-formal business.

The Chair may call extraordinary meetings at their discretion. A minimum of five clear working days' notice will be required in such an event.

Agenda, reports and minutes of all public meetings of this Board can be found on the Council's website www.manchester.gov.uk

Further Information

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

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Manchester Partnership Board

Minutes of the meeting held on Friday, 15 September 2023

Present:
Councillor Craig, Leader MCC (Chair)
Councillor Robinson, Executive Member for Healthy Manchester and Adult Social Care, MCC
Joanne Roney, Place-Based Lead and Chief Executive MCC
Katy Calvin-Thomas, Chief Executive Manchester Local Care Organisation
Tom Hinchcliffe, Deputy Place-Based Lead

Dr Vish Mehra, Chair Manchester GP Board
Dr Sohail Munshi, Chair of Clinical Professional Group
Simone Spray, VCSE Representative
Prof Manisha Kumar, Chief Medical Officer, NHS GM

Also present:
Cordelle Ofori – Deputy Director Public Health, MCC
John Foley – Greater Manchester Mental Health Foundation Trust
Darren Banks, Group Director of Strategy, MFT
Julie Taylor, Director of Strategy and Provider Collaboration, MICP
Leigh Latham, Associate Director of Planning, MICP

Apologies:
Mark Cubbon, Group Chief Executive, MFT
Julia Bridgewater, Group Deputy Chief Executive, MFT
David Regan, Strategic Director - Public Health, MCC
Jan Ditheridge, Interim Chief Executive, GMMH

MPB/23/14 Welcome, Introductions and Apologies

The Leader was not present at the start of the meeting. The Place-Based Lead chaired the first part of the meeting until the Leader joined.

MPB/23/15 Minutes of the previous meeting

Decision

The Board approved the minutes of the previous meeting held on 7 June 2023 as a correct record.

MPB/23/16 ICB Executive update

The Chief Medical Officer, NHS GM provided an update on behalf of the Integrated Care Board (ICB) Executive. In doing so she provided an update on the following areas:-

- The transitioning of staff into new roles and outstanding positions
- The anticipated future financial position; and

- The impact on performance arising from planned strike action

The Leader joined the meeting during his item and took the chair.

Decision

The Board note the update.

MPB/23/17 Winter Planning

The Board considered a report of the Deputy Place Based Lead, which gave an overview of the key elements of the Manchester system's proposed approach to winter planning for 2023/24, alongside updates setting out what would be delivered by partner organisations over winter.

A full system winter plan was to be developed through the two urgent care system boards – Manchester and Trafford Operational Delivery Group (ODG) and Urgent Care Board (UCB). A first iteration of the system plan would be shared at the September Urgent Care Board, with a further update in October, and then as required throughout winter.

In line with previous years, the Manchester and Trafford System Resilience Team would lead and co-ordinate on all aspects of winter planning and the lessons learnt from winter 2022/23 had been incorporated into the organisational delivery plans.

The approach to winter planning had also been considered by the MCC Health Scrutiny Committee and the Council's Executive. The Provider Collaborative would consider the system plan in October and would have an important role in helping to shape the final plan.

The Board discussed the report in further detail. The Board noted that organisations within the Manchester system had more detailed winter plans that each informed the system winter plan. The system winter plan sought to draw out overall pressures across the system and identify areas that required cross-system collaboration. Further work was being done on demand and capacity mapping across the system, which would inform the winter planning process. Work was also underway to align available system funding against the priorities outlined in the winter plan.

Decision

(1) The Board note the contents of the report.
(2) The Board approve the winter planning process proposed and the role of the Provider Collaborative and Urgent Care Board in developing the winter plan further.

MPB/23/18 Measuring progress against MPB priorities

The Board considered the report of the Deputy Place Based Lead that stated that in June 2023, MPB received a paper that set out the MPB priorities and associated

delivery plan, showed the high-level outcomes that the programmes were seeking to achieve, and indicated that further work needed to take place to identify progress measures. The report provided an update of the work which had taken place over the summer to define the success measures and key performance indicators for the MPB priorities.

The locality priorities would be assessed alongside the wider NHS GM performance framework, and in particular those elements where responsibility sat at place level. At the June MBP meeting, whilst an update on the developing GM performance framework was provided, it was not clear at that stage what the role and responsibilities of the locality were relation to this. The work on the ICB Operating Model, through the Carnall Farrar Review of Leadership and Governance had provided further clarity on this. The report also provided further detail for 23/24.

Whilst the NHS GM Operating Model was awaiting final approval by the NHS GM Board later in September, the report provided the latest position.

The Board discussed the report in further detail. It was important that reporting to MPB had a clear purpose, and mapped across to the responsibilities delegated to the locality by the ICB. Maintaining clear lines of accountability was important, and it was noted that in some areas, partners were already reporting into other ICB structures, or reporting directly into NHSE at regional or national level. Care should be taken not to introduce duplication in reporting.

Reporting into MPB needed to reflect the levers the Board had to effect change across the City, and help demonstrate where the partnership added value. Reporting needed to include wider metrics that benchmarked the overall condition of the system, and progress against MPB's strategic aims, as well as individual programmes. The Operating Model provided some additional clarity on roles and responsibilities across the ICS, but further work was needed in order to translate this into an effective performance dashboard.

Decision

The Board:-

(1) Note the progress that has been made to identify metrics against the MPB delivery plan
(2) Note the draft Place-Based oversight of national NHS objectives for 2023/24.
(3) Agree the suggested approach to monitoring progress.

MPB/23/19 Date of next public meeting

The Board agree that its next public meeting would be Friday 10 November at 3.00pm.

MPB/23/20 Manchester Provider Collaborative Board update

The Board considered the report of the Deputy Chief Executive (MFT)/Chair of Manchester Provider Collaborative Board and – Executive Member for Healthy

Manchester and Social Care/Chair of Manchester Provider Collaborative Board. The report provided an update to the (MPB) on the work of the Provider Collaborative Board, as part of the agreed reporting cycle to MPB. The report covered the outputs of the meeting held 20 July 2023.

The key discussion points from the meeting were: -

- Keeping Well at Home (Hospital@Home); and
- GMMH Improvement Plan.

Decision

The Board:-

(1) Note the discussions at the Provider Collaborative Board (PCB) meeting held 20th July.
(2) Note that PCB members will be contributing to the finalisation of the outcome measures for the Keeping Well at Home programme.
(3) Note the progress update on the GMMH Improvement Plan and the remaining system challenges, particularly relating to workforce.

MPB/23/21 Delegated Assurance Board

The Board considered the report of the Deputy Place Based Lead that stated the Delegated Assurance Board (DAB) formed a key element of the governance structure for the Manchester Locality, as part of NHS Greater Manchester Integrated Care (NHS GM). The DAB is a sub-group of the Manchester Partnership Board (MPB) and is a means for the Place Based Lead (PBL) to gain support and assurance in discharging their responsibilities.

The report provided an update from the DAB meetings held on 7 June 2023 and 10 July. No issues or risks were identified that required escalation to the Manchester Partnership Board.

Decision

The Board note the report.

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Manchester Partnership Board	
Report of:	Warren Heppolette, Chief Officer – Strategy & Innovation, NHS Greater Manchester
Paper prepared by:	Warren Heppolette
Date of paper:	23 October 2023
Item number:	3
Subject:	GM Strategic Financial Framework Development
Recommendations:	Manchester Partnership Board is asked to discuss the paper in the context of the city's priorities and approach to delivery and commit to engage on the translation of this analysis into local and system wide activity.

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1.0 Background to the Financial Framework

The Greater Manchester (GM) Integrated Care Partnership (ICP) approved it's 5 year strategy in March. At the end of June the Partnership agreed and submitted the Joint Forward Plan (JFP) as the delivery plan for the ICP Strategy. It sets out the key actions to deliver our ambition against each of the six missions. It draws on a range of existing plans developed across the system and each GM locality. When submitting the JFP to NHS England, we recognised that further work was needed to strengthen our delivery plans to provide much greater detail on the approach to delivering the mission on financial sustainability.

The JFP recognised, therefore, the need for a Strategic Financial Framework (medium term financial plan). The analysis informing the Strategic Financial Framework underpins the JFP and provides the economic detail and mechanics for action for delivery.

It takes a longer term perspective on our health and care economy – building on the more immediate work to identify savings in the system which is responding to the current imperative to support financial recovery in this financial year.

It has the fundamental purpose of identifying the population-based approach opportunities to address our financial gap.

2.0 The Strategic Financial Framework

Methodology

The Strategic Financial Framework is developed via a four-stage approach:

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

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The framework covers:

- The demand for health and care services for the population of Greater Manchester over the next five years, given current trends, and how much it will cost the providers to deliver on those requirements;
- The opportunities to improve the health and care for the population of Greater Manchester to keep people healthier and manage their health needs better;
- How the change in population requirements will impact the demand on providers, and how this demand will be delivered efficiently;
- What the opportunities are for the efficient delivery of this care (provider-side);
- The investments required to realise these opportunities, and how quickly these benefits can be realised to meet national and local priorities;
- The impact of these opportunities on the Greater Manchester financial deficit, and whether there is any residual structural deficit and the drivers of it.

2.1 Headline Findings

The Strategic Financial Framework looks at keeping the population in good health, optimising the way healthcare services are used, and delivering care efficiently.

To support this, the Strategic Financial Framework has set out the baseline position, the ”do nothing” forecast, quantified the population health opportunities, set out the phasing and sequencing over time and considered the position of the 9 NHS providers. In short, this has outlined how a deficit of £570m today will grow to £1.9b in a “do nothing” scenario but can be addressed over time through a combination of population health measures and provider efficiencies.

GM ended 22/23 with a reported underlying financial deficit of £570m after removing nonrecurrent items. This will grow to £1.9b in 27/28 based on expected funding growth compared to activity growth and inflation.

This is driven by demographic growth of 0.4%, nondemographic growth of between 1.3 and 5% and tariff inflation of 1.8% per annum compared to activity growth and cost inflation of 2.9%. As a result, the financial position deteriorates.

To understand the health needs of the population we have used the Advanced Data Science Platform (ADSP) to access linked patient-level data on the GM population and developed a segmentation of the population. This shows that 29% of people in GM are not in good health and account for 79% of total costs. This can be reflected in the fact that a member of the adult population in good health cost £555 per capita whilst adults not in good health ranging from £1.7k per capita through to £84k per capita.

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2.2 Responding to the Challenge

We have explored three opportunities to address the growing needs for healthcare:

1) reducing prevalence growth,
2) optimising models of care, and
3) addressing inequalities in access

Opportunity 1 addresses prevalence growth; we have examined the shift in population due to ageing and prevalence growth, whilst aligning this with the expected total growth in spending on providers. The analysis shows that the total spend on care will rise from £6,147bn to £8,488m based on a combination of population growth (£233m), age and prevalence changes (£1,381m), and tariff inflation (£724m). An opportunity of £249m or 16% of the impact of increasing prevalence and tariff inflation is proposed as the target to be delivered over five years starting in 24/25.

Opportunity 2 addresses variation in the model of care to support more cost-effective delivery. For this opportunity spend per capita across 9 segments of the population and 3 age bands, separated into Core20[1] and non-core20 were analysed. By controlling this way, it is possible to calibrate like with like in GM. Adding the overall opportunity in each segment highlights seven areas for focus: adults in good health, adults and older adults with multiple long-term conditions, children and adults with mental illness, adults suffering from homelessness or substance abuse and older frail adults. In total, this added, the opportunity stands at £1,294m, with over £1,025m concentrated in those seven segments.

Opportunity 3 focuses on addressing inequality. For this opportunity, the spend per capita difference between the Core20 and non-core20 in each segment, was analysed and showed that spend per capita is higher for the Core20 population in every Point of Delivery (POD) except for outpatients and elective. The savings were calculated if that gap was closed. 80% of this gap was assumed realisable to reflect some underlying differences in need. This leads to a £126m opportunity, of which £100m is in non-elective admissions as interactions are happening too late for these communities.

The feasibility of these opportunities is tested in two ways: by validating the scale of the opportunity externally and by testing the achievability of the opportunities with analysis of quality indicators.

- The external validation of benchmarking focused on urgent and emergency care because of the need for elective recovery on the one hand and the difficulty in benchmarking community and mental health given national data quality limitations. This showed comparable scale of opportunity in urgent and

[1] The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

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emergency care when each place is benchmarked with its peers.

- The validation of quality focused on selecting a basket of quality indicators for each segment and analysing a normalised position in GM relative to the rest of the country and comparing this to GM. This in general showed the low spending places within each segment were generally consistent with at least average or better quality. It is clear there is high variation in the model of care for mental illness, however, a particular issue to consider is whether the opportunity is deliverable due to invisible waiting lists – both issues need to be better understood and addressed.
- We also looked overall at how GM benchmarks in quality indicators which show particular gaps in maternity and cancer and suggest that further action may be needed in these areas even though they do not deliver significant opportunity. This requires its own analysis and might represent an area where the system needs to spend more money.

To translate opportunities into potential spend/cost avoidance, each opportunity area has examined the evidence base for return on investment and timing.

- Opportunity 1 initiatives include smoking cessation, obesity management model and Semaglutide for advanced obesity care, which have a 5-year return on investment between 0.4 and 4.8;
- Opportunity 2 initiatives include CVD prevention and monitoring, dementia interventions and Respiratory disease, which have a 5-year return on investment between 1.5 and 3.7;
- Opportunity 3 initiatives include housing, food, transport and substance misuse, which have a 5-year return on investment between 1.5 and 11.6.

Further analysis suggests that a more targeted selection of initiatives would be possible if GM wished to pursue only high Return on Investment (ROI) initiatives.

Total investment requirements for each of the opportunities has been determined by ROI and this investment has been distributed to different settings of care using expert clinical advice. These have been phased on a straight-line basis, with 20% in the first year, and starting April to enable some initial benefits to be realised in that year (24/25).

The overall impact considers the population side and then providers. The reduction in provider demand through these opportunities will have a larger impact on cost and will help towards reducing the forecast deficit.

3.0 Next Steps

Additional work will need to be done to determine the level of provider efficiencies achievable and ensure alignment with the outputs of the current financial recovery work.

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On completing the final outputs for the Financial Framework, the findings will be used initially to support the engagement and understanding across GM. This discussion and engagement will confirm the priority and phasing of initiatives. This in turn, should drive the development of our Operational Plan for 2024/25.

The implementation of the Operating Model should support us in these endeavours. It should remove some of the barriers to at-scale system change – including new approaches to decision-making, collective accountability, how money flows and system leadership development. Finally, it will support the discussion on the approach to implementation through proactive primary care, addressing unwarranted variation, tackling specific social determinants of health through provider collaboration.

4.0 Recommendation

Manchester Partnership Board is asked to discuss the paper in the context of the city's priorities and approach to delivery and commit to engage on the translation of this analysis into local and system wide activity

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Manchester Partnership Board	
Report of:	Katy Calvin-Thomas – Chief Executive, Manchester Local Care Organisation (MLCO) Sohail Munshi - Chief Medical Officer, MLCO Tom Hinchcliffe, Deputy Place Based Lead for Manchester
Paper prepared by:	Danielle Koomen – Deputy Chief Operating Officer, Manchester and Trafford Local Care Organisations
Date of paper:	01 November 2023
Item number:	4
Subject:	Prevention and Admission Avoidance
Recommendations:	MPB is asked to: • Note the elements of the work being undertaken across the Manchester system on prevention and admission avoidance; • Consider the initial feedback from Newton Europe's diagnostic work, and consider the further steps that follow from this; and • Endorse the continued work on the admissions avoidance component of the Keeping Well at Home Programme, and the further rollout of Hospital at Home.

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1. Strategic Context

1.1 Over the past five years, the development of integrated health and social care working in neighbourhoods has been a key strategic goal to support prevention and care closer to home. The Local Care Organisation (LCO) was established by all the partners in Manchester to create operational Integrated Neighbourhood Teams to design and deliver a co-ordinated health and social care prevention approaches in place. There is more to do to integrate the work of the neighbourhood teams across place, and this work is progressing as a priority.

1.2 This approach aligns closely to the work being undertaken across GM on prevention and the development of a Strategic Financial Framework. The long-term financial sustainability of the system relies on an increasing emphasis on avoiding ill health and keeping people healthier for longer. The challenge will be to continue to scale up investment in these areas, whilst recognising the immediate financial and operational pressures being felt across the system. We need to address these tensions head on and navigate a common route forward.

2. Key elements of our approach

2.1 The LCO neighbourhood teams use a **Public Health Management** methodology to upscale targeted prevention work in neighbourhoods. This is a core part of Making Manchester Fairer. This year, the first comparable datasets on targeted improvement work on diabetes prevention, increasing the uptake of bowel screening and preventing heart disease will be available. A full update on our population health management work is going to the Provider Collaborative in November.

2.2 The **Better Outcomes Better Lives** (BOBL) programme has seen a more stable, strength-based approach taken to assessing care needs, and has put adult social care on a more sustainable financial footing (albeit demand is increasing).

2.3 **Keeping Well at Home** is our adult admission avoidance programme. The first priority of this programme was to develop a 'hospital at home' service across the City, with the underpinning infrastructure to manage more complex illness in community settings. This programme also responds to an NHS England mandate to create 320 'virtual beds' across Manchester and Trafford by the end of 2023/24. Further detail around progress on hospital at home is below.

2.4 As part of Keeping People Well at Home, we have adopted a '**Back to Basics**' approach within MFT, which is being rolled out across an increasing number of wards. This is focused on a strength-based need assessment when a person is medically fit, creating a more resilient approach to discharge at a system level. This work is receiving external scrutiny through Newton Europe's Tier 1 work outlined above. The learning from this will enable us to continue to improve our approach to discharge and target key actions to improve flow.

2.5 Finally, MRI has been placed into **Tier 1 for Urgent and Emergency Care** (UEC). This designation has seen additional support provided from NHS England around electronic bed management, Getting it Right First Time (GIRFT) support, and a diagnostic led by Newton Europe, which seeks to map the patient journey through the system and to assess demand and capacity, identifying areas of stress within the system and suggest interventions to alleviate this stress. The Newton Europe work is developing at pace, and they will share their initial feedback at the Partnership Board meeting.

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2.6 This remainder of this paper focuses on the admission avoidance element of the Keeping People Well at Home programme.

3. Admission avoidance programme

3.1 There has been significant progress in rolling out our admission avoidance model since the paper presented to the Partnership Board in July. Evidence from the pilot has been reviewed and has been incorporated into a high-level outline business case to secure funding so that a City-wide Hospital at Home offer can be in place for Christmas 2023. MFT Executive Director Team (EDT) have supported the funding request and the winter roll out plan.

3.2 The Hospital at Home roll out will bring together existing virtual wards with the community-based pilot in central Manchester, creating a consistent city-wide offer. These existing services typically aim at preventing readmissions following a spell in hospital by using remote monitoring technology to enable a proactive response when a patient is at risk of an acute emergency. The existing services create on average 96 virtual beds per day, based on the snapshot data reported back to NHS England

Site	Total patients on daily snapshots	% share
MRI	564	23%
NMGH	555	23%
Wythenshawe	853	35%
Crisis overperformance	309	13%
H@H pilot (central)	178	7%

Table 1: a summary of current virtual ward daily snapshots 23/03-07/09

3.3 In addition to the existing virtual ward offers the city-wide Crisis Response services (part of the Manchester Community Response suite of services) prevents an average of 300 admissions per month. An element of this activity is recorded in the virtual ward daily snapshot because Crisis exceeds its commissioned volumes of activity and so it is included in the virtual ward submission so that the full activity is recorded.

3.4 The city-wide Hospital at Home offer goes beyond the scope and capacity of these existing services to prevent more admissions from more groups of Manchester citizens.

4. Learning from central pilot

4.1 The community-based pilot in central Manchester tested an enhanced Hospital at Home model. This model is based on creating a workforce and infrastructure in the community, which enables the safe care of frail patients who have not been medically optimised.

4.2 This pilot has run for twelve months and there has been significant learning from this period:

- The pilot has supported circa 300 patients.
- 85% of patients are aged 71 or older.
- 74% of patients have a frailty score of 5 or more (a score of 5 is ‘mildly frail’ on the Rockwood Frailty Score).
- 47% of patients in the model have been based on referrals from Crisis; this means that patients in the community were reviewed by Crisis and stepped up to the pilot to prevent

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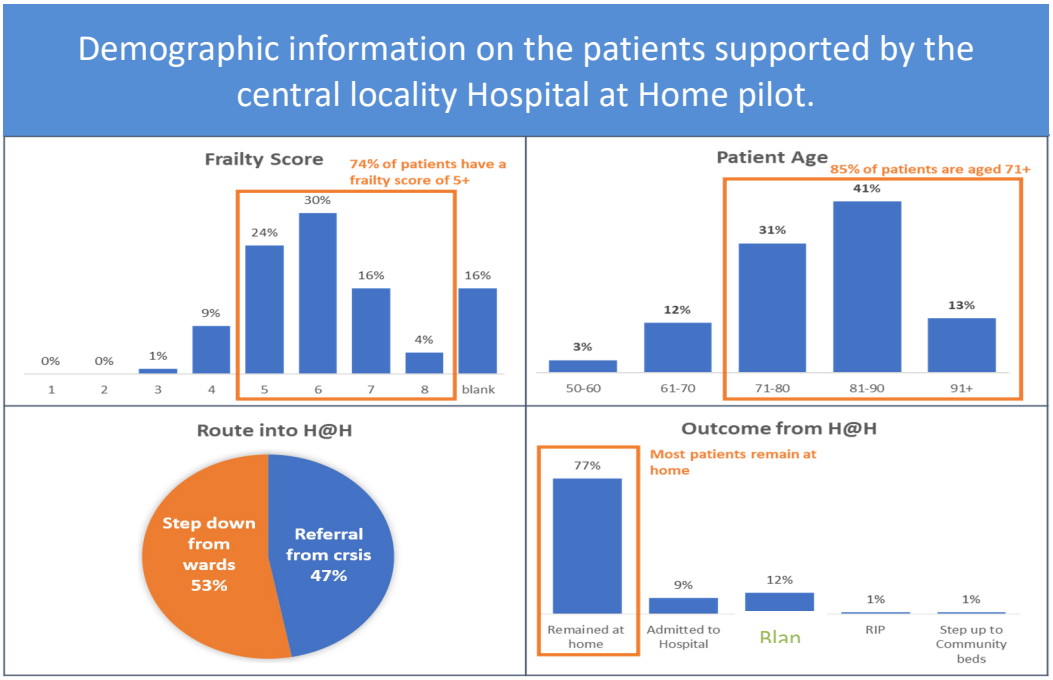
a hospital admission.

- 77% of patients in the pilot remained at home following their intervention.

4.3 This evidence suggests that the Hospital at Home model is capable of supporting frail and elderly people who can currently only be supported by admission to hospital and inpatient stay. This is because the Hospital at Home multi-disciplinary team includes oversight from a hospital consultant, and a GP, alongside nursing, therapy, and social care roles. This mix of staff means that there is a sufficient level of senior clinical decision making, alongside the skillsets required to manage the complexities of frailty.



4.4 There is also a Children's Virtual Ward established by the Royal Manchester Children's Hospital, which supports 20 children per day. This activity is not included within the *Keeping People Well at Home* programme or the Hospital at Home roll out because there is already an established and mature programme of work to oversee the development of the children's offer. The programme focused on adult patients will use opportunities through programme boards and symposiums to learn from the children's work.

4.5 The pilot in the central locality has created a template Hospital at Home team of c16 roles, creating a resilient multi-disciplinary team. North and south localities are also recruiting to their structures. The pilot showed that external recruitment took a long time. A recruitment sub-group has been established to help build community teams and combine external recruitment with options around deployment of existing staff. The biggest challenge has been in recruiting to Advanced Clinical Practitioner roles in south locality, which are critical for a safe go live.

5. September Symposium

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5.1 The second Hospital at Home symposium on 18 September brought system partners together to focus on the operational rollout of the programme. This set out the 'one team approach' that allows MFT staff to move between care settings and go to patients, meaning patients can benefit from the expertise and resources of acute hospitals in their own homes.

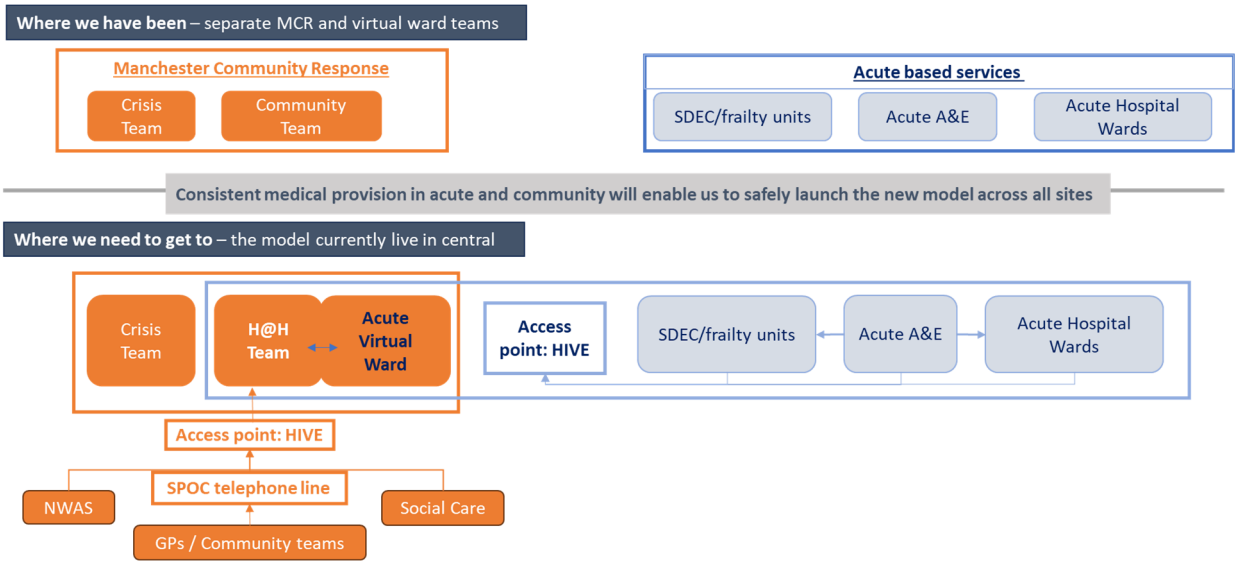

Fig 2: the future operational model of Hospital at Home

5.2 Each locality also fed back on progress. Clinical leaders discussed their work on Hospital at Home with one care of the elderly consultant saying this work was 'the highlight of [her] career' because it gives her the chance to offer really high-quality care, to very unwell patients, in their own homes.

5.3 A further symposium will be held in February 2024 and focus on the progress of operational roll out and the delivery of Hospital at Home activity against plans.

6. In year investment agreed by MFT to enable rollout

6.1 As outlined above, a high-level outline business case was submitted to MFT EDT to secure in-year funding to enable a City-wide roll out before Christmas. The was predicated on creating the infrastructure to manage frailty, and a critical part of this is securing hospital consultant time. To create a 'safe' go live position, EDT were asked to agree funding for five Direct Clinical Care (DCC) sessions per week, which means one session of consultant time per weekday.

Breakdown of phase one costs	North	Central	South	Total
Consultant sessions to enable new model to safely go live	£42,000	£50,000	£33,000	£125,000
Additional IV to enable HF go live		£60,500		£60,500
Additional High Intensity Users programme	£30,000	£30,000	£30,000	£90,000
Remote monitoring kit	£15,000	£10,000	£15,000	£40,000
MRI unfunded consultant post		£50,000		£50,000
			TOTAL	£365,000

Table 2: the linear investments supported by MFT EDT

6.2 In addition, EDT agreed to support:

- *Additional community IV* capacity which enables patients diagnosed with Heart Failure to be supported on Hospital at Home. This is being rolled out to central locality first because they have a community team established under the pilot, but it will also be rolled out to the other two localities.
- *Remote monitoring kit* so that there are sufficient devices to enable proactive monitoring of patients on the pathway (this is not suitable for all patients).
- *High intensity users programme* which is an NHS England sponsored programme which recruits staff to work with patients who attend A&E twenty times or more per year. There will be one staff member per hospital who will connect these individuals into community-based support (both formal and informal forms of support) so that they do not use A&E as a place of first recourse to manage their needs.

6.3 The total quantum of funding will put in place the resources to enable a city-wide roll out. Achieving roll out is subject to the roles being recruited to and team infrastructure being in place.

7. Roll out plans per locality

7.1 Patient safety will guide the roll out and expansion of Hospital at Home. The process will be cautious so that system partners can learn from and understand the full implications of the model before taking further steps. The roll out plan for each locality is as follows:

Date	Pathway to switch on
16/10/23	**Central locality** will start to increase delivery of ***frailty*** to achieve maximum activity
06/11/23	**North** locality will commence delivery of ***frailty***
04/12/23	**South** locality will commence delivery of ***frailty*** **Central locality** will commence delivery of ***heart failure***
The impact of achieving phase one will be to create between **80 to 100 additional Hospital at Home virtual beds per day** (from the baseline position of 100 beds per day in August 2023).	

7.2 An update against the roll out plan:

- *Central locality* is increasing its capacity to deliver frailty step down. The Manchester Royal Infirmary (MRI) have identified consultants to make up the 5 DCCs per week. During the week commencing 16 October the team increased their capacity by five patients per day.
- *North locality* is planning a soft go-live throughout November and will aim to support five patients per day by the week commencing 20 November. All staff are in place or will be in place during November.
- *South locality* is the biggest risk area because they have not been able to recruit to Advanced Clinical Practitioner (ACP) posts in their model. These posts are critical for creating the capability for managing frailty in the community. The MFT Group Executive Director of Nursing is working with the Wythenshawe Hospital Director of Nursing and the

Local Care Organisation Director of Nursing to identify ACP resource who can be deployed into these posts to enable go-live.

7.3 There will be specific communications to GPs in each locality as Hospital at Home rolls out to their localities. For example, there will be webinars so that GPs can meet their local Hospital at Home team, understand the routes of referral into the service, and ask questions of the sorts of patients in scope for support. The first of these webinars took place on 1 November in central locality. In the first instance, GPs will be able to access Hospital at Home by making referrals as per usual practice to crisis response. The crisis response team will stabilise the patient and can then decide on onward referral to Hospital at Home if appropriate.

8. Next steps beyond winter

8.1 This paper has so far focused on Phase 1 of the Hospital at Home rollout. Phase 2 will focus on establishing in reach to cardiac and respiratory specialisms in acute sites. These are two of the national Hospital at Home pathways so will be prioritised once the frailty pathways have been switched on.

	Phase 1	Phase 2	Phase 3
Timeframe	Q3 23/24	Q4 23/24	24/25 onwards
Pathways	Frailty all localities and heart failure in central	Heart failure and respiratory in all localities	Maximise delivery on all pathways
Target additional capacity	**80-110 additional virtual beds** (total target for 2023/24 of 180-210)		**110 additional virtual beds** (total target of 300-320)
Additional resources required	• 5 DCCs per locality • Additional IV capacity in central locality • Funding for High Intensity Users programme (to reduce ED pressure) • *MRI pilot pressure (unfunded consultant time)*	• Additional IV capacity in south and north localities • Ongoing build-up of community teams • Funding for remote monitoring kits	• 10 DCCs per locality • Community teams to be fully established in all localities • Permanent consultants in each team • Funding solutions to be made recurrent

Table 3: the future phases of Hospital at Home roll out

8.2 Phase 3 in the next financial year will focus on driving up and maximising the utilisation of Hospital at Home capacity. Achieving phase 3 will meet the NHS England target of 320 virtual beds across Manchester and Trafford.

8.3 During 2024/25 Hospital at Home capacity will be built into the MFT's annual plan so that the capacity can be used to offset demand for hospital beds in the acute sites. Incorporating Hospital at Home into the planning process will mean that there is an opportunity to create a sustainable funding mechanism for the service. The implications of this will be worked through as part of the annual planning process.

9. Recommendations

9.1 MPB is asked to:

- Note the elements of the work being undertaken across the Manchester system on prevention and admission avoidance;
- Consider the initial feedback from Newton Europe's diagnostic work, and consider the further steps that follow from this; and
- Endorse the continued work on the admissions avoidance component of the Keeping Well at

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Home Programme, and the further rollout of Hospital at Home.

Manchester
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Manchester Partnership Board	
Report of:	Joanne Roney Chief Executive Officer – Manchester City Council (MCC) and Placed Based Lead – Manchester Integrated Care Partnership (MICP)
Paper prepared by:	Sharmila Kar - Joint Director Equality, Inclusion, and Engagement - NHS GM integrated Care (Manchester locality) and MCC
Date of paper:	10 November 2023
Item number:	5
Subject:	Strengthening our approach to Patient Involvement and Engagement in Manchester
Recommendations:	The Manchester Partnership Board is asked to comment on and support the paper.

1. Context

1.1 In Manchester, we want everyone to live longer, healthier and fulfilling lives and have access to the best possible services and support, when needed. Our aim is to achieve better health and care for local people. This ambition aligns with the GM Fairer Health for All population health framework and Manchester's own Making Manchester Fairer programme. Evidence tells us that supporting patients to be actively involved in their own care, treatment and support can improve outcomes and experience for patients, and potentially yield efficiency savings for the system through more personalised commissioning and supporting people to stay well and manage their own conditions better.

1.2 To this end, we have retained Manchester's Patient and Public Advisory Group (PPAG), the only locality to have done so in GM. Manchester PPAG is a voluntary group, with the purpose of informing and influencing health service developments, business cases and how we engage with patients and the public. The role of the group is to play a part in helping to shape services that will make a positive difference to patient's lives. It provides assurance about the involvement of patients and carers in decisions which relate to their care or treatment through the Delegated Assurance Board.

1.3 This paper sets out the opportunities for optimising the potential of PPAG for the wider locality, drawing on the lived experience and knowledge of patients. Manchester has some of the most challenging health inequalities in the country yet has the greatest assets in its diversity of communities. We aim to optimise those assets by addressing the unwarranted systemic and structural discrimination that impacts those communities access, experiences, and outcomes for better health.

1.4 During the pandemic, we built a rapid response to community engagement in the form of CHEM (Covid Health Equality Manchester), now Community Health Equity Manchester, to help us better understand how unwarranted health inequalities play out across the city. It involves diverse community representatives and 'sounding board' members from across those communities who are impacted by the worse health outcomes in the design and delivery of health and care services. The model is based on user led communities reach into their communities to bring real time impacts of health interventions.

1.5 We have also reviewed how we engage with Manchester Healthwatch group, helping us to share resources to and insight to understand the needs, experiences and concerns of people who use health and social care services, providing crucial evidence reviews and inquiries and speaking out on citizens behalf when things go wrong.

1.6 The Manchester Disability Collaborative (MDC) also plays a wider system involvement forum focusing on removing those ingrained systemic inequalities that prevent the full access and engagement of disabled people in their life chances. This forum is system wide and brings partners together to tackle the 'wicked issues' that are blighting disabled citizens full participation in society.

1.7 All add significant value to our knowledge landscape, allowing us to better isolate and remove unhelpful practices and conditions that disadvantage people in their health and wellbeing journeys. Together with the Manchester PPAG, we feel we now have a better infrastructure that allows us to explore and feedback patient experience (PPAG), better understand and address the systemic barriers that gives rise to unwarranted disparities across our communities (CHEM and MDC) and working collaboratively to provide evidence based systemic solutions (Manchester Healthwatch).

1.8 All of this works within the neighbourhood support afforded across Manchester from both council neighbourhood officers and MLCO health neighbourhood teams providing those vital links in to our complex systems at neighbourhood, locality, and Greater Manchester levels through the evolving NHS Greater Manchester People and Communities Engagement Strategy to resolving the inter related issues identified in our community involvement work.

2. Manchester Locality Patient and Public Advisory Group

2.1 The Patient and Public Advisory Group forms part of the governance infrastructure for Manchester Integrated Care Partnership. The group is made up of Manchester residents, registered with a Manchester GP, who provide assurance, insight, and feedback on patient and public involvement across all aspects of work of the organisation. They are a dedicated team of volunteers who provide their time, knowledge, and experiences to improve health and care services for people and communities across Manchester. They work with patients, people who access services, carers, charities, community groups and others to bring diverse perspectives into our work.

2.2 During the past year Patient and Public Advisory Group members have provided patient representation in several groups and committees, led by different MPB organisations including:

- Manchester Area Prescribing Group
- Healthy Lungs Steering Group
- Healthy Hearts Steering Group
- Manchester Primary Care Commissioning Committee
- Community Health Equity Manchester (CHEM)
- Carers Learning and Development Board
- Community Diagnostic Centre (CDC) Equalities Group
- Manchester System Quality Advisory Group

2.3 PPAG members have provided feedback and lived experiences by participating in the Manchester system on a range of subjects over the past year. Some examples of PPAG involvement are listed below:

- Manchester Integrated Care Partnership Operating Model development
- Community Diagnostic Centres business case
- Winter Vaccination Plan
- Manchester Local Care Organisation (MLCO) - transformation of

community services review programme
- Disaggregation of North Manchester General Hospital services between Manchester University Hospitals NHS Foundation (MFT) Trust and Northern Care Alliance
- MFT - Patient Initiated Follow Up (PIFU) appointment system
- Making Manchester Fairer action plan
- Manchester City Council Population Health team – support for the National Institute for Health Research bid to ensure the patient voice was at the heart of the bid.
- Engaging with Healthwatch
- GP Practice Procurement - members have supported the procurement of the APMS GP Procurement process
- PPAG members have informed the development of the Urgent Care strategy and the Urgent Care Needs Assessment in Manchester
- Provided feedback on the GM primary care blueprint
- Understanding Patient Experience Survey - The Patient and Public Advisory Group developed a patient survey to understand the lived experiences of people using their GP Practice following the pandemic. Further work is being undertaken in collaboration with BHA for Equality to engage with communities that experience racial inequality
- Home from Hospital service
- MFT Advice and Guidance system-wide workshop to improve the quality of referrals into secondary care from primary care

3. Embedding Patient Voice

3.1 In Manchester, we are invested in continuing the facilitation and development of patient leaders by ensuring lived experiences continues to inform and influence our work. Regular PPAG meetings are supported by the MICP locality engagement lead with agenda items decided by the membership which often include recent patient experiences (their own or others relayed to them) and discuss opportunities for improvement where it is felt it is needed.

3.4 The current membership is 17 strong, drawing from a range of backgrounds and diverse lived experience. Manchester health colleagues have the opportunity to raise upcoming issues, campaigns, or events, such as the upcoming Covid and flu public health messaging for greater insight into their impact.

3.5 There is an opportunity to further develop and expand the offer of the group. For example, recently two PPAG members have agreed to take part in a Patient Representative Reference Group to help inform the development of a new patient strategy for Manchester Foundation Trust (MFT). This invaluable insight will enable MFT to be assured that they have considered and addressed past issues that have interrupted or presented barriers to patient journeys and built in preventative measures from the outset of the new strategy. This builds on the support provided by PPAG members already described above in terms of condition specific groups, strategy development, procurement and other work led by MLCO, MFT and MCC.

3.6 Evidence tells is that our services are not fully accessible or that a little insight wouldn't help us create better conditions for a patient journey. For example, the recent review and re-alignment of the NHS Accessible Information Standard (which will require more from us as the reset comes in later this year) evidences that only *11 per cent* of patients surveyed in the AIS report have equitable access to the NHS and *81 per cent* of patients reported having an appointment where their communication needs were unmet. This report has gone on to inform the AIS reset.

3.7 There are examples of positive investment in patient infrastructure and patient leaders that are paying off. Like in Manchester, West Yorkshire ICB's long-standing approach has always been to begin with and listen to people, families and local communities or neighbourhoods in which they live. They know this is better for their populations in terms of helping provide a more joined-up experience, more personalised to people's needs and one that helps people stay healthier and well at home and close to home. There is also clear evidence emerging of associated reduction of cost to the system through reductions in Do Not Attends[1] and through a prevention first model.

3.8 It is important that patient experience is placed on an equal footing with other data and information including gathered both at locality and ICB level, that is also included in commissioning plans. This would demonstrate the importance of patient experience and recognise how it can add understanding and meaning to other collected data and information rather than being treated separately.

4. Investing in patient leaders and maximising peer to peer learning

4.1 There is a need to further develop our patient leaders - to widen the pool of talent and provide systematic approaches to learning and development that support a broader array of engagement opportunities for the transformers and enablers. We need to develop different modes of learning for patient leaders, based on experiential and accessible learning opportunities.

4.2 Learning should be co-produced with patients and carers. It must focus on what matters to them, for instance how to deal with professionals and navigate the system, build trusting relationships in order to influence decision making and developing the skills of dialogue.

4.3 Involvement gives people an opportunity to have their say on services, their community, and their lives. By gathering people's views, it helps us with an understanding of what matters to people and communities. This is important to us. Involvement is also about developing relationships and partnerships, we want to make sure that the voices of local people and partners are heard where they need to be across our system and aren't unnecessarily duplicated or responded to systemically but are added to and built on. They are our pressure indicator check and two-way information exchange.

[1] https://www.england.nhs.uk/long-read/reducing-did-not-attends-dnas-in-outpatient-services/

4.4 PPAG is likened to a community of practice. A community of practice involves a group of people, who share a common concern or interest in a specific topic or issue, working together to improve knowledge, share best practice and achieve fulfilment of individual and shared goals. Communities of practice aid collective learning, encourage innovation and create a support network for members.

5. Optimising Manchester PPAG for the system

5.1 All of us delivering public services need reality 'check and confirm' touchpoints. PPAG can be developed to offer this to PCNs, optometry, dentistry, pharmacy, and social care wide as well as for general practice, for trusts, community, and independent health providers as well as for public health messaging, interventions and strategies. More importantly, as we develop our integrated approach to patient journeys, we need to evidence our improved planning and delivery of joined up health and care services. This of course will need to include our joined-up approach to patient and community involvement.

5.2 How we invest in PPAG as a patient infrastructure mechanism and dovetail into existing engagements needs further exploration. To this end, we propose to set up a small working group drawn from system partners (including PPAG) to explore what is possible with a focus on optimising available involvement infrastructure, socialising the roles each play and avoiding duplication and repeated system pressures on the same groups through a more joined up engagement framework.

5.3 There needs to be a renewed emphasis on patient experience work, without this there is a risk that ICSs will end up representing another reincarnation pf an NHS that does not prioritise the voices of people it serves. Services designed without the input of people and communities and with limited focus on people's experiences are less likely to produce good outcomes and more likely to waste stretched resources.

The benefits of having patients as partners for improvement and change include:

- Richer insight into health and healthcare challenges
- Generating solutions
- Changing relationships and conversations
- Benefits for those taking part (staff and patients)
- Better quality decision-making
- Improvements in practice
- Spread and sustainability of healthcare improvements
- Improved efficiency

6. Recommendations

- The board are asked to note and comment on the report.
- Support the work of the locality Equality and Engagement team with MPB partner organisations and GM Integrated Care to ensure we continue to build patient voice and experience into our approach to engagement,

involvement, and quality improvement – to inform decision making to improve services.

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PAPER E

NHS
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Integrated Care

Manchester Partnership Board
System & Locality Position

Part of Greater Manchester
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Introduction

NHS Greater Manchester Integrated Care

- MPB is asked to:
  - Note the financial position at Month 6 across the system
  - Discuss mitigations to manage pressures for the remainder of 23/24
  - Undertake further work to manage recurrent pressures (to come back in December)
  - Note the allocation for UEC capacity funds
  - Discuss further the approach for any additional allocations that may come into the system

NHS GM Key Variances (All Localities)

NHS
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GM Localities	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
( ) deficit	£m	£m	£m	£m	£m	£m
M6	693.3	706.3	(13.0)	1,381.9	1,398.1	(16.2)
M5	571.1	582.5	(11.4)	1,364.6	1,376.4	(11.9)
Inc. / (dec)	**122.2**	**123.8**	**(1.6)**	**17.4**	**21.7**	**(4.3)**

The financial summary by expenditure for forecast outturn to the end of the financial year is as follows

		Analysis of FOT variance						
GM Localities	Forecast variance	Prescribing	MH	CHC	Community	Primary care	Estates, Acute, Reserves & Other	Total
( ) deficit	£m	£m	£m	£m	£m	£m	£m	£m
Bolton	0.7	(1.0)	0.0	0.8	(0.1)	0.9	(0.0)	0.7
Bury	(0.4)	(0.1)	(0.3)	0.4	(0.2)	(0.1)	(0.1)	(0.4)
HMR	(0.1)	(0.1)	0.0	0.0	(0.0)	(0.0)	(0.0)	(0.1)
Manchester	(9.9)	(2.0)	(3.4)	(1.2)	(2.4)	(1.0)	0.2	(9.9)
Oldham	(0.2)	(0.8)	(0.7)	1.9	(0.1)	0.1	(0.6)	(0.2)
Salford	(1.7)	(0.6)	0.1	(1.1)	(1.3)	1.1	0.0	(1.7)
Stockport	(2.6)	0.0	(0.6)	(1.8)	(0.1)	(0.1)	(0.0)	(2.6)
Tameside	0.0	(0.1)	(0.1)	(0.3)	0.8	(0.0)	(0.3)	0.0
Trafford	0.5	(0.6)	0.9	(0.4)	0.6	0.1	(0.1)	0.5
Wigan	(2.5)	(1.9)	(0.7)	(0.1)	0.6	(0.2)	(0.2)	(2.5)
Total	**(16.2)**	**(7.3)**	**(4.7)**	**(1.7)**	**(2.3)**	**0.8**	**(1.1)**	**(16.2)**

NHS GM Provider Financial Position

NHS Greater Manchester Integrated Care

The following table summarises the overall provider position reported at Month 6 and forecast outturn.

GM Providers Income Statement	Year to date			2023/24		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Income	3,624.0	3,631.7	7.7	7,260.3	7,314.3	54.0
Pay	(2,318.0)	(2,406.3)	(88.3)	(4,649.2)	(4,736.9)	(87.7)
Non-Pay	(1,338.2)	(1,349.8)	(11.7)	(2,633.4)	(2,614.4)	19.1
Non Operating Items	(49.2)	(40.8)	8.4	(99.7)	(85.1)	14.7
TOTAL Provider Surplus/(Deficit)	**(81.4)**	**(165.2)**	**(83.8)**	**(122.0)**	**(122.0)**	**0.0**
Surplus/Deficit Breakdown						
MFT	(28.2)	(65.2)	(36.9)	0.0	0.0	0.0
Christie	(4.0)	(2.5)	1.5	(8.0)	(8.0)	0.0
NCA	(9.0)	(46.5)	(37.5)	(32.2)	(32.2)	0.0
Bolton	(6.2)	(6.7)	(0.5)	(12.4)	(12.4)	0.0
Tameside	(16.2)	(16.8)	(0.5)	(31.5)	(31.5)	0.0
WWL	1.0	(6.1)	(7.1)	(6.5)	(6.5)	0.0
Pennine Care	(2.4)	(2.4)	0.0	0.0	0.0	0.0
Stockport	(16.3)	(18.2)	(1.8)	(31.5)	(31.5)	0.0
GMMH	0.0	(0.9)	(0.9)	0.0	0.0	0.0
Provider Surplus/(Deficit)	**(81.4)**	**(165.2)**	**(83.8)**	**(122.0)**	**(122.0)**	**0.0**

System Position as at Month 6 (Healthcare)

NHS
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	Position		Efficiency		
Organisation	M6 Variance £M	Forecast Variance £M	Annual Savings Target £M	Expected Delivery £M	Position Commentary
ICS - NHS Greater Manchester	(82.3)	122	120	120	Surplus position assumed via delivery of system savings targets (£130m). Gross risk remains of £237m relating to efficiencies (£156m), prior year surplus (£30m) and operating pressures (£51m)
ICS - Providers	(83.8)	(122)	356	356	To note, YTD position is a deficit of £165m, against a deficit plan of £81m, representing an adverse variance against plan of the £83.8m
Manchester Locality (NHS GM)	*(5.1)*	*(9.9)*	*6*	*6*	*Deficit re. Prescribing (£2m), Migrant Health (£0.9m), MH & LD, Packages (£3.4m) and Childrens & CHC Placements (£3.6m)*
Manchester Foundation Trust	(36.9)	(66.8)	136	113	Deficit re. WLIs re. Industrial Action & Elective Recovery (£15.2m), Agency Nursing (£15.4m), Non Pay inflation (£4m)
Manchester LCO	*(0.3)*	*0*	*3*	*2*	*Breakeven position assumed via additional income and efficiencies*
Manchester City Council	N/A	(3.0)	4	4	Deficit re. Long Term Care pressures (£8.1m) due to Older People / Physical Disability, Homecare & LD / MH Packages offset by underspends in Short Term Care (£0.6m) and Infrastucture & Back Office (£4.5m)
Greater Manchester Mental Health	(0.9)	0	21	21	Gross risk of £3.8m, however performance improved by £1m from M5 to M6

Locality Position as at Month 6

NHS Greater Manchester Integrated Care

At 30/09/23 Manchester reported **a £5.1m** adverse position, with an expected forecast deficit value of **£9.9m at year end**. This is our current best estimate of where we will be by year end, although we will continue pushing to reduce cost wherever possible. The deficit position is driven in the main by the following:

Description	M4 £m	FOT £m	M6 £m	FOT £m	Movement in FOT £m
Prescribing	1.1	1.6	2.3	2.0	0.4
Asylum seekers (ASC) and Afghan Refugees (ARAP)	0.4	1.2	0.6	0.9	-0.3
Mental Health & LD	1.1	2.7	1.6	3.4	0.7
Subtotal	**2.6**	**5.5**	**4.5**	**6.3**	**0.8**
Community	0.7	1.7	1.2	2.4	0.7
CHC	0.1	0.4	0.4	1.2	0.8
QIPP	0.1		-1.0		0.0
Subtotal	**0.9**	**2.1**	**0.6**	**3.6**	**1.5**
Total Deficit	**3.5**	**7.6**	**5.1**	**9.9**	**2.3**

Final UEC Capacity Funding

NHS
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Integrated Care

- Following the decision to disaggregate Manchester & Trafford's Capacity funding:

	Locality	Capacity (£000)	% Split	Funding Reduction (£000)	Revised Capcity (£000)	Virtual Wards Phase 2 Pause (£000)	Revised Capacity Incl. VW Pause (£000)
Combined	Mcr & Traff	£9,457	28.90%	£1,714	**£7,743**	£888	**£6,855**
Disaggregated	Manchester	£7,112	21.73%	£1,289	**£5,823**	£668	**£5,155**
	Trafford	£2,347	7.17%	£425	**£1,921**	£220	**£1,701**

- The following schemes were submitted back to central GM Urgent Care team:

Scheme title	Paid to	Total
UEC - Excluding virtual wards phase 1		
Manchester - Primary Care (Acute Respiratory Hubs and Additional Sessions)	Manchester Primary Care	**£1,200**
Manchester - Acute Winter Bed capacity across NMGH, MRI and Wythenshawe	MFT	**£3,500**
Manchester - GMMH	GMMH	**£500**
Trafford - Primary Care - Additional Primary Care Resilience Same Day Access	Trafford Primary Care	**£645**
Trafford - Primary Care - Acute Respiratory Infection Hubs	Trafford Primary Care	**£200**
Trafford - MRI Achieving Excellence in Patient Flow	MFT	**£172**
Trafford - Wythenshawe Winter Ward	MFT	**£395**
Trafford - GMMH	GMMH	**£289**
Total		**£6,900**

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Manchester
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Manchester Partnership Board	
Report of:	Julia Bridgewater – Deputy Chief Executive Manchester University NHS Foundation Trust (MFT)/ Chair of Manchester Provider Collaborative Board Cllr Thomas Robinson – Executive Member for Healthy Manchester and Social Care / Chair of Manchester Provider Collaborative Board
Paper prepared by:	Julie Taylor – Manchester Locality Director of Strategy/Provider Collaboration, Manchester Integrated Care Partnership (MICP)
Date of paper:	24th October 2023
Item number:	7
Subject:	Provider Collaborative Board (PCB): Update
Recommendations:	The Manchester Partnership Board (MPB) is asked to: - • note the discussions at the Provider Collaborative Board meetings held 21st September & 19th October 2023; • note the escalations raised by Greater Manchester Mental Health (GMMH) and actions agreed across partners to provide support; • endorse the revised PCB Terms of Reference; • note the progress update on the CYP Reform Programme, the summary of the Child Health Summit and next steps agreed; • note the on-going work in respect of Admissions Avoidance; • note the approach to tackling health care inequalities and inclusion through the work of PCB; • note that PCB gained assurance on the Winter Resilience Plan and agreed the allocation of Manchester's Urgent & Emergency Care funding between Primary Care, GMMH and MFT. It was however noted that the reduced allocation was insufficient to meet Manchester's needs over the Winter period.

Manchester
Integrated Care Partnership

1. Executive summary

1.1 The purpose of this briefing paper is to update the Manchester Partnership Board on the work of the Provider Collaborative Board as part of the agreed reporting cycle to MPB. This report covers the outputs of the meetings held 21st September and 19th October 2023.

1.2 The key discussion points from the meetings are detailed below: -

- Summary of escalations from GMMH;
- Approval of the updated Terms of Reference;
- Healthy Lungs programme – update on actions agreed at the June meeting of the PCB;
- Update on the progress of the Manchester Children and Young People's Reform Programme led by the Strategic Director – Children and Education, Manchester City Council (MCC) and the outputs and next steps from the Children's Health Summit held on the 20th July 2023;
- Update on the on-going work in respect of Admissions Avoidance, including the mobilisation of Hospital@Home;
- The approach to tackling health care inequalities and inclusion through the work of PCB, including endorsement of the 'Plus' groups as part of the work developing on Manchester's Core20Plus5 framework;
- Update on the Manchester system's Winter Resilience Plan and discussion/agreement on the allocation of Manchester's Urgent & Emergency Care funding between Primary Care, GMMH and MFT.

2. Provider Collaborative Board meeting: 21st September 2023

2.1. Approval of the updated Terms of Reference

PCB received and approved the revised Terms of Reference. Revisions take into account feedback from PCB members and reflect the understood role and function of the PCB as part of the Manchester Place governance and Operating Model.

2.2. Summary of escalations from GMMH

John Foley highlighted 2 areas of escalation from GMMH to the PCB. These were: -

- Delayed transfers of care
  PCB noted challenges relating to out of area placements and delayed MH discharges and it was agreed that work would be undertaken with GMMH to include this information in the reports on discharge delays in Manchester;

- Develop joint working between primary care and Community Mental Health

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Teams (CMHTs) enabling access and discharge flow.

PCB agreed this would be useful to take forward and noted that work, facilitated by the Clinical and Professional Advisory Group (CPAG), had commenced across primary care, community health and MFT to look at opportunities to support primary and secondary care interfaces and that the Mental Health interface work could be included in that.

PCB requested the Deputy Place-based Lead to convene a system discussion to check in and review plans for Winter across Manchester and bring an update back to the October meeting.

2.3. Long Term Conditions – Healthy Lungs programme – update

Dr Murgesan Raja presented an update on the work to progress the challenges considered by PCB in June relating to the Healthy Lungs programme. MPB was asked to note the impact for residents of Manchester through the system-wide consideration of a key challenge at PCB.

The update focused on 2 areas: -

- Preparations for 23/24 winter pressures, including mobilising an integrated offer for Adults and Children & Young People from October 2023. It was noted that the MARIS (Manchester Acute Respiratory Infection Service) would support pressures during winter relating to respiratory infections and MLCO was piloting an Acute Children's Treatment (ACT) service in the community with RMCH, with a focus on avoidable Paediatric Emergency Department (PED) attendances;

- Mobilising Quality Assured Spirometry and FeNo diagnostic testing for Adults and Children & Young People. It was noted that a small source of funding had been prioritised to enable delivery through a primary care network model. The Community Diagnostic Centre at Withington would also provide some limited GP direct access for South Manchester. It was noted that quality-assured spirometry is one of the deliverables in the GM Primary Care blueprint, which aligns with our Manchester ambition.

2.4. Children and Young People's (CYP) Reform Programme and the Children's Health Summit

Paul Marshall – Strategic Director: Children and Education provided an update on the work of the Manchester CYP Reform Programme.

The Reform Programme has been focused on 4 key opportunities for system-wide working and does not represent the entirety of work taking place to support Children

and Young People in Manchester. The 4 areas are:

- Think Family;
- Thriving Families;
- SEND;
- Joint Commissioning.

Both the SEND and Joint Commissioning programmes have achieved their ambition, and following increasing engagement of system partners across acute, community and primary care into the Reform Programme, it has been agreed to undertake a stocktake of the programme and outline a key priority for the system to work together on moving into 24/25.

The meeting also considered the impact across the system through the Think Family and Thriving Families work including the reduced number of children being taken into foster care and then long term care as a result of the confident parents programme. The cost benefits analysis (CBA) of this work demonstrates a return on investment of £1.65 for every £1 invested.

PCB also considered the current work on the joint commissioning of children's and education services in Manchester and noted the intention to build further on this to develop an Integrated Commissioning Function in Manchester, in accordance with the NHS Greater Manchester revised Target Operating Model.

Dr Cordelle Ofori, Deputy Director Public Health, presented the outputs from the Children's Health Summit held on 20th July 2023. PCB noted the system leadership engagement in the Summit, which focused on 5 key areas (based on a review of data and service intelligence): -

- Maternal and infant health;
- Immunisations, vaccinations and screening;
- Early childhood development;
- Healthy weight;
- Respiratory illness.

PCB acknowledged the work that had been delivered to date and the effort put into building relationships and trust across providers and commissioners in Manchester to improve services for children and young people.

Building on this, further work will be undertaken to agree a system priority that will deliver improvements in key outcomes and an update will be reported to PCB in November 2023.

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3. Provider Collaborative Board meeting: 19th October 2023

3.1. Admissions avoidance

Katy Calvin-Thomas and Dr Sohail Munshi provided an update on various work streams contributing to admissions avoidance, including Hospital@Home and the work with Newton Europe. PCB noted the 'go live' dates for Hospital@Home across MFT's hospital sites.

3.2. Health care inequalities and inclusion

Dr Cordelle Ofori and Sharmila Kar presented the above paper, which asked PCB to incorporate responsibility for addressing health care inequalities into the role of the Board, to support an Equalities, Inclusion and Human Rights approach to tackling inequalities and to support the development of an approach to Core20Plus5 in Manchester. It was agreed that this would include a focus on the 20% most socio-economically deprived people and on 'plus' groups that reflect Manchester's specific population groups and challenges with an intersectional approach, as follows: -

i) People experiencing complex and multiple disadvantage (homelessness, mental
ii) health, substance misuse);
iii) Communities experiencing racial inequalities;
iii) Asylum seekers and refugees;
iv) People with learning disabilities.

Having approved the recommendations, PCB requested Cordelle and Sharmila to return to PCB at a future date with plans to implement the agreed approach.

3.3. Urgent & Emergency Care: Winter resilience mobilisation and funding

Paul Thomas presented an update on the Manchester & Trafford system Winter Resilience Plan and its mobilisation. It was agreed that this would be enhanced by building in references to the vital work undertaken by the VCSE sector.

Tom Hinchcliffe then updated PCB on discussions regarding the allocation of £5.2m Winter Capacity funding received by Manchester. It was acknowledged that this was less than originally expected and that created significant unfunded pressures across providers. However, it was also recognised that a decision needed to be made so that Winter schemes could be mobilised in time. Consequently, it was agreed that the funding would be split as follows: -

- £1.2m – Primary Care;
- £0.5m – GMMH;
- £3.5m – MFT.

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In summary, PCB agreed to split the funding as indicated above. It was noted that GMMH would need to discuss their allocation with their Director of Finance before the use of this funding was finalised. System partners were also mindful that the limited funding available meant that there would be residual risks to the system over winter. System partners were keen that this was set out clearly as part of the system's return to ICB colleagues.

3. Recommendations

The Manchester Partnership Board is asked to note: -

- the discussions at the Provider Collaborative Board (PCB) meetings held 21st September & 19th October 2023;
- the escalations raised by GMMH and actions agreed across partners to provide support;
- endorse the revised PCB Terms of Reference;
- the progress update on the CYP Reform Programme and summary of the Child Health Summit and next steps agreed;
- the on-going work in respect of Admissions Avoidance;
- the approach to tackling health care inequalities and inclusion through the work of PCB;
- that PCB gained assurance on the Winter Resilience Plan and agreed the allocation of Manchester's Urgent & Emergency Care funding between Primary Care, GMMH and MFT, however, residual risks would remain over winter and these should be set out as part of the system's return within the ICB.

Julia Bridgewater & Cllr Thomas Robinson
October 2023

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Manchester Partnership Board	
Report of:	Manchester GP Board
Paper prepared by:	Caroline Bradley – Associate Director of Primary Care Dr Vish Mehra – Chair, Manchester GP Board
Date of paper:	10 November 2023
Item number:	7
Subject:	GP Board Highlight Report
Recommendations:	Manchester Partnership Board is asked to note the report.

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1. Update on the work of General Practice (GP) Board

Manchester GP Board meets on a monthly basis to discuss a range of current and future priorities relevant to Primary Care. At the meetings in September / October 2023 the Board focused on the following areas:

- **Primary / Secondary Interface -** update on ongoing work at both Manchester / Trafford and GM levels to make care more efficient and joined up for our local population. A Working Group has been established between MFT Group Medical Directors, Locality Associate Medical Directors, NHS Greater Manchester, LMC, GP Board and MLCO/TLCO. Regular meetings have been arranged to progress work against the 4 identified areas:
  - Onward referral
  - Complete care
  - Call and recall
  - Clear points of contact

  Further operational groups will be established to work on individual areas as needed.

- **Urgent & Emergency Care (UEC) / Winter Update -** discussion around the development of the Manchester system UEC / Winter plan and the on-going matter of how to prioritise areas and funding with a limited / oversubscribed allocation. Primary Care has identified three priority areas, included within the system plan, that provide different modes of additional / surge capacity. Previous work shows that these plans can be deployed quickly to support patients, Primary Care and the wider system.

- **NHS GM Quality Scheme Review –** update on progress against the review of locality quality schemes and the intended approach for 2023/24 and 2024/25. This is being led through a Working Group with sub groups reviewing 1. the components of each locality scheme and 2. financial allocations per scheme. Initial baseline information has been collated but needs further review and revision due to the complexities. A template will be shared with all localities to gain further insight and understanding to support further progress.

- **Primary Care Health Infrastructure -** following the update presented at the last MPB, work is progressing to identify and maximise estates opportunities across the City. There was an update on NHS GM Capital Funding that is available in 2023/24 for General Practice including the criteria and how to apply for this to support estate development.

- **Workforce and Additional Roles Reimbursement Scheme (ARRS) –** update on the Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) and the great work that is underway to ensure Manchester utilises the

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full allocation that is available. Challenges with recruitment, and variation across the city, were identified with a discussion on supporting areas that have more deprived and / or complex communities.

- **Hospital at Home –** update received on a recent Hospital at Home symposium, the current Hospital at Home service and operational work that is underway to ensure the delivery of a high quality and responsive service.

- **Winter Vaccination Programme –** overview of the programme requirements, and assurance provided, in relation to winter vaccination plans and coverage for all eligible cohorts. This will be provided via General Practice, Community Pharmacy and a peripatetic offer.

- **Spirometry** - working is ongoing across the locality and with other NHS GM groups to identify an appropriate funding model for delivery via Primary Care. Further meetings are planned to progress the work. Manchester Provider Collaborative has received an update and is supportive of restarting Spirometry in Primary Care.

2. GP Board Development and future priorities

As part of the management of GP Board, the Chair and the Executive Group note and reflect the key issues and risks arising from Board discussions which may impact on development of the role and effectiveness of the Board.

The GP Board has received an offer of consultancy support via NHS GM to aid GP Board Development. The GP Board is working through the practicalities of this including expectations, how the process will work, capturing a baseline / current position regarding maturity and the desired outcomes.

The current key issues and risks remain and include:

- GP Board members being able to operate effectively to support the delivery of MPB priorities with limited resource. Ongoing work continues to review and maximise the use of Primary Care expertise, resource and capacity to support the delivery of priorities as workplans become clearer.
- Additionally, contract changes, national messaging regarding access to Primary Care services and winter pressures may lead to a mismatch between available capacity and ability to meet patient expectations despite ongoing work to improve access to Primary Care. These areas are subject to ongoing dialogue with system partners.

3. Recommendation

Manchester Partnership Board is asked to note the report.

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Manchester Partnership Board	
Report of:	Dr Sohail Munshi, Chief Medical Officer, Manchester Local Care Organisation
Paper prepared by:	
Date of paper:	24th October 2023
Item number:	7
Subject:	Update on the work of the Clinical and Professional Advisory Group
Recommendations:	For information

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Meeting Agenda and Summary of Discussions October 2023

1.0 NHS-GM highlights

- Development of Primary Care quality standards at NHS-GM level under discussion.
- Clinical Effectiveness committee focussed on a future model for Spirometry provision and future Podiatry serices.
- Early discussions on Medicines Optimisation work regarding Inhalers.
- Options for an Integrated Commissioning function at Locality level being considered.

2.0 Interface Work

- Onward referrals workstream to be led by Dr Leonard Ebah, Manchester Royal Informary (MRI)
- Fit Notes and Discharge Letters to be led by Dr Matt Makin (North Manchester)
- Call and Recall to be led by Dr Sally Briggs (Wythenshawe)
- Early discussions also started with Greater Manchester Mental Health (GMMH) regarding Shared Care (Dr R Murugesan, NHS GM GP)
- A series of online and face to face events at Wythenshawe, Trafford, Withington and Altrincham (WTWA) in first week of November has been arranged by site and Local Care Organisation (LCO) colleagues to bring GPs, community and site together to build on relations and mutual understanding.

3.0 Hospital at Home

- Three pathways being developed and implemented supporting patients with 1) Frailty 2) Respiratory conditions 3) Heart Failure - with all 3 localities going live pre Winter. There will be a GP webinar in Manchester on 01/11/23 supported by the locality team and operational teams.
- Clinical conversation on compliance with Academy of Medical Rotal Colleges (AOMRC) guidance on named consultants and prescribing and Out Of Hours (OOH) care considerations.

4.0 High Intensity Users

- A new Voluntary, Community, Faith and Social Enterprise (VCSFE) led service supporting high intensity users of A&E services is to be setup working with and alongside the LCO Neighbourhood model. British Red Cross are experienced in this area and will be approached to progress next steps. The service is expected to be mobilised pre-Christmas at all 3 adult Emergency Departments (EDs).
- A general discussion on locality arrangements and how we will work at locality and system level.

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Manchester Partnership Board	
Report of:	Tom Hinchcliffe Deputy Place Based Lead, Manchester
Paper prepared by:	Owen Boxx – Senior Planning and Policy Manager (Manchester) NHS Greater Manchester Integrated Care
Date of paper:	17/10//2023
Item number:	7
Subject:	Delegated Assurance Board Meetings Update Report, reporting on the meetings of 7 June 2023 and 10 July 2023.
Recommendations:	Manchester Partnership Board is asked to: 1. Note the report.

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1.0 Introduction

1.1 The Delegated Assurance Board (DAB) forms a key element of the governance structure for the Manchester Locality, as part of NHS Greater Manchester Integrated Care (NHS GM). The DAB is a sub-group of the Manchester Partnership Board (MPB) and is a means for the Place Based Lead (PBL) to gain support and assurance in discharging their responsibilities. This report provides an update from the DAB meeting held on 6 September 2023 and 4 October 2023.

1.2 No issues or risks were identified that required escalation to the Manchester Partnership Board.

2.0 DAB update – 6th September 2023 & 4th October 2023

The DAB met on 6 September 2023 and 4 October 2023, and discussed the following key areas:

Finance

- The locality reported an increased overspend in Months 4 and 5. This was due to additional Primary Care costs including increased Prescribing costs and additional High cost placement costs within Mental Health and Children's services.
- The full year Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings are expected to be achieved in 2023/24.
- Increased placement costs across Mental Health, Learning Disability, Children and Continuing Healthcare (CHC) have been identified as risks. Mitigations include a review of the top 25 High cost placements,

Safeguarding, Quality and Nursing

- There is a backlog of CHC annual reviews due to vacancies in the team. All CHC clinical staff are now mobilised to address this. From 19 September, GM have authorised external advertising for the appointment to certain posts which should also support this. Further mitigations will be discussed at the Locality Management Team.
- It was signalled in September that the Joint Targeted Area Inspection (JTAI) for Serious Youth violence was being called for Manchester.

Patient and Public Involvement

The Patient and Public Advisory Group (PPAG) met in August and September 2023. Key issues raised included:

- The need for improved communication about what urgent care means, the need

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for improved access to urgent care as well as a requirement to reduce barriers for people from marginal groups to access services.

- Concern was also raised about whether everyone who was entitled to an Annual Health check was known to GPs.
- It was suggested that an app be made available to provide an update on waiting times within urgent care and accident and emergency.

Governance

- The Manchester CCG Annual Report for Q1 2022/23 was presented and accepted at the NHS GM Annual General Meeting in September 2023. A summary of the key achievements for the Manchester Locality was also presented within the NHS GM Annual Report for remainder of 2022/23.
- An update of the Terms of Reference (ToR) was provided: all of the Groups are in the process of reviewing their ToRs ahead of finalising changes for agreement at MPB.
- A report detailing the locality contingency plans will be developed and shared.
- The annual refresh of Conflicts of Interest will begin in October.

Primary Care

- 14 Primary Care Network (PCN) plans along with an aggregated locality plan were submitted to NHS GM.
- An update around the review of Locally Commissioned Services (LCS) via GP practices was provided.
- The fantastic achievement of the Additional Roles Reimbursement Scheme (ARRS) was highlighted. There was a full draw down of available funding for the project in 2022/23. There are an additional 360 practitioners working in primary care due to the programme, 160 of which were recruited in 2022/23.
- The Primary Care Commissioning Committee (PCCC) have agreed to extend one of the interpretation services for a further two years.
- Primary Care is currently supporting 3 Afghan Relocation and Assistance Policy (ARAP) hotels. It was highlighted that Manchester could become an overflow for other areas.
- PCCC have agreed the final position and funding approach of the Primary Care Quality Resilience and Recovery Scheme (PQRRS) for 2022/23.
- Members received an update that PCNs have been asked to develop an improvement plan related to capacity and access planning.

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Manchester Partnership Board	
Report of:	Tom Hinchcliffe - Deputy Place Based Lead
Paper prepared by:	Tom Hinchcliffe - Deputy Place Based Lead Paul Thomas - System Resilience Urgent Care Manager
Date of paper:	24/10/2023
Item number:	7
Subject:	Winter planning 2023/24 - update
Recommendations:	The board is asked to note the contents of the report

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1.0 Introduction

1.1 This paper gives an update on winter planning for 2023/24.

1.2 In line with previous years, the Manchester and Trafford System Resilience Team will lead and co-ordinate on all aspects of winter planning and the lessons learnt from winter 2022/23 have been incorporated into the organisational delivery plans.

2.0 System Winter Plan

2.1 The system winter plan has been developed in collaboration with system partners, highlighting key areas of delivery and focus into the winter period. These include delivery of Hospital at Home model, acute rollout of Back to Basics, and the bespoke Tier 1 support from national teams and Newton Europe.

2.2 Development of the plan has been led through the Manchester and Trafford Operational Delivery Group (ODG), a system wide group with representation from operational leads across the Manchester and Trafford footprint.

2.3 Details of the plan have been shared through Provider Collaborative Board on 19th October, and a check and challenge on winter preparedness was conducted through the Manchester and Trafford Urgent Care Board on 20th October.

2.4 Further work has been identified to describe how the Voluntary, Community and Social Enterprise (VCSE) sector will support the urgent care system through Winter.

2.3 A first version of the plan has been shared with locality system partners and GM Integrated Care System (GM ICS), with a further iteration of the plan expected in November.

3.0 Urgent and Emergency Care Recovery Funds

3.1 In March 2023, GM ICS informed localities of capacity/recovery funding available for 2023/24 to help plan in a more coordinated way. This funding allocation sits across several separate workstreams supporting virtual wards, discharge and securing additional capacity.

3.2 At the request of Manchester Partnership Board, the Provider Collaborative Board discussed a proposal on which winter schemes are to be funded and allocations, from the capacity/recovery funding. An agreement was reached with system partners on the allocations on an organisational basis, with further work underway on the specifics of delivery.

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3.3 This agreement will allow Primary Care to start an immediate implementation of Winter schemes in support of Urgent Care. Specifically, implementation of the Manchester Acute Respiratory Infection Service (MARIS), providing a high volume of additional same day respiratory capacity at times of surges in demand, and additional clinical and non-clinical sessions. These schemes will help to release capacity in general practice, and reduce pressures on secondary care through emergency department attendance avoidance and admission avoidance.

4.0 **Recommedation**

The board is asked to note the content of the report.

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MANCHESTER CITY COUNCIL

NHS

Manchester Partnership Board	
Report of:	Katy Calvin-Thomas, Chief Executive, Manchester Local Care Organisation (MLCO) On behalf of Julia Bridgewater, Deputy Chief Executive Officer, Manchester University NHS Foundation Trust (MFT) & Cllr. Tom Robinson, Executive Member for Executive Member for Healthy Manchester and Social Care (Co-chairs, MLCO Accountability Board).
Paper prepared by:	Tim Griffiths, Director of Corporate Services, MLCO
Date of paper:	7
Item number:	
Subject:	MLCO update – October 2023
Recommendations:	MPB is asked to note the contents of the paper and note that more detailed papers are provided to LCO Accountability Board.

1. Introduction

1.1 This paper has been written to provide Manchester Partnership Board with an MLCO progress update for October 2023.

1.2 The MLCO Accountability Board met on Thursday 19th October 2023 to consider papers that provided updates against core operational delivery and performance.

1.3 As a reminder the MLCO Accountability Board was re-established in June 2023 and is co -chaired by Julia Bridgewater, Deputy Chief Executive, MFT and Councillor Tom Robinson, Executive Member for Healthy Manchester and Adult Social Care.

2. MLCO delivery

2.1 In MLCO's community health services work remains ongoing to reduce the levels of absence which remains higher than would be liked but comfortably below the levels seen in and around COVID. Through a range of targeted interventions MLCO has reduced absence levels through the course of 2023.

2.2 MLCO Accountability Board receive detailed performance packs for both community health and adult social care and a significant amount of work is being driven through its Performance Board to improve data quality within EMIS, with a particular focus on validating waits in non-reportable community health services. This work, led by the MLCO Chief Operating Officer, is set in the absence of any agreed national framework sought to reduce/validate excess waits. The scale of this work cannot be understated and the MLCO will continue to work on this programme, including with GMICB colleagues to ascertain a definitive reporting position. Likewise, MLCO has seen a huge improvement in its reporting capability across adult social care and is able to use robust data to inform its decision-making processes routinely.

2.3 MLCO activity remains below the forecast set by the organisation (and work is ongoing to understand the variation). Colleagues are advised that MLCO undertook a detailed activity planning exercise at the beginning of 2023/24 and MLCO is forecast to achieve in excess of one million contacts with patients in Manchester.

2.4 Timely discharge of patients from hospital to their place of residence through the MLCO Resilient Discharge Programme and MLCO continues to work to achieve the 240 no reason to reside target that has been set. The MLCO community response teams continue to exceed all performance targets and remain comfortably ahead of national benchmarking thus supporting a significant number of people to avoid an unnecessary hospital admission.

2.5 Across adult social care waiting lists for social work assessments have slightly reduced and reablement performance continues to exceed expectations. Demand for homecare continues to increase and whilst this was anticipated a deep dive has been commissioned to look at root causes; this forms part of a broader programme of work to understand what drives the financial position.

2.6 The core risk within adult social care continues to be the stability of the care market, which is in keeping with local authorities nationally, and work remains ongoing to manage the sector.

2.7 The financial challenge across MLCO remains and the financial position continues to be overseen through the finance subgroup of MLCO Accountability Board.

2.8 MLCO is leading work to develop a robust and comprehensive business case for Hospital at Home and a more detailed update is provided to MPB this month.

2.9 In adult social care the Better Outcomes, Better Lives Programme is overall on track. Workstreams will be developing plans for the final phase of the programme. This includes bringing some of the workstreams to a close with ongoing work to be owned by the service as business as usual.

2.10 MLCO continues to support in the significant work re North Manchester General Hospital Redevelopment and North Manchester Strategy implementation; this includes the redevelopment readiness assessment and the development of Target Operating Models (TOMs) to support the proposed development. Following the development of TOMs for urgent care and outpatients, work has been commissioned to outline a proposed 'living well in my community TOM', which is being overseen by North Manchester General Hospital (NMGH) TOM Steering Group and has been considered by the LCO North Locality Partnership Forum.

2.11 One of the key priorities for MLCO in 2023/24 is the Community Health Transformation Programme which is a multi-year transformation programme to design and mobilise a core community health offer for the residents of Manchester (and Trafford) that will function as part of a wider integrated health, care and wellbeing service offer with social care, acute, primary care and other community providers.

2.12 MLCO population health management priorities of bowel cancer screening and hypertension are now being implemented across all Neighbourhoods. The diabetes work is focussing on creating a consistent approach to measuring impact (rather than new additional activities). Work on co-ordinated care pathway looking at flow of patients and role of care navigator continues, and continued engagement with frailty consultants is planned.

3.0 Recommendations

MPB is asked to note the contents of the paper and note that more detailed papers are provided to MLCO Accountability Board.

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