Public Document Pack

Health and Wellbeing Board

Date: Wednesday, 20 September 2023
Time: 10.00 am
Venue: Council Antechamber, Level 2, Town Hall Extension

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Membership of the Health and Wellbeing Board

Councillor Craig, Leader of the Council
Councillor T Robinson, Executive Member for Member for Healthy Manchester and Adult Social Care (MCC) (Chair)
Councillor Bridges, Executive Member for Children and Schools Services (MCC)
Councillor Chambers Assistant Executive Member for Healthy Manchester and Adult Social Care
Katy Calvin-Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Bill McCarthy, Chair, Greater Manchester Mental Health NHS Foundation Trust
Mike Wild, Voluntary and Community Sector representative
Amanda Smith, Chair, Healthwatch
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Tom Hinchliffe - Permanent Deputy Place Based Lead
Dr Murugesan Raja Manchester GP Board
Dr Geeta Wadhwa Manchester GP Board
Dr Doug Jeffrey, Manchester GP Board
Dr Shabbir Ahmad Manchester GP Board (substitute member)
Dr Denis Colligan, Manchester GP Board (substitute member)

Agenda

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

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

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

4. Minutes 5 - 10
To approve as a correct record the minutes of the meeting held on 7 June 2023.

5. Health Protection - Operational Local Health Economy Outbreak Plan Manchester and Update on Tuberculosis 11 - 90
Report of Director of Public Health attached

6. Joint Local Health and Wellbeing Strategies 91 - 236
Report of Director of Public Health attached

7. Armed Forces Community JSNA 237 - 280
Report of Strategic Director of Children and Education Services attached

8. Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027 281 - 300
Report of Deputy Director of Public Health attached

9. Children and Young People's Health Summit 301 - 306
Report of Deputy Director of Public Health attached

Information about the Board

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

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

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

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Smoking is not allowed in Council buildings.

Joanne Roney OBE
Chief Executive
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Further Information

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This agenda was issued on **Tuesday, 12 September 2023** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 2, Town Hall Extension (Library Walk Elevation), Manchester M60 2LA

Health and Wellbeing Board

Minutes of the meeting held on 7 June 2023

Present:
Councillor T Robinson, Executive Member for Healthy Manchester and Adult Social Care (Chair)
Councillor Chambers, Assistant Executive Member for Healthy Manchester and Adult Social Care
Katy Calvin-Thomas, Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Amanda Smith, Chair, Healthwatch
Neil Walbran, Healthwatch
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Tom Hinchliffe, Permanent Deputy Place Based Lead
Dr Murugesan Raja, Manchester GP Board
Dr Geeta Wadhwa, Manchester GP Board
Dr Doug Jeffrey, Manchester GP Board

Also in attendance:
Ben Squires, Head of Primary Care, NHS Greater Manchester
Jenny Osborne, Strategic Lead, Population Health Programmes
Sarah Hardman, Assistant Directorate Manager, Dental Hospital
Professor Jane Eddleston, Medical Director, Manchester University NHS Foundation Trust
Simon Walsh, Procurement Director, Manchester University NHS Foundation Trust
Nick Bailey, Director of Workforce, Manchester University NHS Foundation Trust
Kate McAuley, Team Leader, Manchester University NHS Foundation Trust

HWB/23/08 Urgent Business

The Director of Public Health informed the Board that due to reporting deadlines, the Better Care Fund that was referred to at section 2.4 of the report titled 'The Formal Establishment of the Manchester Partnership Board' listed as item 5 on the agenda had been signed off by the Chair. He advised that a note for information relating to this would be circulated to members of the Board following the meeting.

HWB/23/09 Minutes

Decision

To approve the minutes of the meeting held on 25 January 2023 as a correct record.

HWB/23/10 The Formal Establishment of the Manchester Partnership Board

The Board considered the report of the Deputy Place Based Lead and the Director of Public Health that described that in January 2023, the Health and Wellbeing Board

(HWB) had agreed the changes to the membership and chairing of the HWB. The report also referenced the work to establish the Manchester Partnership Board (MPB) as a hybrid committee of the NHS Greater Manchester Integrated Care Board. The report provided an update on the role, purpose and priorities of the MPB.

The Director of Public Health stated that the Health and Wellbeing Board would remain a statutory committee and would consider the wider determinants of health, utilising and bringing together the expertise and knowledge of all partners. He commented that the HWB would receive update reports from the MPB, adding that they were due to meet formally in public for the first time that afternoon.

The Deputy Place Based Lead added that the MPB was a formal subcommittee of the ICB and had a distinct identity that was separate to the HWB.

The Chair commented that the HWB would be a critical friend of the MPB, adding that the HWB would receive quarterly update reports on the strategic priorities of the MPB. The Chair further noted the comments raised by a Board member who discussed the need for clarity on the process of decision making, adding that he would discuss this with the Chair of the MPB.

Decision

The Board note the report.

HWB/23/11 Oral Health and Dentistry

The Board considered the report of the Director of Public Health that provided a position statement on the oral health of the city's population and access to NHS dental services. It used a range of data to profile the oral health of Manchester residents, described the provision and use of NHS services, including action to recover from the impact of the Covid-19 pandemic, and information on patient and public feedback.

The report further summarised commissioned prevention and oral health improvement services for children and young people, adults and older people. The report placed a focus on health equity, highlighting known gaps in our knowledge and intelligence and the limitations this placed on our ability to understand and address health inequalities, and provided feedback from partners/providers in relation to a range of vulnerable or health inclusion groups.

Noting that the report made a distinction between dental oral health and wider oral health conditions (such as mouth cancer, gingivitis, halitosis etc).

The Board welcomed the comprehensive and detailed report, noting the stark picture it illustrated in relation to oral health across the city. The Board discussed that the work to tackle this was fundamental to the commitment to address wider health inequalities, in particular, noting the detrimental impact poor oral health had on vulnerable residents' health outcomes, with specific reference to Learning Disabled citizens and older citizens. The Board further discussed and recognised the importance of preventative initiatives around the issue of oral health, particularly in

relation to young people. The Board stated that all opportunities and available levers should be used to address poor oral health.

The Head of Primary Care, NHS Greater Manchester advised the Board that work between commissioners and providers continued in an attempt to address this issue, adding that demand on NHS dental services outweighed provision, adding that this was a national issue and not confined to Manchester. He advised that work was ongoing to review the redistribution of provision across Manchester and Greater Manchester following a number of NHS contracts being ‘handed back’. He advised that negotiations were ongoing with providers to encourage them to increase the number of NHS patients they would treat. He advised that information on individual practices could be found on the NHS UK website. He further referred to the ongoing discussions at a national level regarding an enhanced tariff to encourage and support practices to increase the number of NHS patients they could accommodate. In response to a request from the Chair he advised that he would provide a written summary of these activities so this could be circulated to all elected members for information.

A member of the Board stated that all partners should support activity and awareness regarding the importance of oral health. The Strategic Lead, Population Health Programmes commented that all partners would be consulted with as the Manchester specific action plan was developed, and she further welcomed the support offered from the Board in relation to this activity.

The Strategic Director of Children’s Services welcomed the inclusion of looked after children in the list of groups identified as being vulnerable, adding that he would discuss with the Chair of the Corporate Parenting Panel the need to include consideration of this topic when they had a health themed meeting. In relation to a specific question raised regarding Unaccompanied Asylum Seeking Children (UASC) the Head of Primary Care, NHS Greater Manchester advised that he would clarify the position following the meeting.

The Chair stated that explicit consideration needed to be given to the impact of COVID-19 and young people within the action plan. The Chair further recommended that an update report on this and the wider activity be submitted for consideration by the Board towards the end of the year.

Decisions

The Board:

1. Support the development of a Manchester specific action plan to address poor levels of oral health in the local population, drive improvements to NHS dental services and reduce inequalities for the Manchester population.

2. Support the development of GM strategy and action to address locality requirements around oral health promotion and improved access.

3. Request that the Director of Public Health, in consultation with Greater Manchester NHS and the Manchester Local Care Organisation reports back to the Board on progress and the priority actions agreed by the end of the year.

4. Recommend that the Head of Primary Care, NHS Greater Manchester provide a briefing note that describes the actions being taken to improve NHS dental access across the city that can be circulated to all members of the Council.

HWB/23/12 Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027

The Board considered the report of the Deputy Director of Public Health that provided an overview of progress made during 2023 on the Making Manchester Fairer (MMF) Action Plan.

The Board noted that the Anti-Poverty Strategy (APS) had been formally adopted at Executive in January 2023 and was the main route to delivering against the MMF theme of reducing poverty and debt. It set out our vision that the whole of Manchester would work together to reduce poverty and lessen the impact of poverty on our residents. The strategy contained 53 actions across 12 priorities and 4 themes.

The report described that an overarching narrative had been developed by the Communication Teams that reflected that the Anti-poverty strategy was now part of the Making Manchester Fairer plan. This has also included bringing in the immediate Cost of Living support, so that there was a unified stance to the work and made the most of the city's combined networks.

The Board were informed that the first Making Manchester Fairer Programme Board took place in May after an extensive Expression of Interest process that recruited people to the board that were visibly reflective of Manchester's diverse communities (particularly those most impacted by health inequalities) and had a balance of different types of perspectives including organisational, professional and lived experience.

The Board were further informed that the development of governance and approval process for the Kickstarter Schemes allowed for the Children's element of the Supporting children, young people and their families scheme to begin implementation.

Further to the workstream and programme development, a number of theme leads had developed projects and initiatives that were designed to meet the aims and objectives of the actions under their themes and Manchester NHS Foundation Trust (MFT) had developed a Health Inequalities programme.

The Board heard from representatives from MFT who described the many actions and initiatives that had been implemented to address health inequalities. These included the establishment of an Equalities Lead at each site so as to develop local actions to respond to specific local needs; the establishment of an equalities dashboard; MFT acting as an anchor institution and supporting their staff; initiating

programmes to recruit staff from the local population, recognising that this would further support the issue of staff retention and staff acting as advocates for health equity; using patient data to understand the needs of the local population and identify issues or gaps in provision so that interventions and programmes could be targeted by working at a local level with Primary Care Networks and the Manchester Local Care Organisation. The Board were further advised that the Trust was seeking to employ a Consultant in Public Health to inform and support this area of activity. In response to a comment regarding digital exclusion, Professor Eddleston stated that the Trust were very mindful of this issue and due consideration would be given as to how this could be addressed as part of the ongoing work.

The Board welcomed the report and the update reported by the representatives from the Trust, stating that the work described demonstrated a commitment to place based working, the strength of genuine partnership working and an understanding of the needs of the local population that demonstrated that people were at the heart of everything that was described. The Board stated that the outcomes and impact of this approach needed to be reported and articulated, both at a local and national level and the Board was happy to support this. Professor Eddleston commented that she would be happy to provide an update presentation to the Board in six months' time.

The Chair, Manchester University NHS Foundation Trust stated that the MFT Board fully supported the vision and the work described. She stated the described approach provided a strong foundation on which to address health inequalities, support residents and end the 'revolving door' of health provision.

The Chair concluded the discussion by thanking the representatives from MFT for attending the meeting. He stated that it had been an important and constructive discussion. He invited MFT representative to attend all future meetings of the Board when Health Inequalities was to be discussed.

Decisions

1. The Board note progress made in implementing the Making Manchester Fairer Action Plan, the incorporation of the Anti-Poverty Strategy within the programme, and the work that is taking place across partner organisations to integrate the Making Manchester approach and principles system wide.

2. The Board recommend that a progress presentation be submitted for consideration in six months' time.

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Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 20 September 2023

Subject: Health Protection - Operational Local Health Economy Outbreak Plan Manchester and Update on Tuberculosis

Report of: Director of Public Health

Summary

This report provides background information about the refresh of the Operational Local Health Economy Management Plan for Manchester and includes the draft plan for approval. It also provides a detailed focus on current epidemiology and issues relating to tuberculosis (TB).

Recommendations

The Board is asked:

1. To approve the Operational Local Health Economy Outbreak Management Plan for Manchester.
2. To be aware of the current issues around TB and recommend that the Director of Public Health a) escalates migrant health related issues to the newly established NHS GM Migrant Health Group; b) advocates through professional networks for more latent TB testing to be available for all residents with higher risk of TB, not just new entrants and not just adults.

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	The Local Health Economy Outbreak Plan ensures that Manchester has the appropriate response arrangements to any outbreak of infectious diseases which will mitigate against health related harms across the life course. The work to prevent, detect and treat tuberculosis contributes to the Health and Wellbeing Strategy priorities of the city.
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

Introduction

Protecting and improving the health of our communities is at the heart of public service delivery. Health protection encompasses a range of activities including ensuring the safety and quality of food, water air and the general environment, preventing the transmission of communicable diseases and managing outbreaks and other incidents which threated public health.

Preventing the transmission of communicable disease requires action across the health and wider system on a number of fronts including infection prevention and control in settings, screening, vaccination and outbreak response under the oversight of the Director of Public Health; whose responsibility it is to work through local resilience forums and local health resilience partnerships to ensure tested and effective plans are in place.

The focus of this report is to share the refreshed Local Health Economy Action Plan for approval (Part One) and to provide a detailed picture of the situation and issues relating to tuberculosis in Manchester (Part Two), which is of particular concern.

1.0 Part One: Local Health Economy Outbreak Plan

1.1 The plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the Greater Manchester Multi-Agency Outbreak Plan, providing operational detail helping responders to quickly provide an effective and coordinated approach to outbreaks of communicable disease. The draft plan can be found as appendix 1.

1.2 Whilst the response to outbreaks isn't new and our local health economy routinely demonstrates that is has effective arrangements in place, it is important that we review the arrangements, and that the organisations and people who need to work together in partnership are aware of each other's roles and responsibilities for a range of scenarios.

1.3 In July 2017, the Greater Manchester Resilience Forum and Local Health Resilience Partnership approved the Greater Manchester Multi-Agency Outbreak Plan. It sets out the strategic principles for outbreak management in Greater Manchester, including the roles and responsibilities of key organisations.

1.4 All Greater Manchester Health and Wellbeing Boards were subsequently recommended to ensure completion of a local outbreak plan, using a template provided by the Civil Contingencies Resilience Unit.

1.5 This template was completed by the Manchester Public Health Team in early 2017, and the Plan was presented to the Health & Wellbeing Board and approved in 2019.

1.6 Many organisations have proven that they have a role to play in protecting the public from communicable disease during the last three years. We have refreshed our Local Outbreak Plan to consider learning from the pandemic, in addition to ensuring it reflects the current health economy in Manchester.

Part Two: Update on Tuberculosis

2.0 Background

2.1 Tuberculosis (TB) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs (Pulmonary TB) but can also develop in areas outside the lungs, including the abdomen, glands, bones and nervous system (Extrapulmonary TB).

2.2 Symptoms of TB include a persistent cough that lasts more than 3 weeks and usually brings up phlegm, which may be bloody, weight loss, night sweats, high temperature, tiredness and fatigue, loss of appetite and swellings in the neck. In some cases, symptoms might not develop until months or even years after the initial infection.

2.3 If the person has symptoms, it's called active TB. Sometimes the infection does not cause any symptoms but the bacteria will remain in the body. This is known as latent TB. People with latent TB are not infectious to others but latent TB can develop into an active TB disease at a later date, particularly if the immune system becomes weakened.

3.0 TB treatment and notification

3.1 TB is a potentially serious condition but, in most cases, a six-month course of treatment with the right antibiotics will cure it. TB can become resistant very easily and drug resistant TB can be very difficult to treat. For that reason, only experienced personnel should manage these patients. A Consultant Respiratory Physician must manage all adult patients with TB and a Consultant Respiratory Paediatrician must manage all patients less than 16 years of age.

3.2 Parts of the world with high rates of TB include Africa (particularly sub-Saharan and west Africa), South Asia, Russia, China, South America and the western Pacific region.

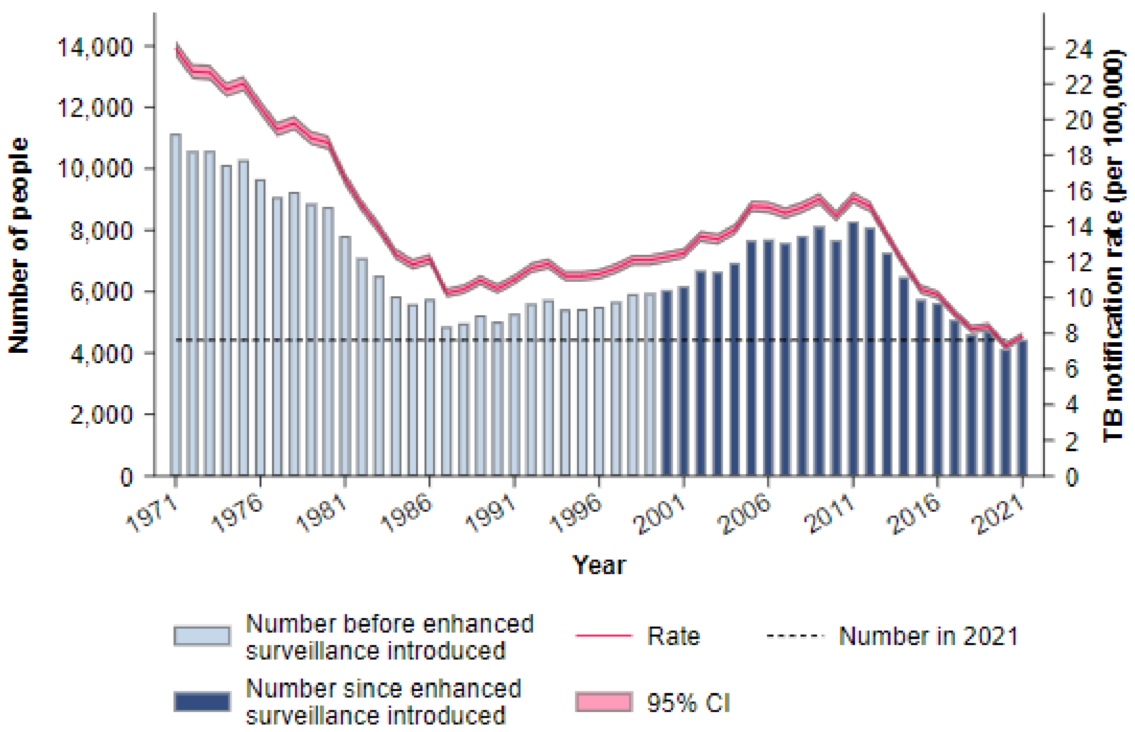
3.3 All new cases of TB must be notified to the UK Health Security Agency (UKHSA) on a web-based surveillance system. Although the incidence of TB is low nationally, it is higher in England than many other comparable countries and as it is concentrated in urban areas. There are pockets of very high incidence in some parts of our cities, including areas in Manchester. TB is a disease of inequality. In 2019, national rates of TB were 5 times higher in the most deprived decile compared with the least deprived decile.

4.0 TB incidence and epidemiology in England, 2021

4.1 In 2021, TB incidence was 7.8 per 100,000 - below the World Health Organisation threshold for a low incidence country (less than or equal to 10 per 100,000 population).

4.2 Nationally, TB incidence has decreased overall since 2011 but the rate of decline is slowing, and England is not currently on target to achieve the plan of reducing TB incidence by 90% from 2015 to 2035 (see figure 1 below).

Figure 1 - Number of TB notifications and TB notifications rate per 100,00, England, 1971-2021



4.3 TB incidence is not evenly distributed across the country and is concentrated in large urban areas. The disease disproportionately affects the most deprived populations, including groups at risk of exclusion and other health inequalities, and people born outside the UK.

4.4 Infectious pulmonary TB is more common in men, people with a history of imprisonment and people with a history of drug and alcohol misuse. Social risk factors (e.g. drug or alcohol misuse and history of imprisonment) in people with TB were more common in the UK-born population compared with the non-UK-born population. In contrast, homelessness, asylum seeker status and mental health needs were more common in the non-UK-born population with TB than in the UK-born population with TB.

4.5 The long-term effect of the global coronavirus (COVID-19) pandemic on TB incidence is difficult to determine but recent patterns mirror those seen in other countries.

5.0 Epidemiology of Tuberculosis (TB) in Manchester

5.1 The latest local epidemiological summary is based on published data up to the end of 2021 (Data published: November 2022) from the Enhanced Tuberculosis Surveillance (ETS) 2022. More information is available through the TB Strategy Monitoring Indicators tool: http://fingertips.phe.org.uk/profile/tb-monitoring

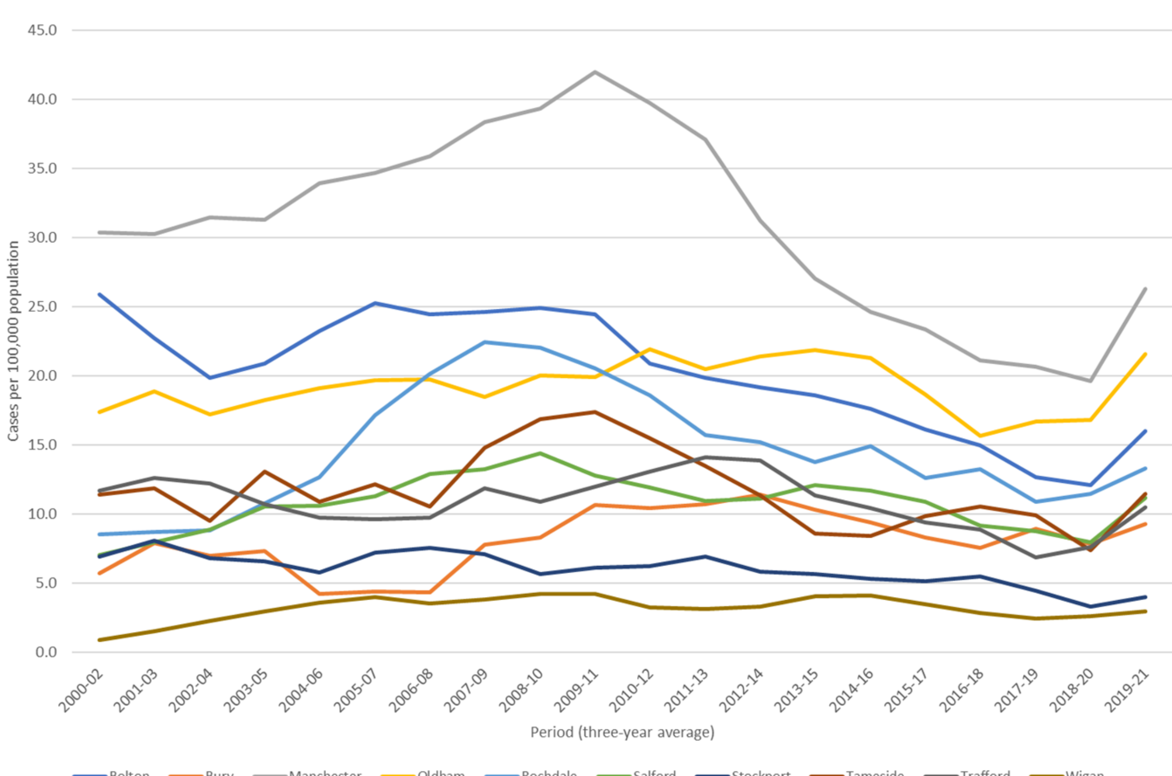
5.2 Table 1 shows the three-year average numbers of TB case notifications and rates by local authority in Greater Manchester, 2019-2021. The average annual rate per 100,000 population in Greater Manchester was 9.5. Among upper tier local authorities, the highest rates were in Manchester at 21.0 per 100,000 population; and in Oldham at 16.8 per 100,000 population. The areas with the lowest rates were Wigan and Stockport.

Table 1 - Three-year average numbers of TB case notifications and rates by local authority: Greater Manchester, 2019 to 2021

Local authority	Average annual no. of people	Average annual rate per 100,000	95% CI (Lower)	95% CI (Upper)
Bolton	35	12.0	9.8	14.6
Bury	13	7.0	5.0	9.5
Manchester	**117**	**21.0**	**18.9**	**23.4**
Oldham	40	16.8	14.0	20.1
Rochdale	19	8.7	6.6	11.2
Salford	23	8.7	6.7	11.0
Stockport	6	2.0	1.2	3.2
Tameside	19	8.4	6.3	10.8
Trafford	19	7.9	5.9	10.2
Wigan	7	2.2	1.4	3.4
Greater Manchester	298	9.5	7.6	11.7

5.3 TB incidence in Manchester has decreased overall since 2009-2011 but the rate of decline started slowing in 2016-18 and then started to increase from 2018-20 (see top line on the graph in figure 2 below). There is a similar uptick in TB incidence in most areas in Greater Manchester from 2018-20.

Figure 2 - TB incidence rate per 100,000 population, Greater Manchester, 2000-02 to 2019-21 (three-year average)



6.0 National Co-ordination of TB work

6.1 **National Action Plan** - For the UK to meet its commitment to achieve the World Health Organisation target of eliminating TB by 2035, a year-on-year reduction in people with TB disease is required, as well as addressing health inequalities that put people at risk of developing active TB disease.

6.2 To help address this, the UK Health Security Agency and NHS England jointly launched the TB action plan for England (2021 to 2026) in July 2021. This action plan is a road map for COVID-19 recovery of TB services and has 5 priority areas:

- recovery from COVID-19 pandemic – understanding and reporting the impact and learning from the pandemic
- prevent TB
- detect TB
- control TB disease
- workforce

6.3 The action plan aims to achieve these objectives through system wide actions involving close partnership working between the UK Health Security Agency with NHS and local authorities.

Figure 3 - TB Strategy for England: Priorities, Actions and Outcomes

Priority 1
Recovery from COVID-19

Priority 2
Prevent TB

Priority 3
Detect TB

Priority 4
Control TB disease

Priority 5
Workforce

Actions for specific population groups
For example, under-served populations, new entrants, drug resistant TB, paediatrics

Measurable outcomes and indicators

Systems wide actions
For example, communications, surveillance, research, prevention and health inequalities agendas

7.0 Local plans and arrangements

7.1 The North West TB Control Board, chaired by the UK Health Security Agency, provides strategic leadership towards achieving TB elimination at a regional level. Sub-regional representation on the group comes from NHS commissioners, NHS providers, microbiology, field epidemiology and includes local authority public health representation. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) represents Greater Manchester Directors of Public Health on the Board.

7.2 The Greater Manchester TB Collaborative leads the development and implementation of a multi-agency TB Control Strategy for GM based on the National TB Action Plan 2021-26. The Collaborative is responsible for providing assurance on the implementation of the GM TB action plan 2021-26, developing and implementing the GM TB control strategy 2022-2025, promoting service improvements that result in reductions in GM TB incidence and providing strategic oversight and direction on the commissioning, quality assurance and performance management of GM TB services. The GM TB Collaborative is accountable to the GM ICS (Population Health Board) and reports to the NW TB Control Board. The Collaborative reports quarterly progress against TB control metrics as outlined in the GM TB control strategy. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) represents Greater Manchester Directors of Public Health on the GM TB Collaborative.

7.3 The Manchester Health Protection Board, chaired by the Director of Public Health, has responsibility for overseeing TB work at a local level. There have been several focussed discussions on TB at the Health Protection Board over the last 12 months, given the complexity of the work and the risks and issues associated with the current situation, described in more detail in section 3.69-3.81 of this paper. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) shares information from the NW TB Control Board, the GM TB Collaborative, and local Manchester Health Protection

Steering Group. The Manchester Health Protection Board reports to this Health and Wellbeing Board.

7.4 As part of the Greater Manchester Health Protection Reform work, a workstream to share learning and further develop joint work on TB is being implemented. Support is being provided from the Local Government Association's National Sector Led Improvement Team and work is currently underway to map existing TB services and processes with all 10 local authorities and their partners. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) is the lead for this workstream, supported by colleagues from within the Manchester Department of Public Health, other GM local authorities and colleagues from NHS Greater Manchester Integrated Care and UK Health Security Agency.

7.5 Learning from other areas of the country will help us to progress our work in Manchester and we are also keen to share what we have learned and influence work at a national level. Team members from the Manchester Department of Public Health are presenting our local work at the National TB Nurses and Allied Health Professionals Conference 2023 on 29th September and are contributing to a national toolkit on TB that is being developed.

8.0 TB Service Provision across Greater Manchester

8.1 Each locality within GM has health professionals who can care and treat a person with latent or active Tuberculosis and each locality has a specific TB consultant. Some areas have a full-time dedicated TB nurse, others may have a part time TB nurse who works in other areas of respiratory medicine or infectious diseases. Table 2 below shows the TB service provision in Manchester from Manchester University NHS Foundation Trust (MFT).

8.2 Any cases of multi drug resistant TB are cared for by a specialist centre such as North Manchester General Hospital Infectious Diseases Unit or the Manchester Royal Infirmary. Every person who has been identified with TB disease is notified to UK Health Security Agency.

8.3 Some patients require more intensive support through treatment with treatment option such as directly observed therapy. In such cases, the TB nurse will visit the patient three times per week and observe the patient taking the treatment.

8.4 In addition to screening and treatment as part of local TB outbreaks, the TB services across MFT have been heavily involved with a large scale TB screening programme for Afghan refugees and with providing TB screening and treatment for residents of a hotel housing asylum seekers in the area.

Table 2 - TB Service Provision in Manchester from Manchester University NHS Foundation Trust

TB Service Provision in Manchester from Manchester University NHS Foundation Trust	
North Manchester	• Team based at North Manchester General Hospital. • Dedicated infectious diseases unit with 6 negative pressure rooms. • Team of 6 TB nurses. • Dedicated paediatric infectious disease consultant also based here
Central Manchester	• Team based at Manchester Royal Infirmary. Part of Respiratory Medicine. • Two consultants and team of 6 nurses. • Facility to care for multi drug resistant TB patients. Hospital has capacity for 2 negative pressure rooms • Royal Manchester Children's Hospital provides TB care to children across the GM footprint. Two Paediatric constants with a special interest in TB based here.
South Manchester	• Team based at Wythenshawe Hospital. Part of Infectious Diseases Unit. • Team of infectious disease physicians and infectious disease nurses who care for people with TB

8.5 There is strong collaborative working between key organisations and teams involved in TB prevention, detection, and control in Manchester. Manchester City Council's Department of Public Health Team works closely with other teams in the Council, such as Housing, Education, Communications, and the No Recourse to Public Funds Team, as well as UK Health Security Agency, MFT TB Team and NHS Commissioners amongst others.

9.0 Delivery of National TB Programmes in Manchester and Greater Manchester

9.1 There are two national TB programmes - National Latent TB infection screening programme in high incidence areas and BCG vaccination programme.

Latent TB Infection Screening Programme

9.2 The Latent TB Infection (LTBI) programme aims to reduce TB by testing and treating latent TB in migrants aged 16 to 35 years who have arrived in England from countries with a high TB incidence (≥150 per 100,000 population or sub-Saharan Africa) within the last 5 years and had been living in that country for 6 months or longer. This has been extended to enable people who were unable to access an LTBI test in 2020 due to the COVID-19 pandemic.

9.3 The LTBI programme is funded by NHS England and implemented locally by ICSs. The delivery model of the LTBI programme is locally determined. There are three models:

1. TB services: Use Flag 4 data (GP registrations of new migrants), filtered for programme eligibility, to invite people in for a test. TB services are based in either secondary or community care.
2. Primary care: New registrations that meet the programme eligibility are offered the LTBI test
3. Dual/hybrid model: A combination of TB services and primary care delivery

9.4 In Manchester, delivery model 1 is used and the programme is run by the TB service at MFT.

3-year LTBI programme plan: Manchester, Bolton and Oldham, 2022-2025

9.5 Manchester, Bolton and Oldham within Greater Manchester ICP are three of the identified high TB burden areas in England able to receive additional funding from NHS England (NHSE) for the provision of an LTBI testing and treatment programme.

9.6 Funding for the national LTBI testing and treatment programme has been confirmed until 2024/25. The NHSE LTBI programme budget is sufficient to fund only 26% of the total number of eligible new registrations, as indicated in Flag 4 data for TB high burden areas.

9.7 Table 3 below is the proposed GM 3 year plan for the LTBI service, including the figure (column three) for 26% of Flag 4 data annual average number.

Table 3 – Greater Manchester 3 year plan for the LTBI service

Area	Planned Screening Activity (per year)	GM Total Planned Screening Activity (per year)	2022/23 expected LTBI activity based on Flag 4 numbers	GM 2022/23 requested NHSE funding allocation
Bolton	350	2,162 each year of the programme	287	£265,081.10 (£122.61 per test)
Manchester	1,512		1,371	
Oldham	300		220	

9.8 Commissioners and clinical colleagues across GM ICB and MFT have been working on a draft business case for the last 12 months. The aim of this business case is to secure additional funding to improve the current TB/LTBI service to enable an offer screening to all eligible patients across Greater Manchester. Delays in securing funding adds to the increasing backlog of people needing to be screened and increases the public health risk of more TB infection.

10.0 Migrant health and TB screening

10.1 The Department of Public Health is working in collaboration with Manchester Foundation Trust Clinicians, Go To Doc Health Care and other providers to implement screening and outbreak management programmes in various settings across the city. Discussions are now underway to ensure the appropriate funding streams are accessed to deliver programmes going forwards. However, there are a number of resource and capacity constraints which will need to be resolved in partnership with NHS Greater Manchester Integrated Care Board (NHS GM ICB).

10.2 A new Migrant Health Group will be established, co-ordinated by NHS GM ICB, that will meet for the first time in Autumn 2023 to oversee work that is best undertaken at Greater Manchester level as many areas of Greater Manchester are now experiencing similar challenges to Manchester.

11.0 BCG Vaccination Programme

11.1 The BCG (Bacillus Calmette-Guérin) immunisation programme was introduced in the UK in 1953 to protect against TB and has undergone several changes in response to changing trends in TB epidemiology.

11.2 The BCG vaccine is not given as part of the routine vaccination schedule but only when a child is at increased risk of coming into contact with TB. The BCG vaccine should only be given once in a lifetime.

11.3 Eligible babies include all new-born babies whose parent/s or grandparent/s was born in a country where the annual incidence of TB is 40 per 100,000 or greater or new-born babies living in areas of the UK where the annual incidence of TB is 40 per 100,000 or greater.

11.4 Traditionally, the BCG vaccine has been offered to babies soon after birth, often whilst the baby is still in hospital. Following an evaluation of the addition of screening for Severe Combined Immunodeficiency (SCID) to the routine new-born screening test at 5 days of age, the timing of the BCG vaccination offer has been moved to take place at around 14 to 17 days after birth. Current guidance states that eligible babies should be offered the BCG vaccine 28 days after birth (or soon after), although vaccination may be administered earlier than 28 days provided that a SCID screen outcome is available.

11.5 All local authorities in Greater Manchester run a selective vaccination programme. This type of programme covers all infants (aged 0 to 12 months)

with a parent or grandparent who was born in a country where the annual incidence of TB is 40 per 100,000 or greater. The Selective programme is run in areas that do not require a universal programme. No eligible population or coverage figures are reported for selective programmes.

11.6 In 2021-21, 2993 Manchester children had been vaccinated for BCG before their 1st birthday (see Table 5 below).

Table 4 - Children vaccinated for BCG by their 1st birthday by Local Authority, 2021-22

Local Authority	Number of children vaccinated
Bolton	1,272
Bury	501
Manchester	**2,993**
Oldham	1,242
Rochdale	850
Salford	681
Stockport	419
Tameside	498
Trafford	485
Wigan	195
Greater Manchester	9,136

Source: Childhood Vaccination Coverage Statistics, England, 2021-22. Copyright © 2022 NHS Digital.

11.7 In April to June 2022, Manchester had 70.7% BCG vaccine coverage of all eligible children at 3 months of age (see Table 6 below). This is a similar percentage to the Greater Manchester average (70%) but much less than the 83.7% achieved in Oldham, the area with the second highest TB rate in Greater Manchester.

Table 5 - BCG vaccine coverage at 3 months of age for eligible children in Greater Manchester local authorities: April to June 2022

Local Authority	Number of eligible children	Coverage (%)
Bolton	266	54.1
Bury	113	66.4
Manchester	**843**	**70.7**
Oldham	239	83.7
Rochdale	183	79.2
Salford	187	64.2
Stockport	94	61.7
Tameside	136	80.9

Trafford	82	58.5
Wigan	63	76.2
Greater Manchester	2,206	70.0

12.0 Managing active TB cases in community settings

12.1 Each case of active TB in a community setting can be very complex to respond to. There are many elements to consider to when considering an effective response. Addressing the risk to close contacts, recommending, planning and delivering screening sessions are vital in controlling spread of infection. Providing care for those identified as having latent TB, as a result of exposure, requires the expertise of many of Manchester's specialist teams working together.

12.2 Manchester City Council's Department of Public Health, Health Protection leads, and GM UK Health Security Agency Health Protection Team work closely with the TB Team at Manchester University NHS Foundation Trust (MFT) who provide clinical care and screening of identified contacts. There is increased demand on services once cases are identified via screening. The MFT TB team follow up with the case for the duration of their treatment, usually a six-month period.

12.3 The Manchester City Council (MCC) Health Protection lead role within the Department of Public Health is vital in ensuring the session runs safely and smoothly, including briefing councillors, the Director of Public Health, Adult Social Care, Education and other MCC leads with up-to-date situation reports.

12.4 Manchester City Council's Adult Social Care, Education, Communications Teams and others, along with care providers & school leaders, are integral to the IMT and respond to situations, providing reassurance to their responsible areas and wider community. Our Communications colleagues have been instrumental in the success of recent responses by developing bespoke easy read materials and translated products. This enables MCC to be consistent in messaging and aware of the specifics of the incident and actions to be taken.

13.0 Support for people with No Recourse to Public Funds

13.1 Housing is a key part of ensuring a person with TB is able to complete their treatment. If people have nowhere suitable to live, with good access to healthcare appointments, it can be difficult to comply with treatment. This puts them at increased risk of becoming very unwell, developing multidrug resistant TB and spreading it to others. Alongside accommodation it is important for TB recovery for patients to have sufficient income to ensure they are able to consume healthy, nutritious food.

13.2 For patients with no recourse to public funds who are homeless, there is no pathway to suitable temporary accommodation through existing accommodation services. Cases typically present at hospital and receive initial treatment as an inpatient and have nowhere to be discharged to.

13.3 National Institute for Health and Care Excellence Tuberculosis guideline recommends that local government and clinical commissioning groups should fund accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation, using health and public health resources, in line with the Care Act 2004.

13.4 As Clinical Commissioning Groups no longer exist, there is currently no identified funding for housing or subsistence under NHS GM Integrated Care Board arrangements and the financial cost is picked up by public health until this issue is resolved. This is in line with our approach to responding to public health risks outlined in the local outbreak management plan (see part one).

13.5 Whilst cases are small in number they are complex and require a multi-agency response to organise discharge, housing and subsistence payments as well as additional support such as primary care provision, language support and social care. Each response is different and is based on public health risk assessment and clinical and social needs. Treatment typically lasts for six months although it can be up to 12 months depending on clinical need. In Manchester our response is coordinated by public health working closely with UK Health Security Agency, MFT and the Council's No Recourse to Public Funds Team.

14.0 Summary and conclusions

14.1 There is strong collaborative working between key organisations and teams involved in TB prevention, detection, and control in Manchester. These strong working relationships have developed over time and from working through complex situations together.

14.2 The local systems are working as well as they can within the resource constraints set out above and Manchester is fortunate to have strong political support from the Executive Member for Healthy Manchester and Social Care. Through the Executive Member, the Public Health team have ensured that local members are briefed appropriately on any outbreaks that relate to their wards.

14.3 The Director of Public Health for Manchester and the Manchester Health Protection Team believe migrants should have screening for active TB before arrival in the UK. However, as this is not the case we are having to respond to cases as they arise and manage the public health risks appropriately.

14.4 We also believe that there should be equitable access locally and nationally to systematic and timely provision of inclusive and appropriately-funded TB screening. This should be accessible to all who are at high risk.

14.5 The newly established NHS GM Migrant Health Group provides the opportunity to review the provision for active and latent TB screening for new entrant migrants. The Group will consider how the appropriate funding and capacity is made available to enable appropriate screening, assessment and subsequent treatment.

15.0 Recommendations

15.1 The Board is asked:

1. To approve the Operational Local Health Economy Outbreak Management Plan for Manchester.
2. To be aware of the current issues around TB and recommend that the Director of Public Health a) escalates migrant health related issues to the newly established NHS GM Migrant Health Group; b) advocates through professional networks for more latent TB testing to be available for all residents with higher risk of TB, not just new entrants and not just adults.

OPERATIONAL LOCAL HEALTH ECONOMY OUTBREAK MANAGEMENT PLAN: MANCHESTER

OPERATIONAL LOCAL HEALTH ECONOMY OUTBREAK MANAGEMENT PLAN: MANCHESTER

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CHANGE HISTORY

Version	Date	Status	Notes
0.01	20-02-17	Initial draft	Following 1st Planning Group meeting
0.02	15-03-17		Following 2nd Planning Group meeting
0.03	05-04-17		Template shared and circulated following Health Protection Confederation discussion
1	15-01-17	1st Draft	Populated with Manchester information
2	31-10-19	2nd Draft	Addition of Manchester Document Control version page Minor changes to titles, addition of Consultant in Public Health Addition of response to single cases needing mass vaccination response EHO/UKHSA role in questionnaires and sampling Additions to contact list
3	23-09-21	3rd Draft	In response to the COVID-19 pandemic, clarification that COVID-related outbreak response and management plans will be captured elsewhere and will not be referred to in this document. Change of title: Community Infection Control Team (CICT) to Community Health Protection Team (CHPT)
4	07-09-23	4th Draft	Refresh of document recommended to all localities as part of Greater Manchester Health Protection Reform.
5	08-09-23	5th Draft	Signed off by Assistant Director of Public Health, Lead for Health Protection and Healthy Environments

FOREWORD

Maintaining and improving the health of our communities is at the heart of public service delivery. Health Protection, and ensuring an effective response to outbreaks of disease is a crucial part of this. Whilst the response to outbreaks isn't new and whilst our local health economy routinely demonstrates that it has effective arrangements in place it is important that we review our arrangements, and that the organisations and people who need to work together in partnership are aware of each other's roles and responsibilities for a range of scenarios.

It is priority for us to keep health equity and tackling health inequality at the heart of what we do through our outbreak response work, including our communications and approach to managing outbreaks in different communities and settings. We will build on learning from our Covid-19 response and follow the latest evidence and insights from our communities. We will work together with our communities, valuing the role of community leaders and neighbourhood working in our health protection system.

This plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective and coordinated approach to outbreaks of communicable disease. It is important for each organisation, having signed off this plan, to support staff to engage in appropriate testing to embed the multi-agency response to an outbreak and create familiarity over key tasks.

Many organisations have proven that they have a role to play in protecting the public from Covid-19 during the last three years. This document aims to identify roles and responsibilities of those across the system to enable the prompt and efficient management of outbreak in a locality. These include the NHS, Environmental Health, Public Health Department and the UK Health Security Agency (UKHSA).

This plan has been completed and agreed by a system wide multi-agency group for use in Manchester. The Plan has been noted and approved by the Health Protection Board

This collaborative approach has enabled local decision makers to manage the challenges presented to the wider system and community members in working together to outbreak manage all infectious diseases and consequences. This partnership approach, together with a robust incident management methodology, has enabled key partners to respond to the significant challenges presented in Manchester during the height of the Covid-19 period, and other infectious diseases during the last 3 years, and the learning of these experiences are incorporated into this outbreak management plan.

David Regan

Director of Public Health, Manchester City Council

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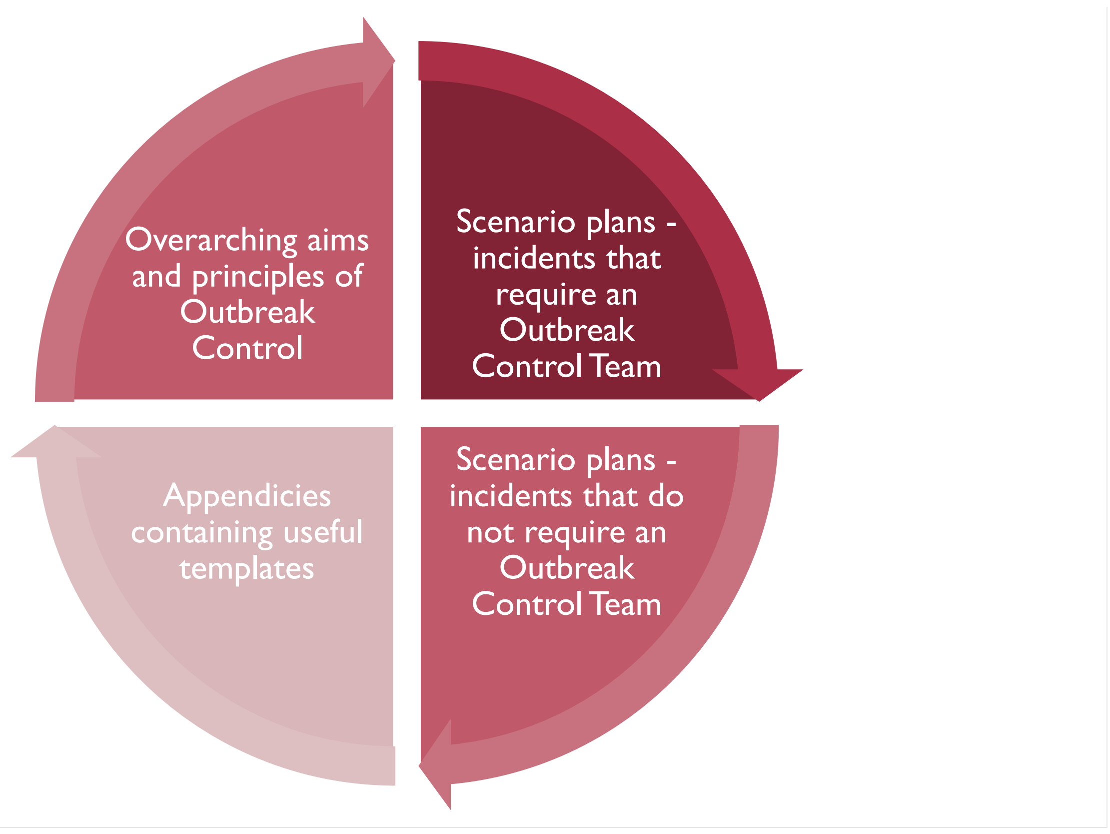
PART 1: AIMS, OBJECTIVES & SCOPE OF THE PLAN

AIM OF THE PLAN

This plan sets out the multi-agency operational arrangements for responding to outbreaks of human infectious diseases within Manchester. This also includes a preventative response to identified single cases of disease, where transmission to others within that population/community could lead to an outbreak or further cases of transmissible infection impacting adversely on the wider public health of that community or population.

This document has been developed to supplement the "Greater Manchester Multi-Agency Outbreak Plan" at a Manchester level and contributes to this statutory responsibility, ensuring the right people are contacted at the right time to ensure that the locality is resilient and can respond appropriately to outbreaks. It focuses on the most likely outbreak scenarios and provides the contact details should an outbreak control team need to be called, and an immediate response made by health and social care partners across the locality.

The structure of the plan is as follows:

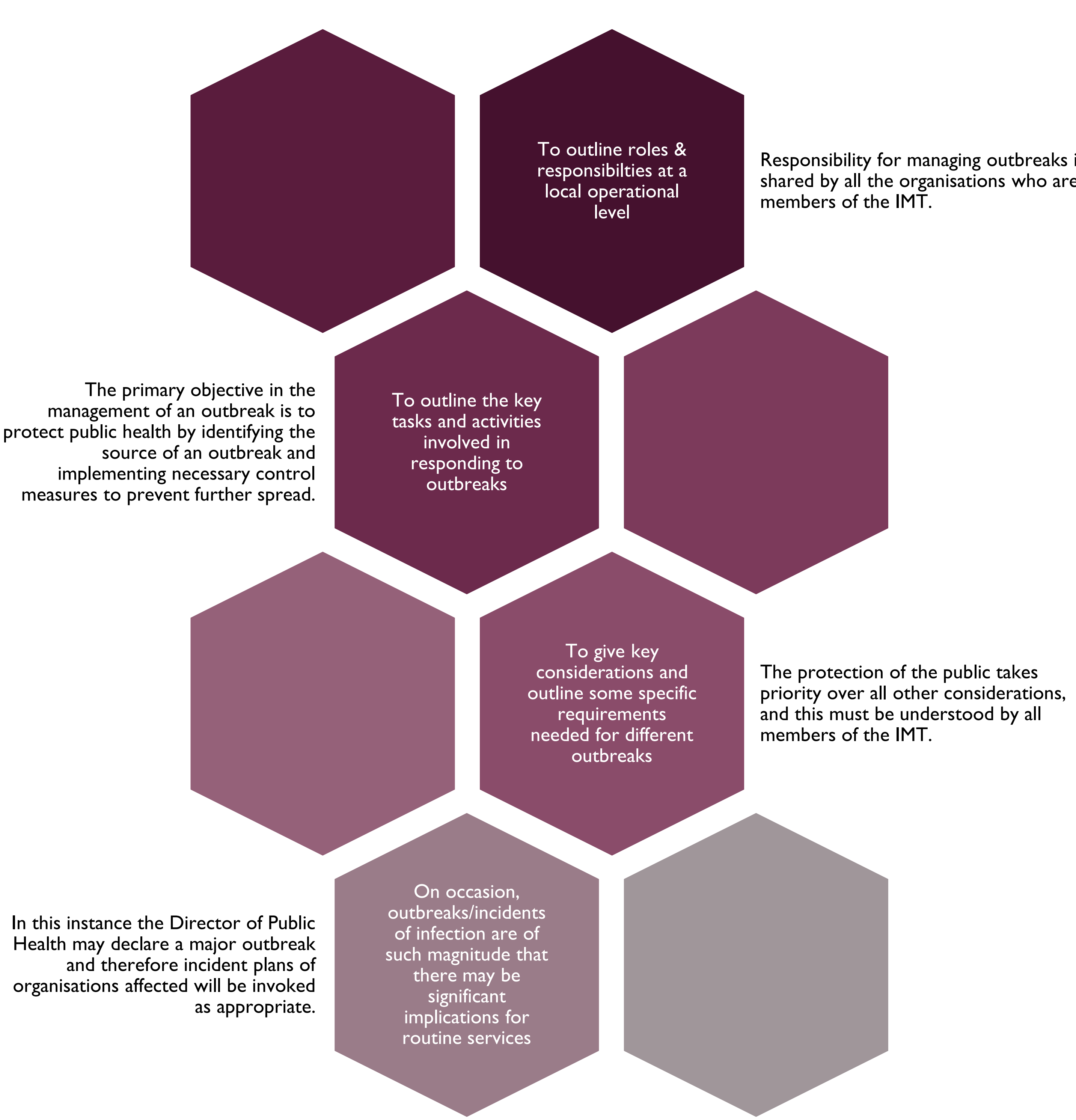


UKHSA, the National Association of Directors of Public Health and the Local Government Association have identified four principles for the design and operation of local Outbreak Control Plans. These can be seen as standards for local systems to test the impact and effectiveness of their arrangements. The prevention and management of the transmission of disease should:

1. Be rooted in public health systems and leadership
2. Adopt a whole system approach
3. Be delivered through an efficient and locally effective and responsive system including being informed by timely access to data and intelligence
4. Be sufficiently resourced.

Further information can be found here: What-Good-Looks-Like-for-High-Quality-Local-Health-Protection-Systems.pdf (adph.org.uk)

OBJECTIVES OF THE PLAN



KEY CONCEPTS

NOTIFIABLE DISEASES

The UK Health Security Agency (UKHSA, formerly Public Health England) aims to detect possible outbreaks of disease and epidemics as rapidly as possible. Accuracy of diagnosis is secondary, and since 1968 clinical suspicion of a notifiable infection is all that is required.

'Notification of infectious diseases; is the term used to refer to the statutory duties for reporting notifiable diseases in the Public Health (Control of Disease) Act 1984 (legislation.gov.uk) and The Health Protection (Notification) Regulations 2010 (legislation.gov.uk).

Registered medical practitioners have a statutory duty to notify of suspected cases of certain infectious diseases. They can do this by completing a notification form immediately on diagnosis of a suspected notifiable disease.

Consult the Notifiable Diseases poster for further information.

DEFINING AN OUTBREAK

An outbreak or incident may be defined as:

- An incident in which two of more people experiencing a similar illness are linked in time or place
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- A single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio
- A suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

Is it recognised that some cases and clusters of disease are handled within routine business of the Local Health Protection Team/CHPT without the need to formally convene an Outbreak Control Team or an Incident Management Team meeting.

OUTBREAK CONTROL TEAM OR INCIDENT MANAGEMENT TEAM MEETING

An OCT or IMT may be convened locally or by UKHSA and this a formal meeting of all partners to address the control, investigation and management of an incident, or a discussion between two or more stakeholders following the identification of a case or exposure of concern. As such all discussions should be appropriately recorded.

Responsibility for managing outbreaks is shared by all organisations who are members of the OCT or IMT.

It should be noted that the terms Incident Management Team and Outbreak Control Team are often used synonymously, however both have very similar aims, membership and procedures.

A suggested agenda, protocol and key roles and responsibilities are described in Appendices C and D Roles and Responsibilities of usual members of an OCT/IMT

CROSS BOUNDARY INCIDENTS

If the situation includes a neighbouring Local Authority (LA), close liaison is vital, with neighbouring LAs and a decision made as to who will lead the investigation. This decision needs to be made as soon as possible. The lead

area will most likely be where the outbreak is first identified, or where the majority of cases reside. Where incidents cross LA boundaries, respective Health Protection teams will need to establish and maintain effective communication with the neighbouring authority.

Some incidents response lead is based on GP location. If the resident lives in another area but has a Manchester GP then Manchester will be the lead locality.

There are some businesses for which Manchester City Council is the Primary Authority. This enables the main regulatory Teams (importantly for this Plan, our Environmental Health Team) to improve compliance and build better relationships with businesses whilst supporting local economic growth. Under Primary Authority, we as the Local Authority partner with a business or National group to provide them with regulatory advice that other authorities must take into consideration during interventions. The service aim of our Environmental Health Team is to ensure the Council fulfils its statutory duties through this partnership work with businesses providing reliable advice in the transparent way.

LIFE CYCLE OF AN OUTBREAK: A SUMMARY

Declaration of an Outbreak

In the case of complex or unusual infections/situations an outbreak will be declared and led by UKHSA. An IMT will be convened by UKHSA and attended by key staff across the health economy.

Community Health Protection Team (CHPT) may be contacted by a variety of settings to report an outbreak, typically these include: UKHSA, nursing/care home staff, schools/nurseries, IPC Team from an NHS Trust, Microbiology/virology or Environmental Health officers.

It is usual that locally confined smaller outbreaks will be recognised and declared by CHPT, with the response being led locally.

Following the recognition and declaration of an outbreak, if needed, ULHSA will make a decision regarding the need and urgency to convene an IMT. This decision should be guided by risk assessment.

The DPH will lead the local response to an outbreak within Manchester. This may be delegated to the Consultant in Public Health (Health Protection) or other appropriate member of CHPT.

When a decision has been made not to declare an outbreak or establish an IMT, the DPH/Consultant should be informed at appropriate iintervals to determine if the formal declaration of an outbreak is subsequently required.

A suggested list of IMT members can be found in Annex 6 and embedded within scenario plans. This is not an exhaustive list and depending on the nature of the outbreak representation from additional organisations may be required.

Control measures should be documented with clear timescales for implementation and responsibility.

A case definition should be agreed and reviewed as required during the investigation.

Basic descriptive epidemiology is essential and should be reviewed at the IMT.

Legal powers relating to the investigation of food posoning outbreaks are vested in Local Authorities. If, during the investigation, it is determined that the outbreak is related to food rhen the management of this would be handed over to the Environmental Health Team and UKHSA.

Communications

The communications response will depend on the nature of the incident/outbreak and the outcome of IMT discussions if an IMT is convened.

For smaller contained outbreaks, CHPT will distribute a Community Oubtreak Summary at agreed times to partner organisations.

Larger outbreaks with an IMT: it is expected that the IMT will idenfity and nominate which agency will lead the media response at the outset of the outbreak.

The MCC Communications Team will work closely with UKHSA to produce communications/information for the public. Social media will be used in accordance with existing MCC policies.

End of the Outbreak

CHPT will decide when outbreaks of a smaller, contained nature are over. The CHPT will make a statement to this effect via the Outbreak Summary email. IT will be based on an ongoing risk assessment and considered when:

- There is no longer a risk to public health that requires further investigation or mangement of control measures.
- The number of cases has declined.
- The probable source has been identified and is no longer a risk/infectious.

Any lessons learnt and recommendations will be discussed at the debrief. If relevant information will be disseminated and refinements to practice considered for implementation where appropriate.

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Appendix 1, Item 5

COMMAND & CONTROL

In the event of UK Health Security Agency (UKHSA) calling an Outbreak Control Team (OCT) or Incident Management Team (IMT) meeting, Manchester's DPH/Assistant and members of the Community Health Protection Team (CHPT) will participate in that group along with any key responders such as Medicines Optimisation, Environmental Health, key Commissioners and the Local Care Organisation's School Health Service.

It is likely that an IMT will be supplemented by a Local Coordination Team (LCT), established by CHPT; the purpose of this group is to coordinate necessary actions and feedback to the IMT.

COMPLIMENTARY GUIDANCE AND DOCUMENTATION

GUIDANCE AT NATIONAL LEVEL

Communicable disease outbreak management: operational guidance

Influenza-like illness (IL): managing outbreaks in care homes

Health protection in children and young people settings, including education

Health and Social Care Act 2008: code of practice on the prevention and control of infections

UKHSA A-Z of infectious diseases

UKHSA Inactivated influenza vaccine: PGD

GUIDANCE AT GREATER MANCHESTER LEVEL

GM Multi-Agency Outbreak Plan: this includes descriptions of the role of the DPH, CHPT, GM IC Manchester, Environmental Health Officer, NHS Trust and UKHSA Consultant/nurse in outbreak situations

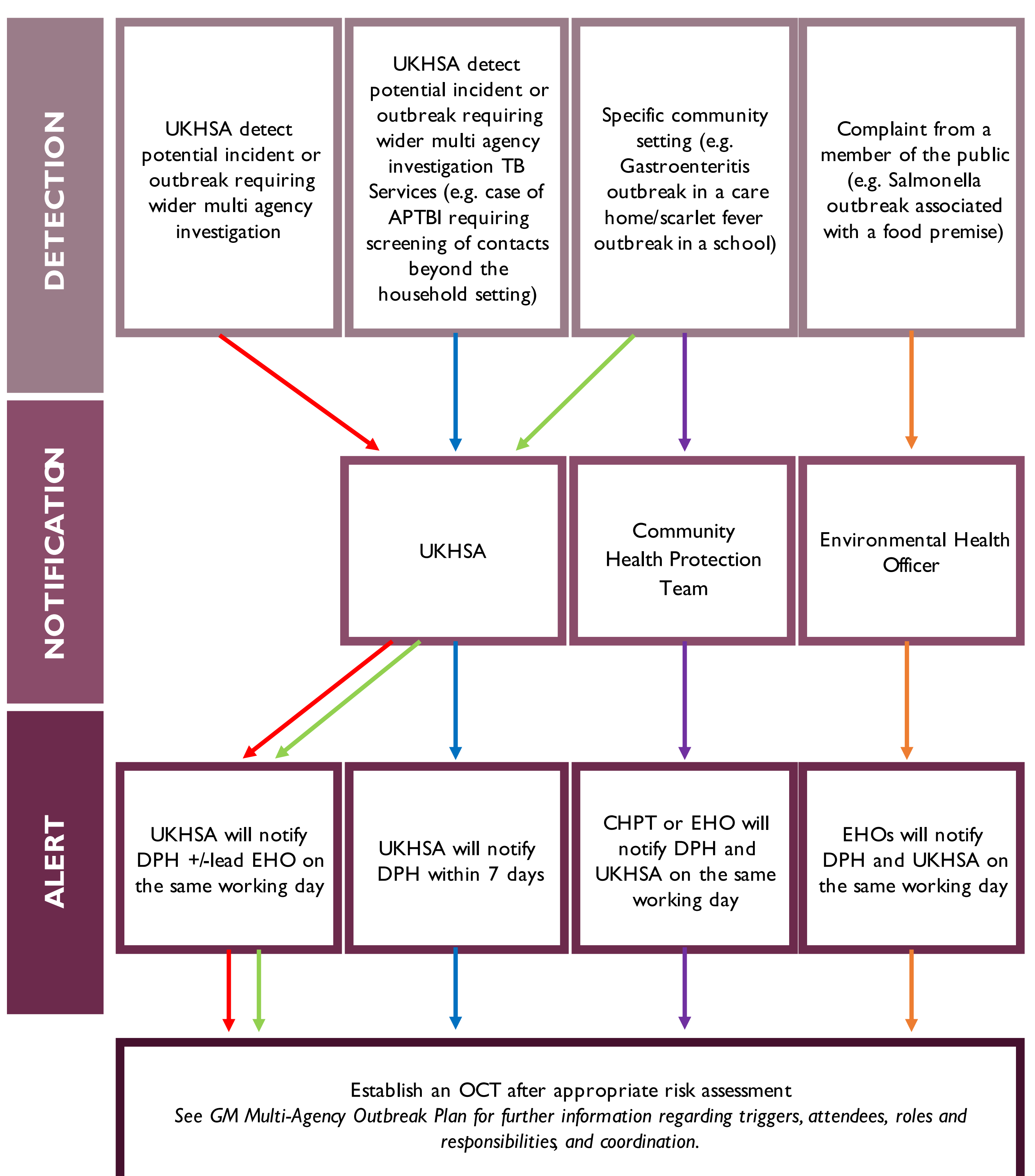
PART 2: KEY ASPECTS OF INCIDENT MANAGEMENT

This section of the Plan will describe the following in turn:

- Detection of a potential incident, notification, and alert to relevant authorities.
- Investigation, including roles and responsibilities
- Control measures available
- Communications
- Funding arrangements

DETECTION AND COORDINATION

INCIDENTs of disease are usually detected and alerted in the following ways:



INVESTIGATION ROLES & RESPONSIBILITIES

Prior to an IMT being set up, UKHSA will liaise directly with relevant partners to recommend and coordinate investigations. Once an IMT is set up, the IMT will agree on coordination of investigations.

The types of investigation involved usually include:

- Epidemiological investigation: establishing links between cases/sources based on questioning of cases/NOK and information on settings.
- Microbiological investigations: where a sample is taken and sent for analysis to a laboratory. There are 2 types:
    - Clinical sampling: from human tissue (blood, respiratory secretions, salivary, faeces etc)
    - Environmental sampling: e.g. water, work surfaces etc

N.B. Any setting where staff affected have access to Occupational Health, the investigation will be delivered through them.

RESPONSE ACTIVITY		POTENTIAL RESPONDER(S) *In hours (9 – 5)*	*Out of hours*	CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
Questionnaires/ Interviews/ Consent		UKHSA 0344 2250562 option 3	UKHSA 0151 434 4819	
		Hospital IPC team	Hospital IPC team	For Acute Trust incidents: MFT Oxford Rd 0161 276 4042 Wythenshawe site 0161 291 2632 NMGH 0161 720 2935
		UKHSA (MCC EHO – Legionella only) Tel: 0161 234 5004 (internal: 34853)	UKHSA	UKHSA undertake the patient questionnaires and sampling for MCC (except in the case of Legionnaires Disease, where MCC officers do undertake the questionnaire).
		LCO Children's Services –School Imms team	UKHSA	Consent to immunisation forms: Schools/Children: Contact: LCO School Immunisation Leads Contact details in contact list.
Sampling	Respiratory samples (e.g. swabbing)	NHS Provider/Nursing Home Staff/GP/School Imms Team Primary care provider	UKHSA/Primary Care Provider	Clinical sampling will be undertaken by Care staff in care setting. Uni/over 18: To be decided at IMT Nursery/Under 5 years – To be decided at IMT Those not registered with GP e.g Homeless/Rough sleepers Option 1: GP option 2: PRIMARY CARE PROVIDER (dependant on INCIDENT) Flu: Flu Swab Kits arrangements yet to be agreed/confirmed and circulated by UKHSA for 2023/24 season. Proposed arrangements likely to require CHPT to undertake ARI risk assessment with home, obtaining Ilog & arranging swabs to be couriered to and from the care setting via the lab. Results via elab to CHP T Further stocks of swabs can be accessed via UKHSA lab. Out of hours ;

			Arrangements also to be confirmed by UKHSA. Other out of hours work will be via NHS GM IC Director on call and meds optimisation response
Faecal (GI Incident)	UKHSA/GP /EHO	UKHSA/ EHO emergency out of hours: 07887916848	UKHSA undertake the patient sampling for MCC for environmental health related incidents UKHSA may notify EHO and CHPT of incident, Samples posted back to UKHSA labs If more than 2 cases unconnected – to see GP GP may be asked to obtain samples depending on organism. E.g. Clostridium difficile
Faecal (GI incident in a care home)	Care /Care Home Staff/ GP	Care home staff/OOH	Initial sampling taken by care home on GP instructions or with advice from CHPT. CHPT coordinate incident response and advise the home. CHPT may contact UKHSA or EHO for advice. Care home staff take samples.
Oral fluid (e.g. Hep A incident)	GP/NHS Provider/LCO/primary care provider	N/A	Risk assessment and contact tracing undertaken by UKHSA Self-administered arranged by UKHSA. If wider community incident : e.g. School/nursery : option 1: School nursing team option 2: PC provider Care Home: Care home nurses/NH team/GP University: PC provider Commercial Premises: UKHSA/CHPT may support staff self sampling GP- for Rough sleepers (Urban Village/The Vallance)
Urine test	UKHSA/GP/Care Home	N/A	If legionella: Care Home – Care Home Staff on request by UKHSA. Primary care: GP
Environmental (e.g. food / water)	Environmental Health Officers / HSE	UKHSA	e.g. Legionella/cryptosporidium Where EH are the enforcing authority then EHO to undertake sampling For certain premises or complex sampling e.g legionella linked to cooling towers EHO to discuss with HSE /and or use Bureau Veritas. 0161 446 4600
Blood test	NHS provider/GP	N/A	e.g Phlebotomy services for adults and children
TB skin test	TB nurses	N/A	e.g Mantoux/IGRA testing : 0161 276 1234 extension 64387.
Scabies (clinical assessment)	GP/Dermatologist	N/A	Most cases treated based on clinical assessment by GP or referral to dermatologist without testing. Advice from CHPT for single cases and incidents. Follow NICE Scabies Guidance

Mass blood tests (e.g. IGRA testing) for TB	TB Nurses MFT	N/A	0161 276 1234 extension 64387. TB service lead nurse. PC provider
Mass X-Ray (incl. mobile x-ray)	NHSE/UKHSA/TB nurses	N/A	When/if required coordinated by MFT TB team as above
Sexually Transmitted Infections	NHS Trust Sexual Health Clinic/GP	N/A	The Northern Sexual Health Services would provide screening/immunisation as required. Sexual Health Commissioning manager- to response & communicate with partner services.
Transport to lab	Local lab transport system	EHO via UKHSA system	GP routine samples in-hours. EHO would liaise with Manchester Public Health Lab for posting of samples.
	UKHSA Postal	N/A	e.g measles on individual cases, Flu packs, UKHSA packs have paid return envelope.
	Hand deliver		Care home flu swab samples Flu swabs – via UKHSA MRI lab process courier

CONTROL MEASURES

Prior to the first IMT meeting, UKHSA will liaise directly with relevant partners to recommend and coordinate initial control measures. Once an IMT meets, they will agree on coordination of control measures.

Control measures usually include:

- Identifying and controlling on-going sources. e.g. A cooling tower suspected of aerosolising Legionella, or a food premise with unsafe food preparation practice
- Preventing/limiting onwards spread
- Reducing likelihood of severe illness in specific vulnerable groups: usually by prompt post-exposure prophylaxis (PEP)

Where compliance with recommendations around control measures is an issue, enforcement powers may be used. For the purposes of incidents, enforcement powers lie with MCC. Further info can be found here: Chartered Institute of Environmental Health Toolkit / DoH guidance on Health Protection regulations

The key partners involved depend on which control measures are recommended, but are most commonly:

- EHOs: IPC advice for cases/contacts of GI illness + enforcement powers
- CHPTs: IPC advice and monitoring for community settings
- GPs: prescribing of treatments and PEP
- School nurses: delivery of PEP in a school setting
- NHS community providers: delivery of PEP in community settings (excluding schools) e.g. traveller sites
-

RESPONSE ACTIVITY	POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
	In hours (9 – 5)	*Out of hours*	
Advice on infection, prevention & control measures	Community Health Protection Team communityhealthprotectionteam@manchester.gov.uk EHO Tel: 0161 234 5004 (internal: 34853) UKHSA 0345 225 0562 opt 3	UKHSA 0151 434 4819 EHO	9am-5pm The CHPT have a central email address communityhealthprotectionteam@manchester.gov.uk UKHSA also provide some infection control information and advice if related to a specific notifiable disease not routinely dealt with by CHPT or if unusual situation EHO for commercial food premises/preparation
Exclusion advice	CHPT /UKHSA	UKHSA	Using national UKHSA guidelines and advice. Would depend on the incident
Enforcement of control measures	Local Authority(Proper officer) with UKHSA support	Local Authority with UKHSA support	Proper Office EH for Part 2a Order (EHO team)
Treatment and Prophylaxis (including immunoglobulin, vaccines, antivirals, antibiotics and anti-toxins)	Trust Pharmacy – order vaccines for use by MFT staff NHS IC Manchester Medicines Optimisation – order vaccines/coordinate delivery. Identify local of antiviral stock pile in key pharmacies. Antivirals for ARI available from general community pharmacies on prescription May use Immform or order direct from manufacturer for non- immunisation programme vaccines	UKHSA to order vaccines in specific cases Trust pharmacy/NHS IC Manchester meds op Out of hours arrangements also to be confirmed by UKHSA. Other out of hours work will be via NHS IC Manchester Director on call and meds optimisation response use of LCS /PC provider etc for antivirals – assessment	There may be vaccine manufacturing shortages or ordering issues, ordering at short notice in some unusual outbreaks. – UKHSA to advise/support if vaccination recommended by them

	UKHSA may order direct in some circumstances/use own stocks- antivirals/vaccines at UKHSA discretion PGDs to be available from Trust for imms team GM SIT to advise primary care with use of PSD	of patients/contacts and prescribing.

COMMUNICATIONS – ROLES AND RESPONSIBILITIES

RESPONSE ACTIVITY		POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
		In hours (9 – 5)	*Out of hours*	
To public	Setting specific advice letters (eg businesses, care homes)	IMT: NHS IC Manchester/EHO/UKHSA	UKHSA	Dependent on topic and setting. Template letter provided by UKHSA for Infectious Diseases Template letter provided by UKHSA/EHO for food related or Environmental
	Update NHS 111	UKHSA	UKHSA	UKHSA/MCC Comms Team
	Helpline	Contact centre	Contact centre	Script and algorithm provided by UKHSA for any MCC comms via the Contact Centre. This would need to be pre-agreed.
	Websites / social media	UKHSA/MCC/NHS IC Manchester	MCC//NHS IC Manchester	Comms Lead for UKHSA//NHS IC Manchester /MCC
	Door to door	MCC /NHS IC Manchester /UKHSA	MCC//NHS IC Manchester /UKHSA	Need would have to be clearly identified and resourced.
To health partners	Briefings / sitreps from IMT	UKHSA /NHS IC Manchester Comms & PC Commissioner	UKHSA /NHS IC Manchester – Comms & PC Commissioner	see list of contacts for community cases in appendix
	Other relevant groups	Responsibility of each agency	Responsibility of each agency	
To the media		Coordinated by UKHSA//NHS IC Manchester /MCC via IMT	UKHSA//NHS IC Manchester /MCC via IMT	Include all partner agencies in discussion of key comms messages
To Elected Members / Committees e.g. Health and Wellbeing Boards		DPH	DPH NHS IC Manchester on call director	David Regan Director of Public Health
		NHS IC Manchester /MCC	NHS IC Manchester /MCC	NHS IC Manchester Comms lead 0161 765 4004 communicationsmanchester@nhs.net Senior Communications Manager 07976883111

MCC Comms 0161 234 3166
communications@manchester.gov.uk

FUNDING ARRANGEMENTS

Guiding principles:

- Protection of human health takes priority over funding challenges/financial discussions
- Where a local arrangement is in place re delivery of a certain aspect of the response (e.g. delivering an immunisation session in a school setting): partners must actively:
    - Involve key decision makers form the relevant agency to formally approve the agreement (i.e. do not assume that the organisation will do it)
    - Consider whether activity should be absorbed in existing contracts or whether additional funding is required and if so, which commissioner will sort this.
- Key commissioners in Manchester health economy include:
    - NHS IC Manchester which commissions: Primary care and acute and community/social care providers
    - LA PH, which commission public health services (school nurses and HVs) –
    - GM Health and Social Care Partnership (GMHSCPICS), Dentists and GPs which are jointly commission with NHS IC Manchester
    - Specialist Commissioning commissioned by NHS IC Manchester
    - LA Environmental Health

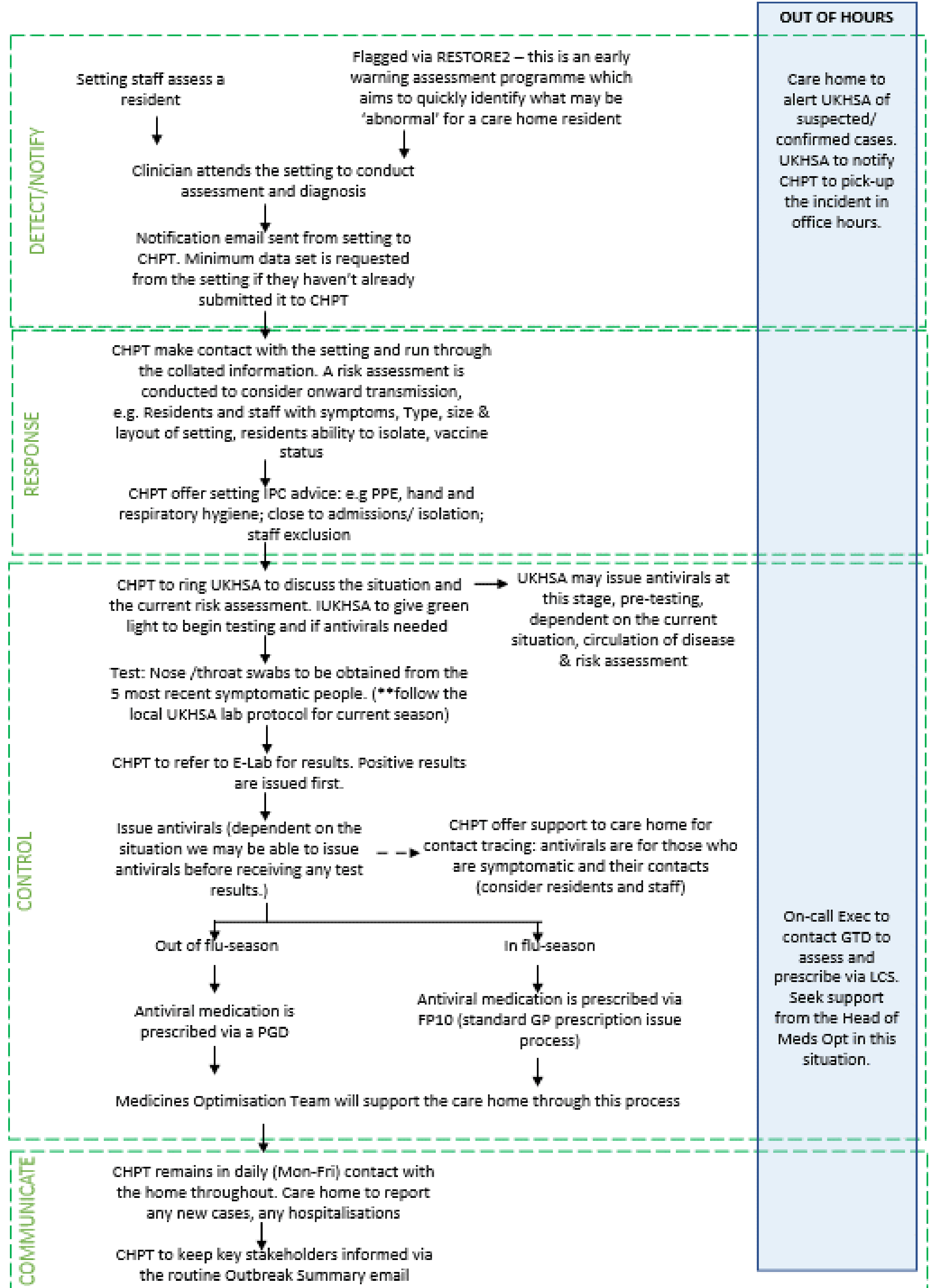
N.B. NHS IC Manchester Medicines Optimisation: A Locally Commissioned Service Specification is agreed for use with GPs including OOH in case of outbreak responses for antiviral treatment/prophylaxis and vaccination

RESPONSE ACTIVITY	POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
	In hours (9-5)	*Out of hours*	
Vaccination session arrangement and provision by MLCO Schools Immunisation Team	Response by NHS Trust	N/A	Response to outbreak to be undertaken. Funding agreed after event.
Obtaining vaccines from Immform or other sources	NHS Trust NHS IC Manchester meds Opt		Response to outbreak to be undertaken. Funding agreed after event.
Vaccination and prophylaxis activity	GPs/PC provider	GPs/PC provider	LCS used for payment
Legionella Testing **D+V sampling (specific outbreaks/cases)**	EHO		Specific situations identified by UKHSA/EHO
Immunisation/Prophylaxis for under 5 years and over 18 years/Uni	PC provider/GPs		Use of LCS

PART 3: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS REQUIRING AN IMT

- Arrangements for an outbreak of acute respiratory illness (ARI) in a care home
- Arrangements for responding to Tuberculosis in a university setting
- Arrangements for responding to Meningococcal disease in a university setting
- Arrangements for responding to Hepatitis A in a school or childcare setting
- Arrangements for responding to Diphtheria in an asylum seeker setting
- Arrangements for responding to MPox
- Arrangements for responding to Measles in a school setting

ARRANGEMENTS FOR AN OUTBREAK OF ACUTE RESPIRATORY ILLNESS IN A CARE HOME



Key reference documents

Seasonal influenza: guidance, data and analysis - GOV.UK (www.gov.uk)

Respiratory viruses - GOV.UK (www.gov.uk)

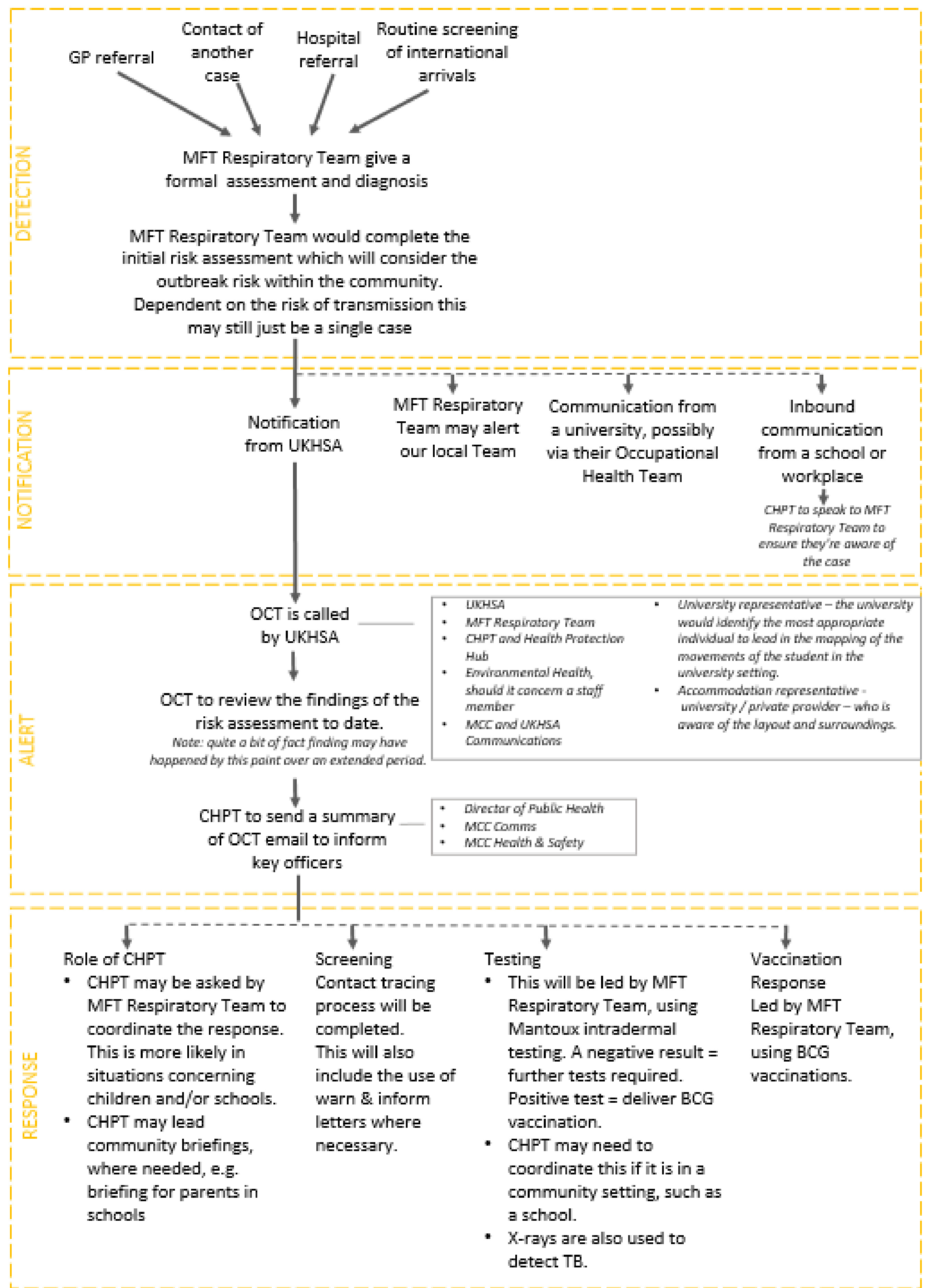
Influenza-like illness (ILI): managing outbreaks in care homes - GOV.UK (www.gov.uk)

Guidance on outbreaks of influenza in care homes poster - GOV.UK (www.gov.uk)

Influenza post exposure prophylaxis and treatment: PGD templates - GOV.UK (www.gov.uk)

Investigation and management of outbreaks of suspected acute viral respiratory infection in schools: guidance for health protection teams - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO TUBERCULOSIS IN A UNIVERSITY SETTING



Signs and Symptoms

- Infection: may be asymptomatic, cause primary progressive systemic illness, or reactive months to years later.
- Active disease: fever, night sweats, poor appetite, and weight loss
  - Pulmonary TB: prolonged cough, sputum, chest pains, shortness of breath. May present as acute pneumonia, especially in immunocompromised patients.
  - Other symptoms of TB depend on the affected body part (e.g. bone, brain, gastrointestinal system, urinary system, lymph nodes etc)

Incubation Period and Infectivity

- The incubation period is usually 3-8 weeks; the latent period (time to development of disease) may be many decades, but is accelerated in immunosuppressed (e.g. HIV infection)
- The infectious period is for as long as viable organisms persist in the sputum. Most cases of TB are non-infectious after two weeks of treatment.

Mode of transmission

- Respiratory droplet transmission requires prolonged, close contact with sputum-smear positive cases.

Confirmation (diagnosis)

- Clinical
  - Symptoms, and indicative Chest X-ray but need to be confirmed by laboratory tests.
- Laboratory
  - Microscopy of stained sputum samples indicates presence of mycobacterial organisms.
  - Culture and drug sensitivity testing
  - Rapid molecular testing is becoming increasingly available.

Differences in response from other settings

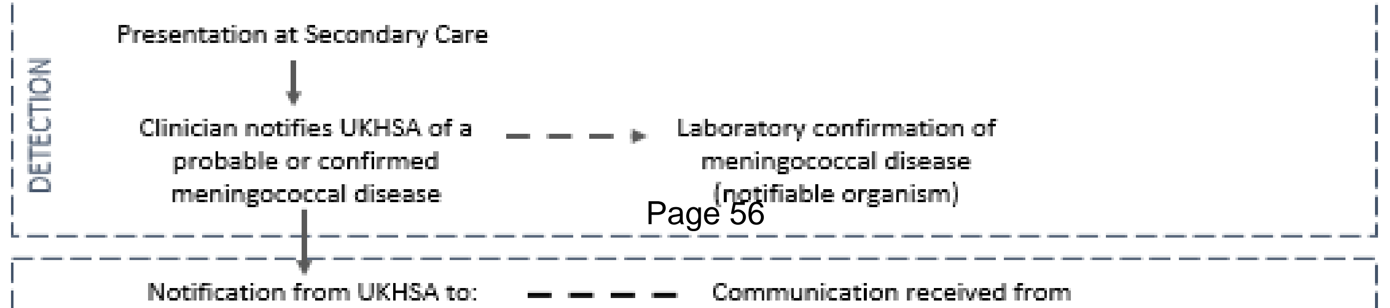
- The MFT Respiratory Team will lead on the majority of TB case response. There is often no community link which causes concern. For this reason, we may not be made aware of cases at all.
- CHPT are more likely to be asked to lead the outbreak response to an outbreak in a setting in the community concerning vulnerable/complex cohorts. For example, the testing response to an outbreak in a school may require a mobile testing unit. This is different to outbreaks concerning adult, who can be asked to attend clinic at MFT.
- Environmental Health will be involved in outbreaks which concern workplace settings. UKHSA will notify CHPT, who will then reach out to Environmental Health for involvement in the Outbreak Control Team meetings as appropriate.
- Unlike many other infectious diseases, the response to cases of Tuberculosis may be extended over a period of time.

Key reference documents

- Tuberculosis (TB): diagnosis, screening, management and data - GOV.UK (www.gov.uk)
- Tuberculosis: the green book, chapter 32 - GOV.UK (www.gov.uk)
- Tackling tuberculosis in under-served populations - GOV.UK (www.gov.uk)
- Managing tuberculosis (TB) in prisons - GOV.UK (www.gov.uk)

- Tuberculosis (TB) and asylum seekers - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO MENINGOCOCCAL DISEASE IN A UNIVERSITY SETTING



Signs and Symptoms

- Symptoms: meningism, nausea & vomiting, rash
- Signs: petechial non-blanching rash and/or Kernig's sign

Incubation period and infectivity

- Incubation period is 2-5 days.
- Infectivity: while organism is present in nasopharynx.

Mode of transmission

- Invasive disease caused by Gram-negative bacterium (meningococcus) spreads through exchange of respiratory and throat secretions.

Confirmation (diagnosis)

- Clinical
    - Possible case: other diagnosis at least as likely
    - Probable: most likely diagnosis
    - Confirmed: by laboratory tests.
- Laboratory
    - Blood: culture, PCR
    - Nasopharyngeal swab (normally through mouth): bacterial culture

Action

- Early detection: Treatment; Isolation and Infection Control
    - Arrange urgent admission if petechial non-planching rash and/or Kernig's sign
    - Immediate parenteral antibiotics; do not delay transfer to complete
- Prophylaxis (Vaccination/immunoglobulin/antibiotics/antivirals)
    - Chemoprophylaxis: Ciprofloxacin is antibiotic of choice.
    - Identify close contacts; arrange chemoprophylaxis as soon as possible (ideally within 24 hours); can be given up to 4 weeks after onset if reporting delayed.
    - Consider, arrange appropriate meningococcal vaccinations for cases and contacts.

Key reference documents

- Meningococcal disease: guidance, data and analysis - GOV.UK (www.gov.uk)
- Meningitis and septicaemia: prevention and management in higher education institutions - GOV.UK (www.gov.uk)
- Meningococcal disease and ciprofloxacin: PGD template - GOV.UK (www.gov.uk)
- Meningococcal disease: guidance on public health management - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO HEPATITIS A IN A SCHOOL OR CHILDCARE SETTING

Scenario to consider

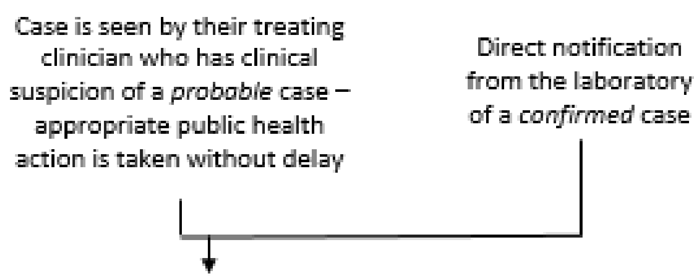
You are contacted by UKHSA to advise that a 4yo child attending the nursery at a local Primary School has been confirmed as a case of acute hepatitis A following recent travel abroad. The child attended the setting during their infectious period.

UKHSA would like to convene an urgent Outbreak Control Team (OCT) or Incident Management Team (IMT) meeting to confirm the facts and assess the degree of exposure at the school in order to consider whether hep A vaccination needs to be offered in the school as post-exposure prophylaxis

Stage 0: Local notification

Case is seen by their treating clinician who has clinical suspicion of a *probable* case – appropriate public health action is taken without delay

Direct notification from the laboratory of a *confirmed* case



UKHSA Duty Team are notified and take as much detail as possible, using the set questionnaire which considers:

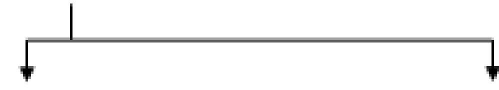
- Awareness of the source of the infection
- Recent travel history
- Details of household contacts
- Any contacts within the community setting

Consideration given at this early stage if the case has attended an educational setting.

Via email, UKHSA alert:

- Director of Public Health
- Consultant in Health Protection
- Lead Nurse in Health Protection

Likely telephone conversation between UKHSA & Lead Nurse Health Protection at this stage to share the details gathered so far.



Lead Nurse in Health Protection to send a brief email summary to key officers as an early alert for the case:

- Council Health & Safety team
- Press Office
- Director of Education
- Cc. Director of Public Health

Lead Nurse to also alert the Community Health Protection Team of the case

Possible request at this stage from the DPH & DOE to inform key members. Lead Nurse would prepare this.

Stage 1: steps to take pre-Incident Management Team meeting

If the Community Health Protection Team and UKHSA share similar concerns regarding the setting:

The Community Health Protection Team may conduct a visit to gather further information, inc. discussing IPC policies & procedures and assessing the set-up/ environment.

On some occasions, UKHSA may have already gathered key information to feed into the incident risk assessment, such as class sizes, ages, school routines and layout. Sometimes this may be done at this stage by CHPT upon request from UKHSA

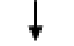
The Community Health Protection Team will ensure the setting are aware of their role and the support they can offer, in addition to offering reassurance and answering any questions

The Education Business Partner will work with the setting's Quality Assurance Officer (SSQA) to support the headteacher and wider setting. This is particularly important from an employment perspective, should staff be identified as contacts, for example.

Stage 2: Convening an Incident Management Team (IMT)

UKHSA will take leadership in convening an IMT, and decide who will be the Chair (Typically UKHSA).

UKHSA may reach out to the Lead Nurse in Health Protection to agree the membership list, and to establish who is expected to bring particular pieces of information (which may need to be outlined when partners are first invited to the IMT)



Proposed membership list for IMT:

- UKHSA
- Community Health Protection Team
- Education Business Partner/SSQA
- UKHSA/MCC Comms
- Medicines Optimisation Team
- Rep from the setting
- Rep from the laboratory
- Medicines Optimisation Team
- Provider commissioned to deliver the response, OR Primary Care if it still needs commissioning
- Child Health Information Service (CHIS)
- If an outbreak – UKHSA Field Epi Service
- If an outbreak - UKHSA national swabbing team

Unlikely we would send out any details to the IMT pre-meeting for this scenario due to it being a single case.

Stage 3: Conducting an Incident Management Team (IMT) meeting

Important to ensure members of the IMT understand their role and responsibility in attending, e.g.:

Education Business Partner/ SSQA	Considerations for employment – potential need for communications to involve Unions if staff are involved. Also providing support if staff cover and capacity are a concern as a consequence of the incident.
Specialist Vaccinations & Immunisations Nurse	Would attend with knowledge of the Green Book, and an overview of the potential vaccination response

IMT to explore & agree on control measures required to respond to the case (continued below)

Post-IMT, if any members were not able to attend they will be contacted and any tasks allocated explained.

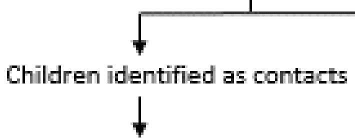
Lead Nurse Health Protection to prepare a summary email outlining the key decisions that have been made

- Council Health & Safety team
- Press Office
- Director of Education
- Director of Public Health

UKHSA to share minutes of the meeting with all IMT members.

Stage 4: Implementing the agreed response

IMT agrees who is offered post-exposure prophylaxis. The general principle is to keep the response small if you are able to. Pragmatically in this scenario it would be the group sharing the same room(s).



Children identified as contacts

Ideally this response is delivered on site. CHIS would support the IMT to establish a line list.

PGD is already prepared for Hep A (on a GM level). Responsibility for ordering the vaccine would be dependent on the provider.

Staff identified as contacts

IMT would prepare a letter for them to use to attend their GP. In addition, the IMT would directly advise Primary Care of the names of adults who require vaccination.

Details of the response would be tailored to the incident and dependent on the setting and the provider

HEPATITIS A – ADDITIONAL INFORMATION

In the event of a Hepatitis A incident/outbreak occurring in Manchester, CHPT will act as a facilitator, providing the link between UKHSA and various parts of Manchester Health Economy (these will vary according to location of outbreak and who is involved). The CHPT will also act as a point of contact for individuals seeking advice

Signs & Symptoms

- Children: acute onset with non-specific features, including fever, malaise, appetite loss, abdominal discomfort, vomiting, diarrhoea; 30% develop jaundice.
- Adults: frequently symptomatic; ~70% develop jaundice
- Illness usually a few weeks; may last 6 months; longer duration in older people

Incubation period and infectivity

- Incubation about 28 days (range 15-50 days)
- Infectivity:
    - Maximum from latter half of incubation period (approx. 2 weeks before symptom onset) to 7 days after jaundice onset; and
    - Asymptomatic patients: during first few days when liver enzymes maximally elevated.

Mode of transmission

- Spread mainly through faecal-oral route; through blood transfusion; and may be transmitted sexually

Confirmation (diagnosis)

- Clinical and laboratory
    - Appearance of IgM in a patient with compatible illness confirms the diagnosis; IgM appears at the onset of symptoms, lasting about 6 months.
    - IgG appears during convalescent phase, lasting many years; may be lifelong.

Action

- Early detection; treatment; isolation and infection control
    - Advise index case about good hygiene practices, exclude from work, school or nursery for 7 days after jaundice onset; seek source of infection
- Prophylaxis (Vaccination/immunoglobulin/antibiotics/antivirals)
    - Offer vaccine to household and sexual contacts seen within 14 days of exposure to index case.
    - Offer Human Normal Immunoglobulin (HNIG) to contacts aged 50+ and to those with chronic liver disease.

Key reference documents

- Hepatitis A: guidance, data and analysis - GOV.UK (www.gov.uk)
- Hepatitis A infection: prevention and control guidance - GOV.UK (www.gov.uk)
- Hepatitis A: oral fluid testing for household contacts - GOV.UK (www.gov.uk)
- Hepatitis A: the green book, chapter 17 - GOV.UK (www.gov.uk)
- Immunoglobulin: when to use - GOV.UK (www.gov.uk)
- Hepatitis A: outbreak information - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO DISEASE IN AN ASYLUM SEEKER SETTING

Infectious Disease Care Pathway

20 December 2022

for AS Accommodation Settings

Legend

- Housing Support Team (orange)
- Hotel Domestic Team (blue)
- GTD (green)

Actions for Housing Support Team

- Update spreadsheet to identify residents and contact isolating and date of expected isolation end
- Resident provided with laundry bags & waste bags with instruction for use – advised to double bag and tie securely & confirm date for leaving outside room
- Arrange for delivery of meals during isolation period
- Ensure regular welfare checks (at least once a day):
  - Check resident compliant with treatment; medication taken, or creams applied. If wounds dressed ask if dressing intact.
  - Continue to check on residents' health and wellbeing and speak to GTD if further assessment or review required - If residents need to see a clinician out of hours seek advice from 111 or call 999 in an emergency

Actions for Hotel Domestic Team

- Update room cleaning schedule – rooms where residents isolating NOT to be cleaned by staff until isolation ends
- Resident provided with cleaning wipes for period of isolation
- Collection of bagged waste and linen from outside resident's room
  - Waste should be double bagged and tied securely before disposal
  - Linen to be double bagged and tied securely and marked as infectious linen prior to collection
    follow laundry provider guidance for infectious linen including use of red soluble bags if provided
    *follow IPC standard precautions when handling bags including appropriate use of PPE & hand hygiene
- Arrange for full clean on completion of isolation – ensure infection prevention and control precautions

Pathway

Report of a resident with suspected or confirmed infectious disease / organism

Is the disease notifiable?

- Yes → Notify UKHSA as per guidance → All urgent cases to be notified by phone within 24 hours, followed by written notification within 3 days → CC to CHPT email: communityhealthprotectionteam @manchester.gov.uk
- No → Notify CHPT by email; communityhealthprotectionteam @manchester.gov.uk → Complete log sheet on request

Is isolation required?

- Yes → Information leaflet given to resident about isolation - Translated version where necessary → Period of isolation confirmed, and information shared with resident → Housing Support Team notified of isolation period → Hotel Domestic Team notified of isolation period → Has treatment been prescribed?
- No → Has treatment been prescribed? (Antibiotics, skin washes or creams, dressings, antivirals)

Has treatment been prescribed?

- Yes → Notify Hotel Support Officer to add verbal prompts for medication / dressing checks to welfare checks → Provide translated instructions for condition and treatment → Provide clinical waste sack for disposal of dressings if required → Is clinical review required?
- No → Is clinical review required?

Is clinical review required?

- Yes → Arrange follow up appointment
- No → No further action

ADDITIONAL NOTES / CONSIDERATIONS
***During isolation period:**

Only enter patients' rooms in an emergency and ensure infection prevention and control precautions maintained including use of appropriate PPE

If residents need to leave their room during the isolation period, they should avoid contact with others or using communal areas. For certain infections residents can be advised to wear a mask if they need to leave their room during isolation period.

FOR EXAMPLE: DIPHTHERIA

Signs & symptoms

- Usually asymptomatic or mild; occasionally severe upper respiratory tract infection, localised skin infection or systemic infection. Bacterial exotoxin can damage other organs.
- Initial symptoms frequently non-specific (low-grade fever, malaise, headache), resembling viral upper respiratory tract infection.
- Sore throat with pharyngitis, dysphasia, and hoarseness, with pseudomembrane
- Cutaneous diphtheria: indolent, poorly healing ulcers covered with grey membrane, frequently co-infected with other pathogens.

Incubation period & infectivity

- Incubation period usually 2-5 days (range 2-10)
- Without antibiotics, patients can be a source of infection for 2-6 weeks.
- Cases no longer infectious after 3 days of antibiotic treatment.

Mode of transmission

- Transmitted through aerosolized secretions from patients with pharyngeal/respiratory disease; direct contact with skin ulcers can spread infection.

Confirmation (diagnosis)

- Clinical
    - Symptoms not diagnostic; toxigenicity vital (laboratory confirmation)
- Laboratory
    - Diagnosis based on both culturing organism and demonstrating toxin production; culture takes 48 hours.

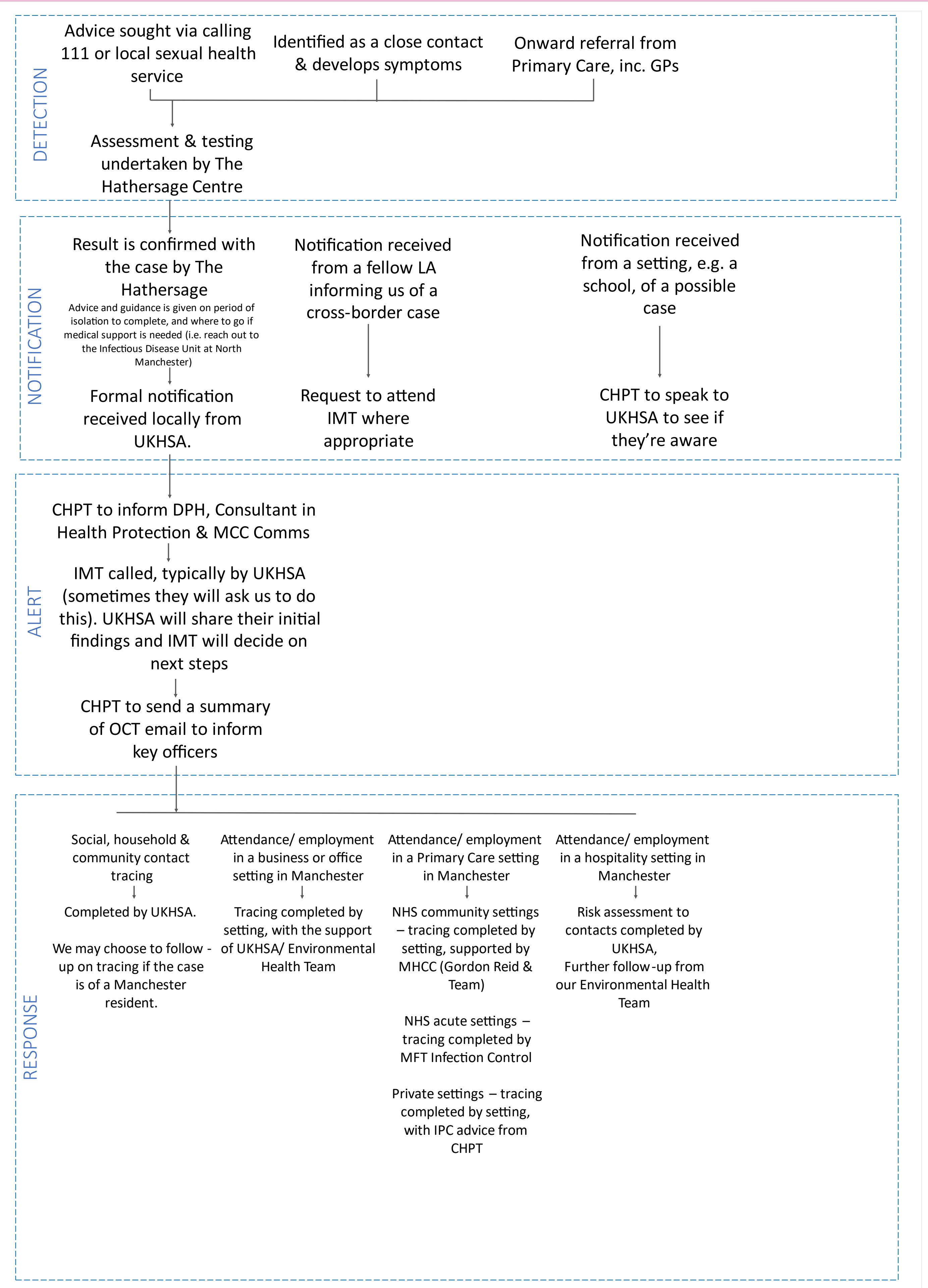
Action

- Early detection; treatment; isolation and infection control
    - Confirmed or probable case should be isolated in hospital.
    - Implement appropriate precautions for droplet-borne infection or direct contact
    - Non-hospitalised patient should restrict contact with others until 3 days course of antibiotics.
- Prophylaxis (vaccination/immunoglobulin/antibiotics/antivirals)
    - Five doses needed: vaccine given at 2,3,4 months of age, pre-school and school-leaving booster.
    - Following completion, >99% develop protective antibodies expected to last many years, if not life-long.

Key reference documents

- Diphtheria: guidance, data and analysis - GOV.UK (www.gov.uk)
- Diphtheria: public health control and management in England - GOV.UK (www.gov.uk)
- Diphtheria: the green book, chapter 15 - GOV.UK (www.gov.uk)
- Diphtheria disease and azithromycin: PGD template - GOV.UK (www.gov.uk)
- Diphtheria warn and inform letter - GOV.UK (www.gov.uk)
- Diphtheria: vaccination resources - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO MPOX



Signs & symptoms

- Fever, headache, muscle aches, backache, swollen lymph nodes, chills, exhaustion, joint pain
- Not all people who have mpox will experience these symptoms.
- Within 1 to 5 days after the appearance of fever, a rash develops, often beginning o the face and then spreading to other parts of the body including the soles of the feet and palms of the hands. Lesions can also affect the mouth, genitals and anus. The rash changes and goes through different stages before finally forming scabs which eventually fall off.
- Some individuals may not have a widespread rash, and in come cases only genital lesions are present. These may be blisters/vesicles, scabs or ulcers.

Incubation period & infectivity

- An individual is contagious until all the scabs have fallen off and there is intact skin underneath. The scabs may also contain infectious virus material.
- The incubation period of the situation/time between contact with the person with mpox and the time that the first symptoms appear is between 5 and 21 days.

Mode of transmission

- Prevention of transmission of infection by respiratory and contact routes is required. Appropriate precautions are essential for suspected and confirmed cases.
- It spreads from contact with infected:
  - Persons, though touch, kissing or sex. Respiratory droplets or short-range aerosols from prolonged close contact.
  - Animals, when hunting, skinning, or cooking them
  - Materials, such as contaminated sheets, clothing or needles. Scabs are infectious and care must be taken to avoid infection through handling bedding and clothing.

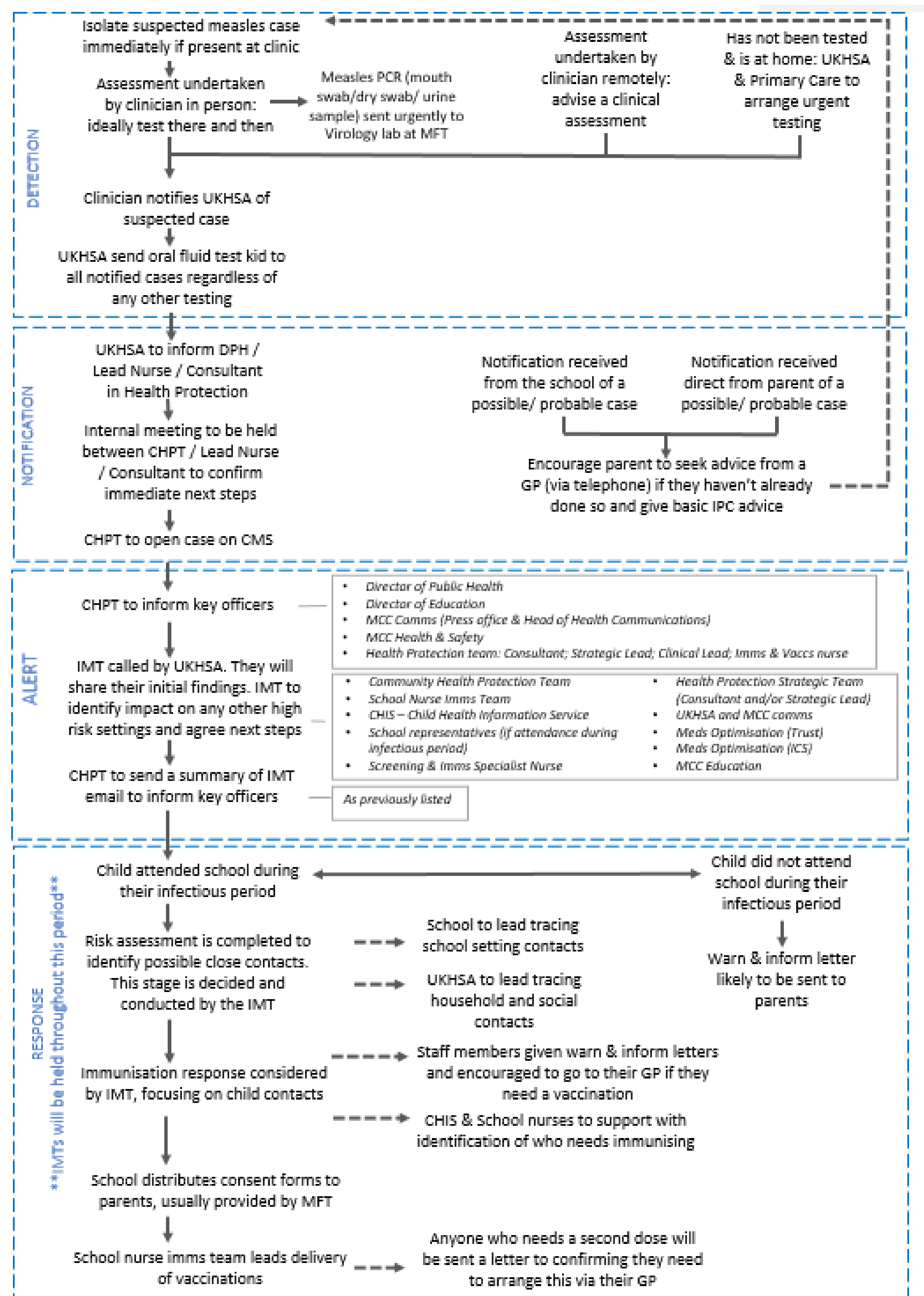
Confirmation (diagnosis)

- Clinical diagnosis of mpox can be difficult, and it is often confused with other infections such as chickenpox. A definite diagnosis of mpox requires assessment by a health professional and specific testing in a specialist laboratory.
- Laboratory confirmation of mpox is done by testing skin lesion material by PCR.

Key reference documents

- Mpox (monkeypox): guidance - GOV.UK (www.gov.uk)
- Mpox classification and appropriate infection prevention and control (IPC) pathways - GOV.UK (www.gov.uk)
- Mpox (monkeypox): case definitions - GOV.UK (www.gov.uk)
- Monkeypox: contact tracing - GOV.UK (www.gov.uk)
- De-isolation and discharge of mpox-infected patients: interim guidance - GOV.UK (www.gov.uk)
- Mpox (monkeypox): prisons and places of detention - GOV.UK (www.gov.uk)
- Mpox (monkeypox): cleaning sex-on-premises venues - GOV.UK (www.gov.uk)
- Mpox (monkeypox): planning events and mass gatherings - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO MEASLES IN A SCHOOL SETTING



MEASLES – ADDITIONAL INFORMATION

Signs & symptoms

- Infection starts with high fever, runny nose, red watery eyes, sore throat: Koplik spots (small red spots, bluish-white centres) seen in 1/3 patients on buccal mucosa opposite molar teeth.
- Several days later: rash, first on face; upper neck, spreading over body; reaching hands, feet. Rash lasts 5-6 days, disappears in order it started. Rash appears about 14 days after first exposure.
- Complications include primary viral or secondary bacterial pneumonia, encephalitis, exacerbation of tuberculosis, diarrhoea, hepatitis, pancreatitis, myocarditis
- May be worse in susceptible infants, pregnant women, and immunocompromised individuals.

Incubation period & infectivity

- The incubation period: 7-14 days (average 10 to 12 days)
- Infectivity from about 4 days before to about 4 days after onset of rash.

Mode of transmission

- Fifteen minutes of face to face contact sufficient for transmission.
- Highly infectious: 90% susceptible close contacts develop disease following exposure.

Confirmation (diagnosis)

- Clinical
    - Frequently clinical: generally unreliable in non-outbreak/non-epidemic situations
    - In liaison with the reporting clinician, experienced health protection professional will classify case as likely (probable), unlikely (possible) based on clinical assessment plus epidemiological information.
    - Assessment plus cases' occupation, location, household contacts, local measles epidemiology determines actions.
- Laboratory
    - Laboratory confirmation on oral fluid or serum for IgM, IgG antibodies, +/- measles RNA.
    - Take diagnostic laboratory samples at earliest opportunity; send oral fluid samples by post to national viral reference department

Action:

- Early detection; treatment; isolation; infection control
    - Confirmed or likely case prompts immediate public health action, for patient and community.
    - Cases should be excluded from school/workplace for 4 days from onset of rash.
- Prophylaxis (vaccination/immunoglobulin/antibiotics/antivirals)
    - Individual: assess immune status, as MMR vaccination or immunoglobulin may be recommended.
    - MMR can be given to susceptible contacts up to five days after exposure to modify/prevent disease.

Should there be an escalation in a situation to community transmission

Primary Care would hold the ultimate responsibility for a vaccination response.

IMT would consider:

- Community hubs to vaccinate larger groups
- Ward level intervention – support with data from Public Health Intelligence needed
- Support from CHIS on vaccination uptake levels in young people

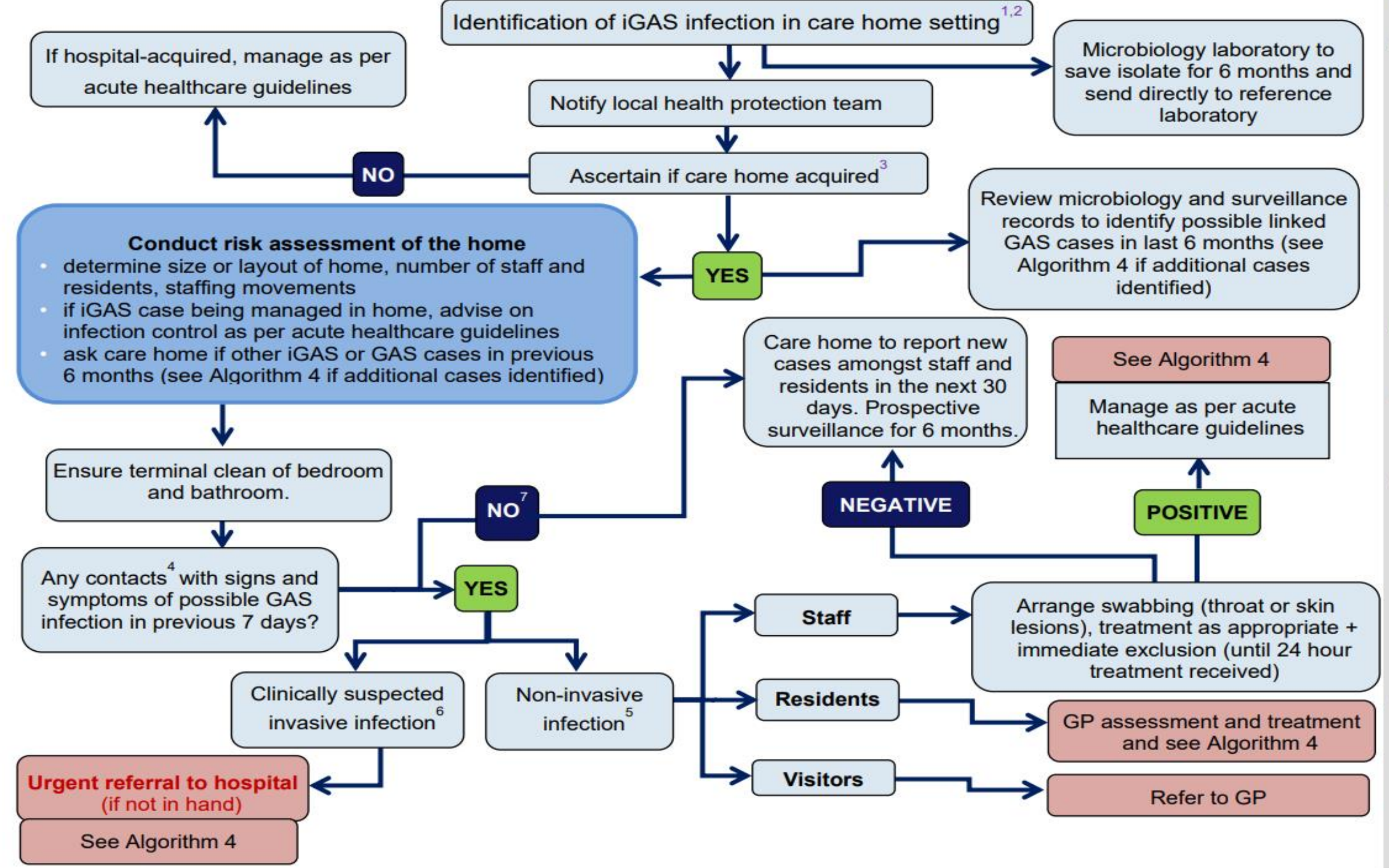
- Neighbourhood teams needed to support engagement
- Comms support needed to promote sessions, inc. developing easy reads, organising key messages to be translated etc
- IMT to give extra consideration for vulnerable groups, inc. pregnant women
- Members to be briefed.

Incident vaccination response

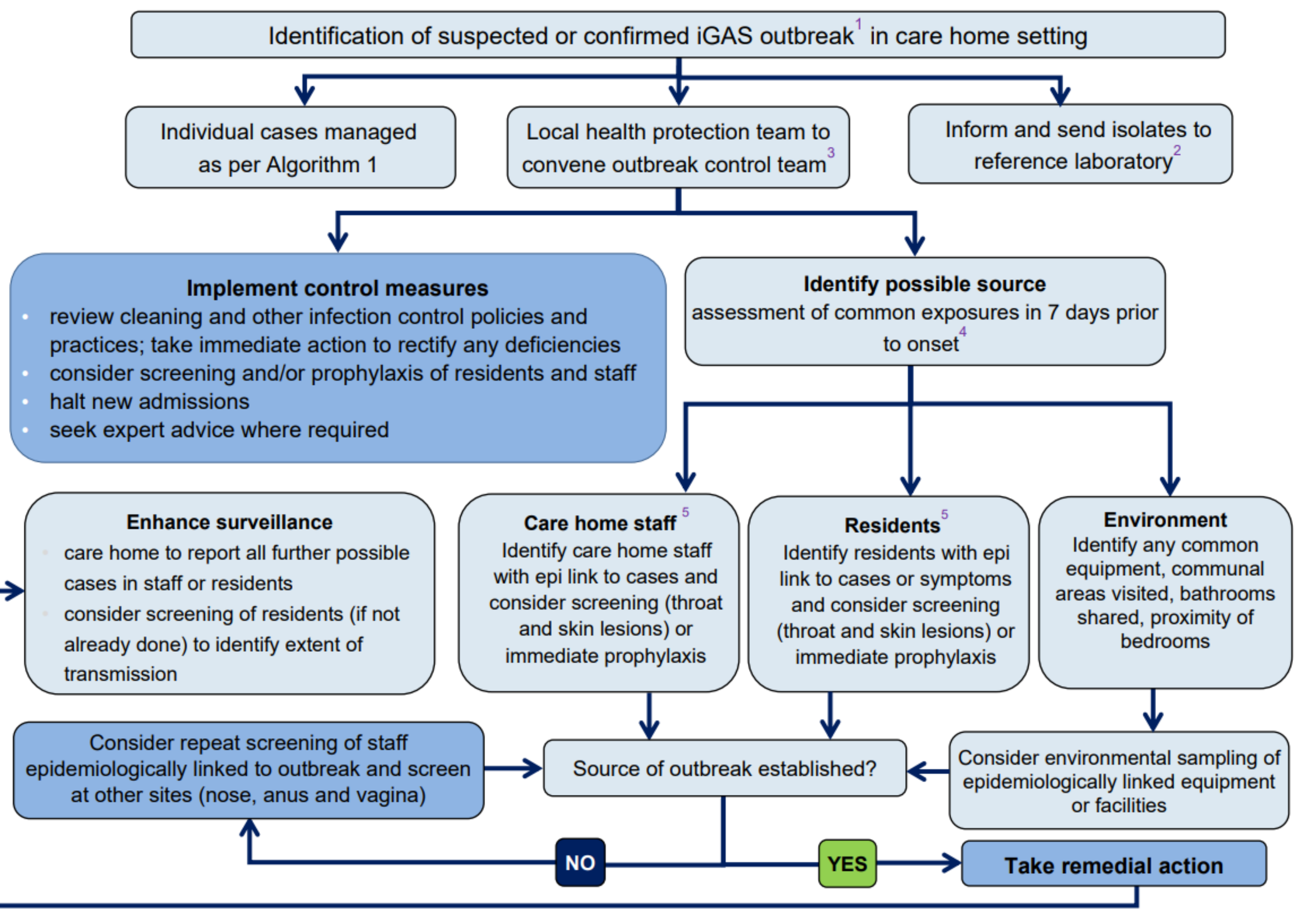
Individual has had two prior does of vaccination	→	Do not need a booster even if they're a contact of the confirmed case. There would need to be documentation of two doses received – if there is any uncertainty they will be assumed to be unimmunised and offered a vaccine to bring them in line with the UK schedule
Individual has not had a full course of MMR	→	Would be offered first/second dose as part of the incident response. If the incident is related to a setting (e.g. school), even if they are not identified as a close contact they will be encouraged to receive a vaccination.

Key reference documents

- National Measles Guidelines, published by UKHSA in Nov 2019
- Measles: the green book, chapter 21 - GOV.UK (www.gov.uk)
- The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)
- Managing outbreaks and incidents - GOV.UK (www.gov.uk)
- Vaccination of individuals with uncertain or incomplete immunisation - GOV.UK (www.gov.uk)



1. Patient resided in a care home in 7 days prior to onset
2. Invasive GAS infection (iGAS) is defined through isolation of GAS from a normally sterile body site. GAS isolated from non-sterile site in combination with severe clinical presentation should be managed as per iGAS.
3. Consider care home acquired if symptoms or signs of infection not present on entry to care home and no other possible source of transmission identified, such as from recent hospital stay.
4. Carers, peripatetic staff, visitors, other residents with direct contact or close proximity to case.
5. Symptoms suggestive of non-invasive GAS infection include sore throat, fever, minor skin infections
6. Symptoms suggestive of invasive disease include high fever, severe muscle aches or localised muscle tenderness +/- a high index of suspicion of invasive disease. In the absence of a more likely alternative diagnosis then emergency referral to A&E (contact A&E to advise of incoming patient).
7. Consider whether asymptomatic staff contacts should be screened. Indications may include strong epidemiological link, absence of alternative potential source and/or where recent transmission of GAS within the home suspected.



1. Two or more cases of confirmed or probable iGAS infection related by person or place. These cases will usually be within a month of each other but the interval may extend to several months.
2. Clearly label isolates sent to the reference laboratory as being part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventive measures should not await results of typing.
3. Outbreak control team may include care home manager, consultant microbiologist, occupational health adviser, local GP, local commissioning lead and communications adviser.
4. Assess possible sources according to case's movements or contacts in the home 7 days prior to onset. Carers, other residents, equipment and the environment are possible sources of outbreaks. Develop time lines and network analyses to identify common exposures (2 or more cases).
5. Carers, peripatetic staff (hairdressers, podiatrists, GPs, district nurses etc), visitors, other residents with direct contact or close proximity to case within 7 days prior to diagnosis. Consider kitchen staff.

IGAS – ADDITIONAL INFORMATION

Signs & symptoms

- Symptoms: toxic shock syndrome, necrotizing fasciitis, bacteraemia, peritonitis, puerperal sepsis, osteomyelitis, septic arthritis, myositis, surgical site infection.
- Signs: localised pain, localised inflammation, fever, shock

Incubation period & infectivity

- Incubation period: 1-3 days (up to 7 days)
- Infectivity: 2-3 weeks for untreated sore throat. Treatment with penicillin reduces infectivity within 48 hours.

Mode of transmission

- Direct contact: blood, bodily fluids, infected tissues
- Droplet exposure: respiratory secretions, splashes with blood, body fluids

Confirmation (diagnosis)

- Clinical and laboratory
  - Group A Streptococci (also known: Streptococcus pyogenes) isolated from sterile site, or from non-sterile site along with severe clinical presentation.
  - Sites indicating iGAS: blood, tissues, wound swabs, aspirates, exudate, or pus positive for Group A Streptococci
  - All samples consistent with iGAS should be sent to reference lab for further typing.
  - It is best practice for the lab to store all Group A Streptococci samples for 6 months for retrospective outbreak investigation.

Action

- Early detection; treatment; isolation and infection control
  - Check lab result, clinical presentation consistent with iGAS. Check patient receiving appropriate antibiotics. Check patient isolated (minimum 24 hours after commencing antibiotics)
- Identify contacts
  - Anyone with prolonged close contact with case in household-type setting: 7 days before onset; includes: living and/or sleeping in same household; boy/girlfriends; students sharing kitchen in a hall of residence
  - Healthcare workers (and others) with direct exposure to eyes, nose or mouth or non-intact skin by respiratory droplets, wound exudate, blood, bodily fluids
- Prophylaxis (vaccination/immunoglobulin/antibiotics/antivirals)
  - Recommend antibiotics to close contacts with symptoms (sore throat, fever, superficial skin infection); entire household if two or more cases within 30 days; healthcare workers with high risk exposure

Key reference documents

- Group A Streptococcus - GOV.UK (www.gov.uk)
- Guidelines for prevention and control of group A streptococcal infection in acute healthcare and maternity settings in the UK (his.org.uk)
- Invasive group A streptococcal disease: managing close contacts in community settings - GOV.UK (www.gov.uk)
- Invasive group A streptococcal outbreaks: home healthcare - GOV.UK (www.gov.uk)

PART 4: OPERATIONAL ARRANGEMENTS FOR MANAGING SPECIFIC TYPES OF INCIDENTS – LOCALLY LED

The detail included in this section is for incidents which are typically managed locally, without requiring an IMT/OCT. These are typically non-notifiable diseases.

Arrangements for responding to these incidents is flexible and situation dependent. Some incidents, although not requiring an IMT will still be discussed with UKHSA e.g. respiratory outbreaks in care settings. Equally some incidents may escalate and require an IMT. Response will continue to be led by risk assessments.

Detail is included on the following common situations:

- Investigating & controlling outbreaks of viral gastroenteritis in schools/nurseries
- Investigating & controlling outbreaks of viral gastroenteritis in care homes
- Investigating & controlling outbreaks of respiratory disease in care homes (excluding seasonal ILI-covered in part 3a)
- Investigating an outbreak of a HCAI
- Investigating & controlling outbreaks of scabies in care homes

*In the event of any of these incidents a daily summary email is sent out stating the location and nature of the outbreak, and the number of people affected. This is used to notify the following where appropriate:

- Infection Prevention Teams : MFT, PAHT, GMMHSCT, MLCO
- Adult Social Care
- Education and Early Years (when appropriate)
- NW Ambulance Service
- Environmental Health
- UKHSA
- LCO key contacts

INVESTIGATING & CONTROLLING OUTBREAKS OF VIRAL GASTROENTERITIS IN SCHOOLS/NURSERIES

Detection/Alerting

- Community Health Protection Team will be contacted by the setting when two or more cases are noted. This will be via telephone, email or the online notification form.

Response

- Phone call between school & CHPT to discuss symptoms and numbers of affected staff & students
- CHPT daily contact updates with school via phone
- Outbreak form details added to outbreak spreadsheet daily.
- Stool sample to collect by school nurse supported by the HP Nurse

Control

- Ill pupils & staff to stay home for 48hours post last symptoms
- Outbreak email sent out daily*
- Notify LA Education Directorate and Health and Safety
- Extra hygiene measures advised
- Deep clean of school 48 hours after last symptoms

Treatment/Prophylaxis

- Unnecessary in most cases

Reference Documents

Gastrointestinal infections: guidance for public health management - GOV.UK (www.gov.uk)

Gastrointestinal illness: outbreak investigation following a mass-participation River Thames swim - GOV.UK (www.gov.uk)

INVESTIGATING & CONTROLLING OUTBREAKS OF VIRAL GASTROENTERITIS IN CARE HOMES

Detection/Alerting

- Community Health Protection Team will be contacted by the setting when two or more cases are noted. This will be via telephone, email or the online notification form.

Response

- Phone call between home & CHPT to discuss symptoms and numbers of affected staff & residents
- Home contacts MRI lab for Ilog number
- CHPT contact home daily during the outbreak (mon-fri) for update. Can contact UKHSA OOH
- Outbreak details added to daily outbreak summary sheet
- Home to take stool samples (type 5-7) from affected residents and sent to laboratory (see outbreak Management doc)

Control

- Ill residents isolated for 48hours post symptoms
- Ill staff excluded for 48 hours post symptoms
- Closure to admissions, avoid unnecessary appointments and restrict visitors until 48 hours post symptoms
- Extra hygiene measures advised
- Deep clean before reopening (48 hours after last symptoms)
- Outbreak summary email updated and sent out daily*

Treatment/Prophylaxis

- Unnecessary in most cases

Reference Documents

Gastrointestinal infections: guidance for public health management - GOV.UK (www.gov.uk)

Gastrointestinal illness: outbreak investigation following a mass-participation River Thames swim - GOV.UK (www.gov.uk)

INVESTIGATING & CONTROLLING OUTBREAKS OF RESPIRATORY DISEASE IN CARE HOMES

Detection/Alerting

- CHPT contacted by home/other source when 2+ cases are noted
- CHPT alert UKHSA to alert of cases and discuss approach

Response

- Phone call between home & CHPT to discuss symptoms and numbers of affected staff & residents
- CHPT email outbreak form to Care Home to be completed and emailed to HP team on daily basis
- Outbreak form details added to outbreak spreadsheet daily
- CHPT Obtain Ilog number
- Arrange for swabs, Urine and sputum samples if needed s to be taken from affected people, and sent to laboratory

Control

- Depends on cause.
- Ill residents & staff to stay home for 5 days post last symptoms
- Flu/other vaccinations up to date
- Outbreak summary email sent out twice weekly
- Isolation where possible, respiratory hygiene measures advised
- Deep clean of home before reopening, must be 5 days after last symptoms

Treatment/Prophylaxis

- Resident's GP to clinically assess and prescribe or use PRIMARY CARE PROVIDER - LCS

Reference Documents

- UKHSA ILI national document

Seasonal influenza: guidance, data and analysis - GOV.UK (www.gov.uk)

Respiratory viruses - GOV.UK (www.gov.uk)

Influenza-like illness (ILI): managing outbreaks in care homes - GOV.UK (www.gov.uk)

Guidance on outbreaks of influenza in care homes poster - GOV.UK (www.gov.uk)

Influenza post exposure prophylaxis and treatment: PGD templates - GOV.UK (www.gov.uk)

Investigation and management of outbreaks of suspected acute viral respiratory infection in schools: guidance for health protection teams - GOV.UK (www.gov.uk)

INVESTIGATING AN OUTBREAK OF A HCAI

Detection/Alerting

- CHPT contacted by processing laboratory or another source e.g IPN at NHS Trust, GP
- Notify UKHSA of outbreak

Response

- Outbreak form to be completed
- Visit by CHPT to premises
- Excel spreadsheet updated
- I log number to be obtained by CHPT
- Sampling as required or as advised by UKHSA e.g. stool,swabs
- Obtain ribotyping in discussion with microbiologists

Control

- Dependent on causal organism
  - MRSA
  - PVL
  - ESBL
  - C.diff
  - CPE
- See relevant national or local protocol document

Treatment/Prophylaxis

- Antibiotic treatment or decolonisation if needed – Provided by GP on advice from microbiologist
- See relevant national or local protocol document

Reference Documents

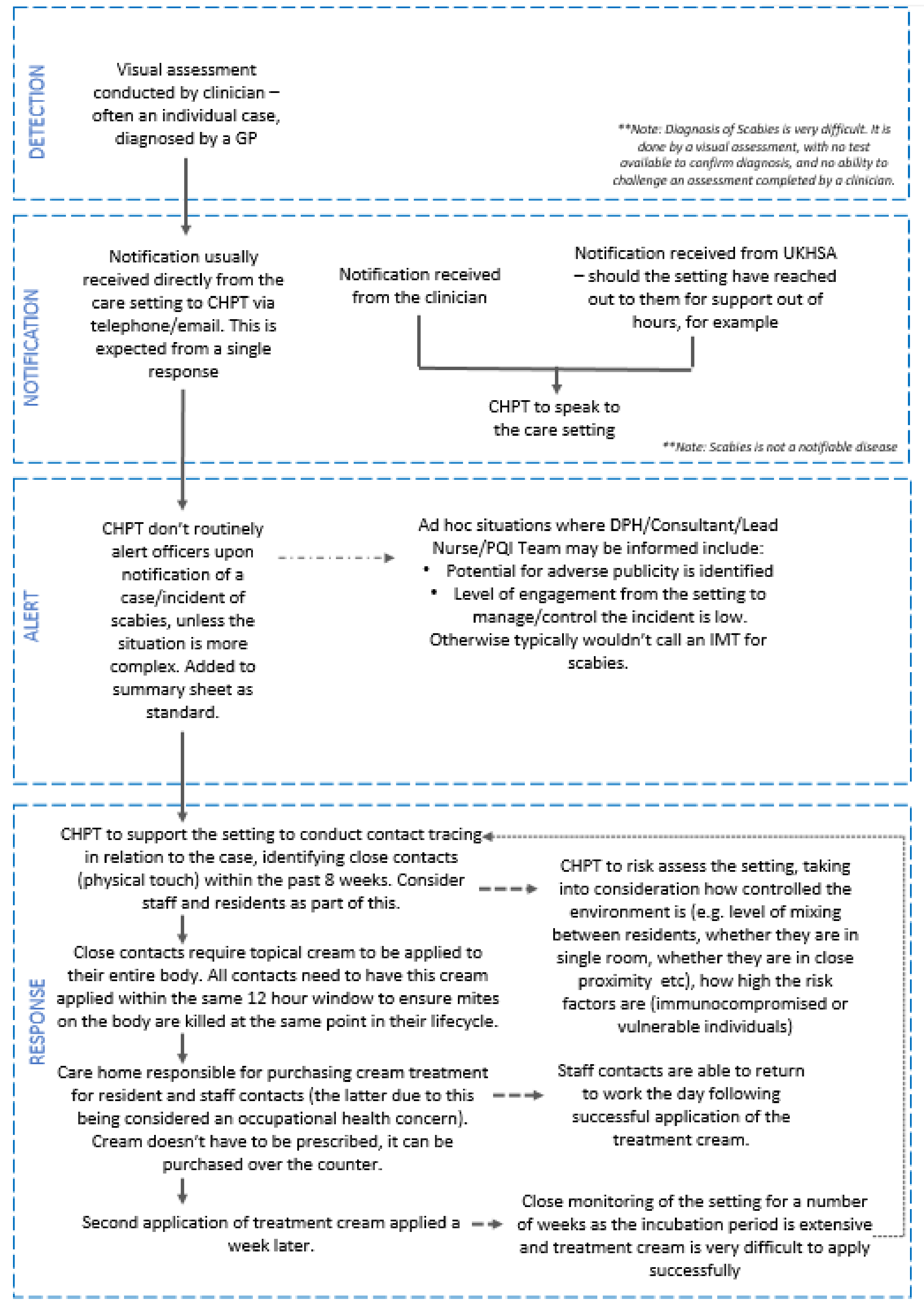
- Outbreak spreadsheet

Healthcare associated infections (HCAI): guidance, data and analysis - GOV.UK (www.gov.uk)

Healthcare associated infection (HCAI): operational guidance and standards - GOV.UK (www.gov.uk)

Care homes: infection prevention and control - GOV.UK (www.gov.uk)

INVESTIGATING & CONTROLLING OUTBREAKS OF SCABIES IN CARE HOMES



PART 5: APPENDICIES

To include:

A. Stocks of laboratory testing kits, medication, and other equipment
B. Outbreak or Incident Meeting Details and Protocol
C. Template Outbreak Control Team meeting Agenda
D. Roles and Responsibilities of usual members of an OCT/IMT
E. Common Acronyms list
F. Key Contacts List

APPENDIX A: STOCKS OF LABORATORY TESTING KITS, MEDICATION, AND OTHER EQUIPMENT

Type of Stock (e.g. swabs, tubes etc.)	Where Located	Quantity	Arrangements for Access
Antivirals	Key pharmacies and Community Pharmacies Lloyds (Sainsbury's) Fallowfield: Lloyds Sainsbury's Heaton Park: UKHSA contingency stock as required.		Pharmacies via prescription via Med management- Stephanie Pacey UKHSA stock access via UKHSA GM Team
Swab kits for influenza **Measles/hep A**	UKHSA MRI Public Health Lab hold main stock UKHSA	UKHSA –Lab	Influenza -See Manchester swabbing procedure contact Clare Ward at MRI for replacement swab kits 2021/22 process TBC Others e.g measles UKHSA arrangements
Vaccines	Immform urgent order Order directly from manufacturer by MFT Pharmacy or NHS IC Manchester meds opt	Depends on size of outbreak	Order via immform web site. Local SIT Team may be able to expedite when needed. UKHSA MFT Pharmacy NHS IC Manchester Meds Optimisation
Stool sample pots	UKHSA GP EHO		Obtain from GP- Little/no stock in most care homes for early response to outbreak samples
Sterile Food Pots **Stomacher Bags (Sterile Food Bags)** **Water Bottles (500ml & 1 Litre)** **Charcoal (Probact) Swabs**	Environmental Health, 1 Hammerstone Road, M18 8EQ	If any further stock was required, Environmental Health would liaise with Food, Water and Environmental Microbiology Services – York or via the	Monday to Friday, during office hours: Jonathan Owen, Environmental Health: Jonathan.owen@manchester.gov.uk Or 07947 360 215.

Neutralising Buffer (SRM) Swabs **SpongeSicle Swabs** **Sterile Templates (use with swabs) 10cm x 10cm** **Sterile Scoops** **Sterile Scalpels** **Single use PPE; Gloves, Overcoats, coveralls, foot covers and masks** **Postal Faecal Kits** **Ice Packs** **Cool Boxes** **Data Loggers** **Food Grade Bags** **Security Tags** **Lockable Fridge, Freezer and Ambient Store**	Public Analyst, Lancashire County Scientific Services to obtain additional stock as required.	**If Jonathan is out of office, an alternative contact will be provided on his email. If this function is not available, please call the Contact Centre on 0161 234 5004 and they will make contact with the team. Emergency Out of Hours, Monday to Friday 6pm to 8am, San – Sun 24 hours: Duty Officer: 07887 916 848

APPENDIX B: OUTBREAK OR INCIDENT MEETING DETAILS AND PROTOCOL

Meeting invite to include link e.g Microsoft Team link

In order for a teleconference to run smoothly, participants must follow certain rules of etiquette while on the call.

CONFERENCE CALL ETIQUETTE- CHAIR

- Send handout materials/documents in advance if possible so attendees will have an opportunity to review beforehand.
- Be on time, and stress the importance of being on time to other participants.
- Choose a location with little background noise.
- Determine who will take minutes for the meeting (this should not be the conference chair).
- Draft and if possible agree an agenda prior to or at the beginning of the meeting.
- Compile a list of attendees in advance if possible.
- At the start of the meeting establish who is present. Ask them to introduce themselves and their agency.
- Emphasise to all participants that they MUST remain on mute unless they wish to speak.
- Direct questions to a specific person instead of posing them to the audience at large where appropriate.
- Speak clearly and pause frequently especially when delivering complicated material.
- Before ending the meeting ask for AOB
- At the end of the meeting, summarise the key actions and agree the next meeting date and time.

MEETING ETIQUETTE – PARTICIPANTS

- Remain on mute when not speaking. Choose a location with little background noise
- If you do have to use a mobile phone in a car, please park up and turn off the radio and engine to reduce background noise when speaking.
- Make a list of any issues you need to raise and note where they can slot into the agenda.
- Take care not to rustle paper, type or make a noise that might disturb the call when your line is open.
- Speak clearly and pause frequently when delivering complicated material

APPENDIX C: TEMPLATE OUTBREAK CONTROL TEAM MEETING AGENDA

Manchester Health Protection

MANCHESTER CITY COUNCIL NHS

Title of meeting:
Date:
Time:
Chair:
Venue/Teams link:

1	**Introduction and Apologies**
2	Purpose of Meeting
3	Overview of Incident
4	Review of Evidence
5	Current risk assessment
6	Control measures
7	Further investigations
8	Communications
9	Next Steps
10	AOB
11	Further meetings

APPENDIX D: ROLES AND RESPONSIBILITIES OF USUAL MEMBERS OF AN OCT/IMT

Consultant in Communicable Disease Control/Health Protection / Epidemiologist

- declare an outbreak following appropriate consultation
- convene the OCT and ensure appropriate membership
- chair the OCT unless a different chair has been agreed
- ensure initial response and investigation begins within 24 hours of outbreak reported
- identify resources that might be needed to manage the situation
- liaise with clinicians over need for testing and management of cases
- agree with OCT who will lead the media response
- ensure communications such as letters/bulletins/press statements and so on are agreed and disseminated
- arrange for appropriate identification and follow up of contacts
- provide advice on and arrange with partner organisations the provision of prophylaxis or immunisation as necessary
- provide epidemiological advice and support analysis and interpretation of data
- ensure appropriate stakeholders are informed and updated, including LA, NHS England, ICSs, acute trusts, microbiologists, FES and CIDSC Colindale
- inform relevant UKHSA director as necessary
- ensure all documentation relating to the outbreak is correctly managed and disseminated, incorporating information governance and data protection requirements
- ensure the constructive debrief is held and lessons learnt disseminated and acted on
- coordinate production of outbreak report and ensure recommendations are acted on

Environmental Health Officer (representative of Chief Environmental Health Officer)

- investigate potential sources of outbreak and secure improvements where the LA is the enforcing authority or where it is the home authority for companies that operate across LA boundaries
- advise the OCT where enforcement falls to another body, for example the HSE
- provide help and advice including the investigation of cases or contacts
- provide mechanisms for out of hours communications with the OCT and stakeholders
- arrange collection of samples from cases and contacts and undertake appropriate sampling of food, water and environmental samples
- arrange delivery of all samples to appropriate laboratories
- liaise with the office of the public analyst and PHE laboratories for analysis of samples if chemical contamination is suspected
- provide reports to the LA and undertake necessary enforcement actions
- inform relevant food and non-food businesses of hazards as appropriate
- arrange for the identification, seizure, removal and safe disposal of contaminated food within their LA area
- ensure infection control advice is implemented, using relevant legal powers as necessary and working with UKHSA staff, NHS Infection Control Nurse or others
- ensure arrangements for collection and disposal of clinical waste remain appropriate. discuss with OCT and contractors any changes required
- identify resources so that tasks can be undertaken efficiently
- monitor the progress of the investigation and provide updates to the OCT
- report to colleagues in the Environmental Health Department and liaise with those in neighbouring districts
- be jointly responsible for communicating the cessation of the outbreak to the stakeholders and the general public, in collaboration with UKHSA
- ensure continuity of evidence in case results are needed for subsequent criminal prosecution

Director of Public Health (Lead Nurse Health Protection as deputy)

Under the Health and Social Care Act (2012) the Director of Public Health (DPH) is responsible for the MCC contribution to health protection, including planning for and responding to incidents that present a threat to the public's health. They are also responsible for:

- overall executive responsibility for reviewing the health of the population including surveillance, prevention and control of communicable diseases
- ensuring, in liaison with NHS England and NHS IC Manchester, that appropriate resources are available to support the investigation and control of outbreaks
- ensuring 24-hour MCC emergency management availability
- ensuring that hospital trusts are alerted and able to cope with a potential influx of patients
- Informing MCC Chief Executive and Chairman, as appropriate
- liaison with other LAs as appropriate
- agree who will lead the media response

UKHSA communications lead

- liaise with incident lead to establish an incident spokesperson
- coordinate media handling for local HPTs in close liaison with partners
- ensure appropriate heath protection advice is made available to the public and media throughout, including appropriate messages articulating HPT advice locally
- provide a regional lead for communications relating to high impact outbreaks
- manage the reputation of UKHSA in the region, specifically horizon scanning for issues that might damage that reputation and as appropriate provide high level advice to the Director of Public Health and other colleagues on any action required
- monitor press and social media coverage of the outbreak

Administrator

Administrative support should be provided to each outbreak control team. Responsibilities include:

- taking accurate and detailed minutes of OCT meetings including a record of actions and the individual or organisation responsible
- timely circulation of minutes to members of the OCT
- organisation and circulation of dates for OCT meetings or associated activities
- act as task manager for incidents where this is required
- other administrative support as required

APPENDICIES E: COMMON ACRONYMS LIST

APTBI	Acute Pulmonary Tuberculosis Infection
ARI	Acute Respiratory Infection
BBV	Blood Borne Viruses
CMS	Case Management System
CCG	Clinical Commissioning Group
CHPN/P	Community Health Protection Nurse/ Practitioner
CHPT	Community Health Protection Team (sits within Dept of Public Health, MCC)
CICT	Community Infection Control Team
DPH	Director of Public Health
EHO	Environmental Health Officer
GI	Gastrointestinal
HSE	Health and Safety Executive
HCAI	Healthcare Acquired Infection
ICS	Integrated Care System
ILI	Influenza-Like Illness
IPC	Infection Prevention & Control
LA	Local Authority
MCC	Manchester City Council
MFT	Manchester Foundation Trust
MLCO	Manchester Local Care Organisation
MRI	Manchester Royal Infirmary
MSM	Men who have sex with men
NWAS	Northwest Ambulance Service
OOH	Out of Hours
IMT	Outbreak Control Team
PGD	Patient Group Directive
PAHT	Pennine Acute Hospital Trust
PEP	Post-exposure Prophylaxis
TB	Tuberculosis
UKHSA	UK Health Security Agency
UEC	Urgent and Emergency Care

APPENDICES F: KEY CONTACTS LIST

In the event of an outbreak, the following contact details may be of assistance:

Out of hours contact for NHS IC Manchester is via NWAS ROCC on 0345 113 0099, Option 1 for GM team. Ask for NHS IC Manchester Director On Call.

Manchester Council: Public Health	David Regan- Director of Public Health	Mobile: 07770 981699	david.regan@manchester.gov.uk
	Sarah Doran - Assistant Director of Public Health & Consultant in Health Protection	Mobile: 07976 226 866	sarah.doran@manchester.gov.uk
Manchester City Council: Environmental Health	Sue Brown - Manager	Mobile: 07944 166 142	Susan.brown@manchester.gov.uk
	Tim Birch - Manager	Mobile: 07940 758 258	tim.birch@manchester.gov.uk
Manchester City Council: Pest Control		Tel: 0161 234 4928	pest.control@manchester.gov.uk
Manchester City Council: Children's & Education	Amanda Corcoran		amanda.corcoran@manchester.gov.uk
	Sharon Gardner - Strategic Lead Safeguarding	Mobile: 07950 359 752	sharon.gardner@manchester.gov.uk
	Liz Clarke - Schools QA & SEND	Mobile: 07971 587 112	liz.clarke@manchester.gov.uk
Manchester City Council: Early Years	Gillian Blackwell – Quality Assurance Lead (Early Years)	Mobile: 07960 592 913	gillian.blackwell@manchester.gov.uk
Manchester City Council: Rough Sleeping Team	Laura Stevenson, Outreach Coordinator (Rough Sleepers)	Mobile: 07989 132 910	laura.stevenson@manchester.gov.uk
Manchester City Council: Communications	Penny Shannon - Head of Health Communications	Mobile: 07734137407	penny.shannon@manchester.gov.uk
	Safika Munshi - Deputy Head of Communications	Mobile: 07814 082403	safika.munshi@manchester.gov.uk
	Alun Ireland - Head of Strategic Communications	Mobile: 07971 385049	alun.ireland@manchester.gov.uk
Manchester City Council: Risk & Resilience	Kimberley Hart	Tel: 0161 234 3313 Mobile: 07899 664 614	k.hart@manchester.gov.uk
Manchester City Council: Internal Audit and Risk Management	Simon Gardiner - Health and Safety Manager	Tel: 0161 234 5260 Mobile: 07810 557 473	simon.gardiner@manchester.gov.uk

Manchester City Council: Waste/recycling/Cleansing Team	David Sabet, Contract Manager	Tel: 0161 234 1155	d.sabet@manchester.gov.uk
Manchester City Council: Homelessness	Nicola Rae, Strategic Lead	Mobile: 07940795195	nicola.rea@manchester.gov.uk
Manchester City Council: ASC Commissioning and Contracting	Paul Bickerton	Mobile: 07960 728 403	paul.bickerton@manchester.gov.uk
Manchester City Council & NHS Manchester Locality Team	Jenny Osborne - Assistant Director, Integration & Population Health	Mobile: 07773 474 945	jenny.osborne4@nhs.net
Manchester Community Health Protection Team (MCC)	Leasa Benson, Lead Nurse in Health Protection	Mobile: 07939 995 154	leasa.benson@manchester.gov.uk
	Helen Fabrizio, Deputy Lead Nurse in Health Protection	Mobile: 07506 959 356	helen.fabrizio@manchester.gov.uk
	Specialist Nurses and Practitioners		communityhealthprotectionteam@manchester.gov.uk
Manchester University Foundation Trust – Infection Prevention & Control	Office	Tel: 0161 276 4042	
	Michelle Worsley - Assistant Chief Nurse IPC and Tissue Viability	Mobile: 07929 861 190	michelle.worsley@mft.nhs.uk
	Lorraine Durham - Lead Nurse	Mobile: 07929 729 048	lorraine.durham@mft.nhs.uk
	Julie Mullings - Infection Control in Community	Mobile: 07970 146 566	julie.mullings@mft.nhs.uk
	Rajesh Rajendran - Associate Medical Director for Infection Control	Mobile: 07960 772 744	rajesh.rajendran@mft.nhs.uk
Manchester Foundation Trust/UK Health Security Agency Laboratory	Andrew Fox - Consultant in Public Health Infections for North West	Mobile: 07736 244 920	andrew.fox@UKHSA.gov.uk
	Rachel Jones - UKHSA Regional Head of Operations for North West	Tel: 0161 276 5747	rachel.jones@UKHSA.gov.uk
Manchester Foundation Trust: TB Team	Ryan Noonan – TB Lead	Tel: 0161 276 4387	ryan.noonan@mft.nhs.uk

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Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 20 September 2023

Subject: Joint Local Health and Wellbeing Strategies (JLHWS)

Report of: Director of Public Health

Summary

In November 2022, the Department of Health and Social Care confirmed that local Health and Wellbeing Boards will continue to be responsible for assessing the health and wellbeing needs of their local population through the publication of a Joint Strategic Needs Assessment (JSNA) and a Joint Local Health and Wellbeing Strategy (JLHWS). This report focuses specifically on the statutory guidance and the November 2022 update and what it means for Manchester.

Recommendations

The Health and Wellbeing Board is asked to:

1) Note the report and its statutory duties and powers in relation to the Joint Local Health and Wellbeing Strategy
2) Agree to delegate the co-ordination of the approach to comply the statutory duty to the Director of Public Health and the Deputy Place Based Lead

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	All of the recently published strategic health and wellbeing plans, such as the Manchester Population Health Plan and the Making Manchester Fairer Plan, provide detailed information on how a strong partnership approach will contribute to all of the Our Manchester Strategy outcomes and specifically, a progressive and equitable city
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection):

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

1.0 Background

1.1 Health and Wellbeing Boards were established in 2013 and are a key mechanism for driving joined up working at a local level. The Health and Care Act 2022 introduced new architecture to the health and care system, specifically the establishment of integrated care boards (ICBs) and integrated care partnerships (ICPs).

1.2 Guidance on Health and Wellbeing Boards published by the Department of Health and Social Care on 22 November 2022 confirmed that the Manchester Health and Wellbeing Board will continue to be responsible for the JSNA and a Joint Local Health and Wellbeing Strategy.

2.0 Duties and powers of Boards in relation to the Joint Local Health and Wellbeing Strategy

2.1 Statutory guidance on Joint Health and Wellbeing Strategies was published by the Department of Health and Social Care in March 2013. The Health and Care Act 2022 amended section 116A of the Local Government and Public Involvement in Health Act 2007, renaming Joint Health and Wellbeing Strategies to Joint Local Health and Wellbeing Strategies (JLHWS) but, apart from this change of name, the statutory guidance on JLHWSs currently remains unchanged.

2.2 Health and Wellbeing Boards are responsible for publishing a JLHWS which sets out the vision, priorities and actions agreed by the Health and Wellbeing Board to improve the health, care and wellbeing of local communities and reduce health inequalities across a local authority footprint. The responsibility for the production of a JLHWS falls on the Health and Wellbeing Board as a whole and so success will depend upon all members working together throughout the process. JLHWS are unique to each local area and there is no mandated standard format or update schedule.

2.3 The JLHWS should translate the findings from the JSNA into clear outcomes the Health and Wellbeing Board wants to achieve which, in turn, will inform local commissioning activities and lead to the development of locally led initiatives that meet those outcomes and address the need. The JLHWS should also directly inform the development of joint commissioning arrangements (set out in section 75 of the National Health Service Act 2006) in the place and the co-ordination of NHS and local authority commissioning, including Better Care Fund (BCF) plans.

2.4 The JLHWS must be published and made available to the local community. It should also provide clear measures of progress to hold the Health and Wellbeing Board to account over time. The JLHWS should show what evidence has been considered and what priorities have been agreed and why. It should include a summary of community views and how those views have been taken into account.

2.5 Each Health and Wellbeing Board also has a separate statutory duty to develop a Pharmaceutical Needs Assessment (PNA) for their area. A PNA cannot be subsumed as part of the JLHWS but can be annexed to it.

JLHWS and integrated care strategies

2.6 The integrated care strategy should build on and complement the JLHWS, identifying where needs could be better addressed at the system level. It should also bring together learning from across the system to drive improvement and innovation.

2.7 A Health and Wellbeing Board needs to consider the integrated care strategy when preparing its own JLHWS to ensure that they are complementary. A Health and Wellbeing Board should be an active participant in the development of the integrated care strategy as this may also be useful for HWBs to consider in the construction of their JLHWS. When the Health and Wellbeing Board receives an integrated care strategy from the ICP, it does not need to refresh the JLHWS if it considers that the existing JLHWS is sufficient.

3.0 The Manchester JLHWS

3.1 The Manchester Joint Health and Wellbeing Strategy was first agreed by the Health and Wellbeing Board in 2013 and was subsequently refreshed in March 2016. The priorities in the refreshed Joint Health and Wellbeing Strategy (JHWS) were substantively the same as those set out in the original strategy but were updated to align the strategy with the development of the Locality Plan and the Greater Manchester health and social care devolution arrangements. The revised priorities were;

- Getting the youngest people in our communities off to the best start
- Improving people's mental health and wellbeing
- Bringing people into employment and ensuring good work for all
- Enabling people to keep well and live independently as they grow older
- Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme
- One health and care system – right care, right place, right time
- Self-care

3.2 The Joint Health and Wellbeing Strategy has not been refreshed further since 2016. The 2016 refresh of the JHWS was published on the then Manchester Partnership website but this website is no longer live.

3.3 Following discussions with partners, there is a consensus now that the 2016 version of the Joint Health and Wellbeing Strategy is no longer the overarching Health and Wellbeing Strategy for the city, however, since that date a number of key strategies have been published and formally endorsed by the Health and Wellbeing Board. These are the Manchester Population Health Plan 2018-2027, Our Healthier Manchester (2021) and more recently the Making Manchester Fairer (MMF) Plan in 2022.

3.4 Furthermore, the Greater Manchester ICP published in April 2023 the Greater Manchester Integrated Care System Strategy 2023-2028 which now provides the overarching framework for all ten Health and Wellbeing Boards in Greater Manchester. In addition to this strategy, national guidance required each Integrated Care Board to publish a five year Joint Forward Plan (JFP) setting out how they propose to exercise their functions. The JFP is attached as Appendix 1.

3.5 In the Manchester Locality, the Manchester Partnership Board (MPB) has agreed its priorities for 2023-2026 and has produced a delivery plan setting out how actions to address these priorities will be delivered. This is attached as Appendix 2.

3.6 The establishment of the Greater Manchester Integrated Care Board and the agreed interface with the Manchester Partnership Board provides an opportunity for the Health and Wellbeing Board to agree a process for what constitutes a Joint Local Health and Wellbeing Strategy that can ensure the Board complies with its statutory duties. It is envisaged that there will not be a need to write another new strategy but the Our Healthier Manchester Strategy which was refreshed in 2021 alongside Making Manchester Fairer will be sufficient to constitute the Joint Local Health and Wellbeing Strategy. The Our Healthier Manchester Strategy will reflect both the Greater Manchester Strategy and the five year forward view.

3.7 It is proposed that the Board agrees to delegate the lead role for the co-ordination of this approach to the Director of Public Health in partnership with the Deputy Place Based Lead.

4.0 Recommendations

4.1 The Health and Wellbeing Board is asked to:

1) Note the report and its statutory duties and powers in relation to the Joint Local Health and Wellbeing Strategy
2) Agree to delegate the co-ordination of the approach to comply the statutory duty to the Director of Public Health and the Deputy Place Based Lead

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Greater Manchester Integrated Care Partnership

Joint Forward Plan

2023-2028

30th June 2023

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1 Introduction

The way in which health and care services are organised in every part of England changed on 1st July 2022, as new national legislation came into force. Greater Manchester (GM) is now an Integrated Care System (ICS) – a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in GM.

There is a requirement for all ICSs to develop a strategy. NHS organisations and local authorities must then have regard to this strategy when making decisions about the use of health and care resources. The five-year Strategy for the GM Integrated Care Partnership (ICP) was approved in March 2023 and can be found here.

National guidance states that each Integrated Care Board (ICB) must publish a five-year Joint Forward Plan setting out how they propose to exercise their functions. This should include the delivery of universal NHS commitments address ICSs' four core purposes and meet legal requirements. The guidance encourages ICSs to develop the Joint Forward Plan as the delivery plan for the ICP Strategy – and this is the approach we have taken in Greater Manchester.

JFP Principles

Principle 1: Fully aligned with the wider system partnership's ambitions

Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments

Principle 3: Delivery focused, including specific objectives

This plan describes how GM will achieve the outcomes described in the ICP strategy. Achieving these outcomes involves not only integrated health and care services but also action on the things that determine good lives. The strategy and plan describe a complex system which includes, but is not limited to, the activities under the direct influence (and resourcing) of NHS Greater Manchester Integrated Care (NHS GM) Our ICP strategy describes our GM model for health, which builds on the strong partnerships already in place with wider public services, the VCSE and people and communities.

The Strategy was developed through extensive engagement with communities, partner agencies and staff, across all ten localities. Its development adapted to the feedback received and it reflects the needs and expectations of our communities. This Joint Forward Plan is built from the results of that engagement.

1.1 The GM Context

Greater Manchester is home to more than 2.8 million people with an economy bigger than that of Wales or Northern Ireland. Our population in the 2021 Census was estimated to be 2,867,800. This is an increase of 185,272 on the 2011 Census and represents a growth of 6.9% in ten years, higher than the growth across England and Wales (6.3%) over the same period.

There are ten councils in Greater Manchester: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. All are unitary authorities, eight are metropolitan borough councils and two, Salford and Manchester are city councils.

The Greater Manchester Combined Authority (GMCA) is made up of the ten Greater Manchester councils and the Mayor, who work with other local services, businesses, communities and other partners to improve the city-region as described in the Greater Manchester Strategy (GMS)[1].

1.2 The composition of our Partnership

The **Greater Manchester Integrated Care Partnership** (this is the name of our integrated care system) connects NHS Greater Manchester Integrated Care, the Greater Manchester NHS Trusts and NHS providers across the whole of primary care with the GMCA, councils and partners across the VCSE, Healthwatch and the trades unions.

Greater Manchester Integrated Care Partnership Board is a statutory joint committee made up of NHS Greater Manchester Integrated Care and councils within Greater Manchester. It brings together a broad set of system partners to support partnership working and it is the responsibility of this Board to develop this Integrated Care Strategy - a plan to address the wider health, and care needs of the population.

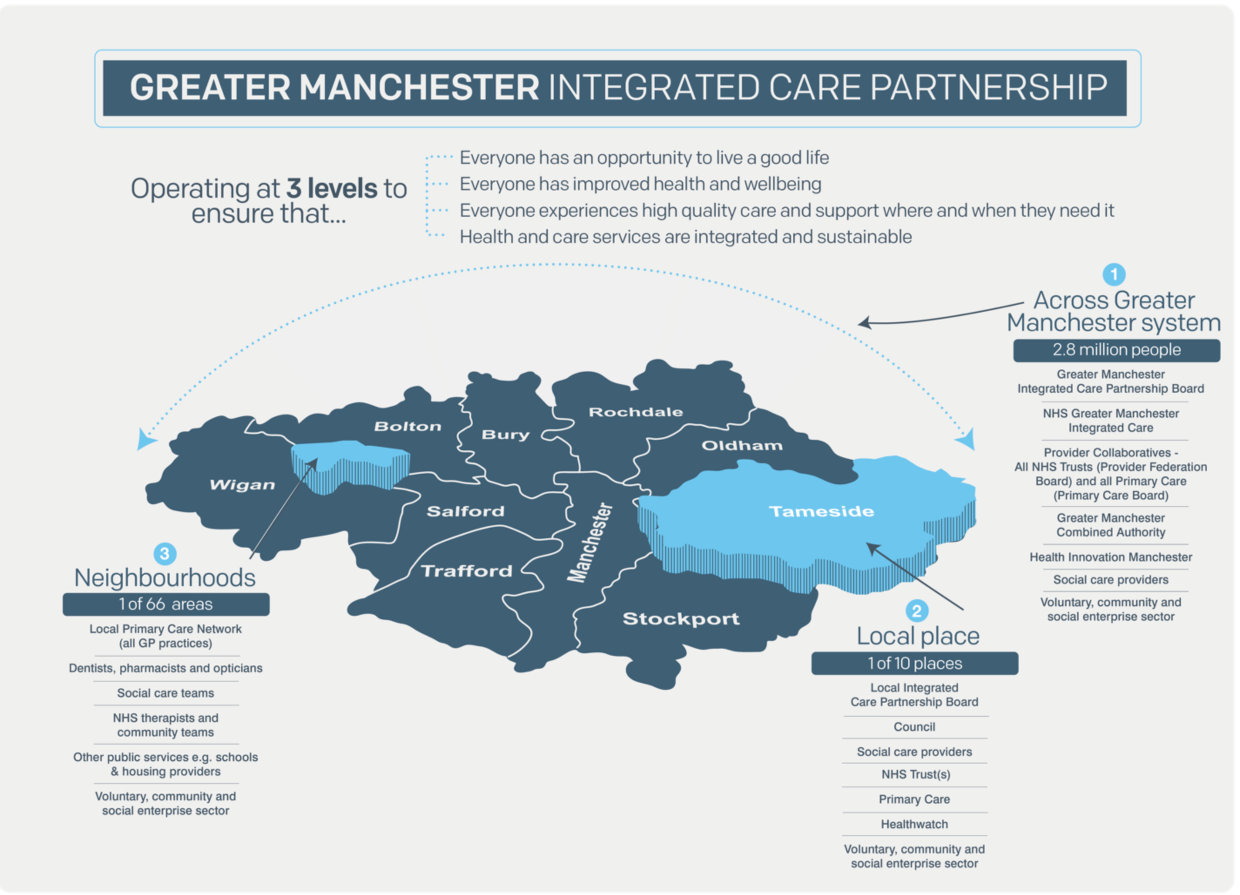
NHS Greater Manchester Integrated Care, or NHS Greater Manchester (our integrated care board) is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in a geographical area. It supports ten place-based integrated care partnerships in

[1] https://aboutgreatermanchester.com/

Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities.

Figure 1 highlights how partners across health and care, wider public services and the VCSE work together as part of integrated neighbourhood teams across our ten localities in place-based partnerships and, where appropriate, across the whole of Greater Manchester to ensure consistency of access and experience and pursue improvements at scale.

Figure 1



Within Greater Manchester we have arrangements for providers to work together effectively at scale, including:

- The Greater Manchester Provider Federation Board (PFB): a membership organisation made up of the eleven NHS trusts and foundation trusts who provide NHS funded services across Greater Manchester and East Cheshire. It includes the NHS providers of 111, 999, patient transport services (PTS), community mental

health and physical health services and hospital mental health and physical health services.
- The Greater Manchester Primary Care Board (PCB) has been supporting collaboration and integration since 2015 and will continue to support the delivery of outcomes at all levels of, and across, the system, through its various programmes and its work with all 67 Primary Care Networks[2] (PCNs) in Greater Manchester.
- Greater Manchester Directors of Adults' and Children's Social Care collaborating to support transformation of social care at scale. For adult social care this also includes joint working with the Greater Manchester Independent Care Sector Network.
- Voluntary, Community and Social Enterprise (VCSE) sector providers are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE Sector represented by the Greater Manchester VCSE Leadership Group, based on a relationship of mutual trust, working together, and sharing responsibility, and providing a framework for collaboration. The VCSE sector has also established an Alternative Provider Federation as a partnership of social enterprise and charitable organisations operating at scale across Greater Manchester. It provides an infrastructure for alternative providers to engage with NHS Greater Manchester on a Greater Manchester footprint.

1.3 What the Data is Telling Us

The Greater Manchester Integrated Care Partnership Strategy gives a comprehensive picture of the data about our system. This includes:

- Demographic information
- Information on inequalities
- Demand on health and care services
- The financial picture
- Workforce pressures

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[2]Primary Care Networks involve GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices

.

We have also drawn on our locality plans and local Health and Wellbeing Strategies which together identify the needs of our population and the plans in each locality to address these, aligned with our strategy and this plan (see section 10.5)

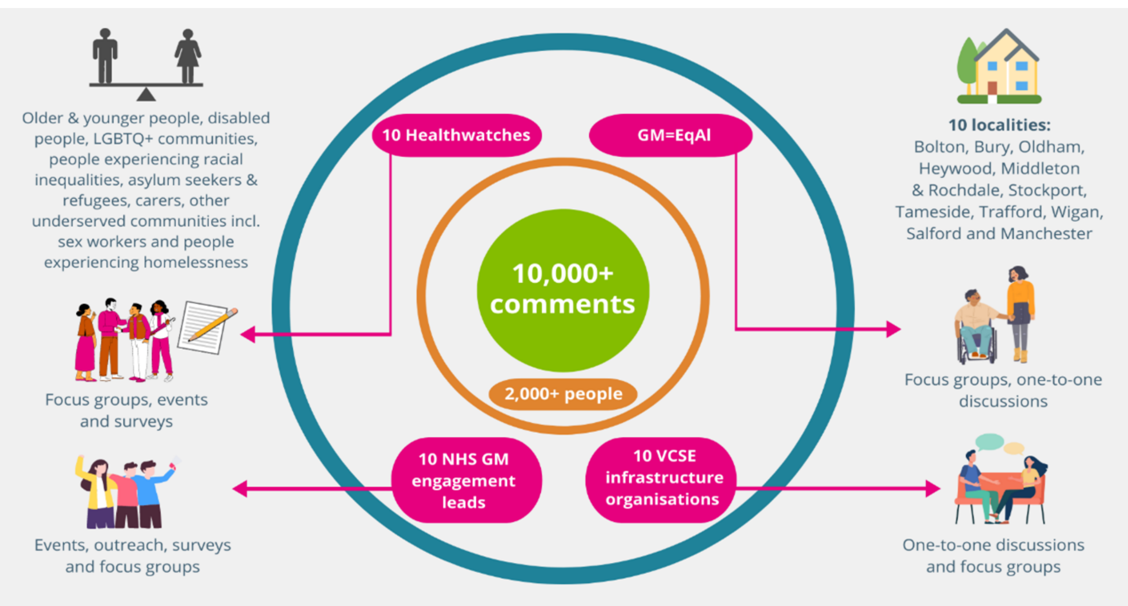
1.4 What residents are telling us

We carried out a major engagement exercise 'The Big Conversation' to inform the development of our ICP Strategy and this plan.

The Big Conversation had two phases. Phase one ran between March and May 2022 with the aim of consulting on the proposed vision and aims that had been suggested by the ICP leaders following a stakeholder engagement event they took part in. 1,332 people gave their views and consensus was most respondents agreed with the proposed aims and visions.

Phase two ran in October 2022 with the aim of ensuring the GM ICP had the insight it needed to be able to understand what matters most to communities across all ten localities - to help shape the priorities and actions for the strategy. A summary of the 'Big Conversation' is set out in Figure 2 .

Figure 2



2 Our Strategy

2.1 Overview

The Integrated Care Partnership Strategy outlined the key challenges facing the Greater Manchester health and care system:

- How to continue the improvements already made in GM's approach to integrated care and population health improvement
- The wider influences on health and good lives
- Economic inclusion
- Access to services, operational pressures and increasing demand
- Health outcomes and heath inequalities
- The challenge of financial sustainability

The Strategy is clear that we must both meet these immediate pressures and continue to address their underlying causes through improving the health of our population. The missions in the strategy were developed to ensure a recognition of these challenges.

This Joint Forward Plan will describe how we will realise these aims over the next five years – with a greater emphasis on years one to three. We will revise and update this plan each year. The Plan covers all ages as we support people to start, live and age well.

2.2 Our vision and outcomes

As partners in Greater Manchester, we share the Greater Manchester Strategy (GMS) vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region.

For the Greater Manchester Integrated Care Partnership, this means we want to see a Greater Manchester where:

Everyone has an opportunity to live a good life
Everyone experiences high quality care and support where and when they need it
Everyone has improved health and wellbeing
Health and care services are integrated and sustainable

2.3 The Greater Manchester Model for Health and Wellbeing

Underpinning all our work is the Greater Manchester Model for Health and Wellbeing. This shows how we work with communities to protect against and prevent poor health and ensure support is available before crises occur to reduce demands on formal NHS and social care services. It is a social model for health and wellbeing with people and communities at its heart. It recognises that Greater Manchester will make the most progress in improving health if steps to tackle the social causes of health complement our clinical interventions.

Figure 3

Our challenge is that this Model is not universally realised across Greater Manchester. Our aim through the strategy and this delivery plan is to confirm the actions and approaches necessary to achieve this and maximise the efficiency and effectiveness of how we work together to improve our outcomes.

3 What we will do - our missions

3.1 Our missions

Our strategy sets out the following missions in response to the current challenges, within the context of our vision and outcomes

- **Strengthening our communities**

  We will help people, families and communities feel more confident in managing their own health and wellbeing. We will act on this with a range of programmes, including working across Greater Manchester to support communities through social prescribing, closer working with the VCSE and co-ordinated approaches for those experiencing multiple disadvantages.

- **Helping people stay well and detecting illness earlier**

  We will collaborate to reduce smoking rates, increase physical activity, tackle obesity and drug and alcohol dependency. We also want to do more to identify and treat high blood pressure, high cholesterol, diabetes, and other conditions which are risk factors for poor health. Working in partnership and with targeted interventions, we will embed a comprehensive approach to reducing health inequalities.

- **Helping people get into, and stay in, good work**

  One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by expanding our Work and Health programmes, working with employers on employee wellbeing, through the Greater Manchester Good Employment Charter[3] and developing social value through a network of anchor institutions[4].

- **Recovering core NHS and care services**

  We will work to improve ambulance response and A&E waiting times, reduce elective long waits and cancer backlogs, improve access to primary care services and core mental health services, improve quality and reduce unwarranted variation

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[3] https://www.gmgoodemploymentcharter.co.uk/
[4] https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

for adults and children alike. Consistent delivery of NHS constitutional standards is a priority as our system recovers.

- **Supporting our workforce and our carers**

  We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people choosing health and care as a career and feeling supported to develop and stay in the sector. We will consistently identify and support Greater Manchester's unwaged carers.

- **Achieving financial sustainability**

  Financial sustainability - 'living within our means' - requires a focus on financial recovery of the health system to achieve a balanced position. We will identify the main reasons for financial challenges in our system, and implement a system wide programme of cost improvement, productivity, demand reduction and service transformation. Our work needs to address the current significant challenges we face across health and social care as well as taking the steps to make our system more sustainable for the long-term.

For each of the missions, we have set out the key areas of focus and the actions to deliver our vision and outcomes. These are described in greater detail in the next six chapters of this document. We have set out the accountability for the delivery of the missions. We describe this as:

- **Delivery Leadership** – the board/organisation leading change and improvement in the relevant part of the system. This recognises that the key responsibility for bringing together and driving delivery will sit with Locality Boards, providers, and provider collaboratives
- **System Leadership** – This recognises the board/group accountable for creating the system-wide conditions, frameworks, and standards to enable delivery

The proposals on accountability in this document will be revisited as part of the leadership and governance review that took place in the first quarter of 2023/2024. We expect to complete the process of implementing the recommendations by October 2023.

3.2 Our ways of working

The way that we work together will play an important part in achieving our vision through our missions. To transform public services and integrate care we need to change the way we work with communities and fundamentally challenge our approaches to delivery. These ways of working run through all our missions.

Behaviours	We will …
Understand and tackle inequalities	✓ Take action at individual, team, organisation, and system levels, informed by data, to understand and tackle inequalities.
Share risk and resources	✓ Set out our expectations of each other, share data effectively, support joint working with shared resource and create a culture of collaboration. This must happen at every level and in every place.
Involve communities and share power	✓ Consistently take a strengths-based approach with co-design, co-production and lived experience as fundamental ingredients.
Spread, adopt, adapt	✓ Share best practice effectively, test and learn, and celebrate success, with supportive governance and resources. Adapt and implement best practice locally, in organisations and across systems.
Be open, invite challenge, take action	✓ Be open, honest, consistent and respectful in working with each other. Work on the boundaries and differences that we have in a constructive way, to support effective change.
Names not numbers	✓ Ensure we all listen to people, putting them at the centre, and personalising their care.

4 Strengthening our communities

We will help people, families and communities feel more confident in managing their own health. Our approach recognises that the organisation of the delivery of health and care services is only one of a range of contributors to the health and well-being of residents. The quality of housing, the availability of quality work, the extent to which residents are connected to their communities, and whether people feel safe also make a significant contribution.

Being deprived of these helps create and exacerbate the persistent health inequalities we see in many communities in Greater Manchester. Tackling these issues will play a key part in securing long term stability for our system – principally through keeping people well and independent in their homes and communities and reducing demand on expensive, acute services.

Our approach to this mission is underpinned by the Greater Manchester People and Communities Framework which defines our strategic approach to public engagement and involvement including key principles and commitments that support our ways of working.

Strengthening our communities Delivery Leadership: Locality Boards System Leadership: Population Health Board	
Areas of focus	**Actions**
Scale up and accelerate delivery of person-centred neighbourhood model	Continue to develop Live Well and Social Prescribing
	Continue to Embed Creative Health Approaches
	Enhance the role of NHS GM in tackling poverty as a driver of poor health
	Expand community-based mental health provision
	Living Well at Home
	Take an inclusive approach to digital transformation
Develop collaborative and integrated working	Embed the VCSE Accord
	Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage
	Embed the GM Tripartite Housing Agreement
	Giving every child and young person the best start in life
	Ageing Well
	Increase identification and support for victims of violence
Develop a sustainable environment for all	Delivering our Green Plan

4.1 Area of Focus: Scale up and accelerate delivery of person-centred neighbourhood model

Neighbourhood and place-based working provides the closest connection to the broadest range of factors affecting people's health and wellbeing. Most people will receive most of their day-to-day care for most of their lives in the neighbourhood or locality. The only place where local authority spend and planning, not only on care services, but also on the wider determinants of health, comes together with NHS spend is at the locality level.

We have a locality model in place in Greater Manchester, comprising:

- A Locality Board to ensure the priorities are decided together in the locality and support the effective joint stewardship of public resources benefiting health
- A Place Based Integrated Care Lead with dual accountability to the local authority and to NHS GM
- A place-based provider collaborative or alliance providing comprehensive, integrated care at neighbourhood and place levels
- A means of ensuring clinical and care professional input and leadership to place based working

Our localities are made up of neighbourhoods of 30,000 to 50,000 population – with Primary Care Networks at their heart. The neighbourhood model ensures that support is available before crises occur, to reduce demands on formal NHS and social care services. This is pivotal to our social model for health.

Health and Wellbeing Boards play an important role across our localities (HWBB) – including providing support and challenge to Locality Boards to ensure that a focus on health inequalities flows through all aspects of the locality's work. This key to our work to address wider societal and economic issues through local partnerships

4.1.1 Action: Continue to develop Live Well and Social Prescribing

Only by working alongside people and communities to create healthier happier lives will we see sustainable improvements in the health of our population. Live Well is our programme to support this across Greater Manchester, as a key component of the person-centred neighbourhood model.

Every day, people help each other, and take part in activities that keep them moving, creative, and sociable – improving their physical health and mental wellbeing. Many

people, particularly those experiencing inequalities, do not have the same chances to access these opportunities - this is where Social Prescribing can help.

Social Prescribing is a way for local organisations, services and professionals to refer people to a worker who acts as a 'link' between the health and care system or wider public services and the community. There are now over 200 Social Prescribing Link Workers in Greater Manchester working alongside GPs and other community organisations. Over 30,000 people a year directly access this. Through Live Well, we are committed to expanding this offer, and to ensuring it makes a targeted difference to people who experience inequalities.

We will work with, and build, on the community-led work in all our localities to expand the 'Live Well' offer so that all residents, particularly those experiencing inequalities, are offered the chance to maintain and improve their health, wellbeing, resilience and social connections through access to information, activities, volunteering and support. This will include:

- Expanding the 'Live Well' offer for key groups of people, including children and young people, and people with cancer, and people experiencing health inequalities.
- Making it easier for people to get social prescribing support, through improving connections and pathways between different parts of the system, and through new workforce roles. In our developing Primary Care Blueprint, we set out our intention to improve interdisciplinary referral pathways for Primary Care and enable wider Primary Care teams to refer directly into social prescribing initiatives, behaviour change services, and wider welfare support.
- Support community organisations to provide opportunities for people, led by what communities want, including for green social prescribing, and creative health
- For those who need more help to live well, we will continue to develop and support person centred practice in Primary Care and other public services by equipping the workforce with a framework, tools, and training. We will expand and improve the quality of personal health budgets. This supports our delivery of the comprehensive model of personalised care.

Measuring our Delivery

- Increase in social prescribing activity
- Increase in Social Prescribing Link Workers and other community connectors
- Proportionate investment in social prescribing and allied activity compared to deprivation index

- Improvements in wellbeing as measured through the ONS survey (GMS measures of anxiety and life satisfaction)
- Community wellbeing measured through GM resident survey ('satisfaction with their local area')
- Proportionate investment in social prescribing and allied activity compared to deprivation index
- Numbers of personal health budgets
- Rate of personalised care interventions
- Workforce training data

Accountability

- Locality Boards
- Live Well Steering Group
- Primary Care System Board
- Population Health Board

4.1.2 Continue to Embed Creative Health Approaches

In November 2022, the Integrated Care Partnership launched the Creative Health Strategy, setting out a commitment to creative health as a core tool for addressing health inequalities and for improving access to and, in some cases, the effectiveness of specific clinical pathways

We will:

- Develop a distributed leadership network across GM to support the health and social care workforce to best employ creative health interventions and approaches.
- Promote the systematic and sustained use of creative health approaches by ensuring that clinicians, commissioners and other colleagues have access to information about creative health methodologies and practice and evidence of what works
- Support practitioners to develop and implement rigorous outcome measures and methodologies for creative health and work with HEIs (Higher Education Institutions) to generate new research on impact and outcomes.
- Deliver creative health interventions across the life course, from gestation to a good death, contributing to the delivery of Live Well.
- Develop referral pathways and opportunities to access creative health interventions and activities, especially within early years settings, secondary schools, within social prescribing and in dementia care.

Measuring our Delivery

- Creative health demonstrated to improve wellbeing of adults as measured through ONS4
- Where targeted activity has taken place- an increase in wellbeing of dementia sufferers and their carers
- Increase in creative health activity

4.1.3 Action: Enhance the Role of NHS GM in Tackling Poverty as a Driver of Poor Health

Poverty is the single biggest determinant of health outcomes and health inequalities. Building upon a 'deep dive' into poverty and health that was undertaken by the GM Population Health Board, the GM Integrated Care Partnership approved a range of actions aimed at addressing this issue.

A key feature of this response has been the development of a strategic partnership with Greater Manchester Poverty Action and tapping into their nationally recognised expertise to support NHS GM to establish an approach which can serve as an exemplar to other ICSs.

Our focus during 2023/24 is on completing the ongoing strategic review of the role of NHS GM in tackling poverty, including:

- Reviewing the current NHS GM response to poverty against existing examples of good practice and the recommendations made by the Kings Fund in their publication – 'The NHS's Role in Tackling Poverty'

- Assessing the feasibility of NHS GM developing an anti-poverty strategy and adopting and implementing the socio-economic duty, a tool by which public bodies can ensure decisions they consider the needs of people experiencing poverty.

In addition, during 2023/24 and 2024/25 we will:

- Complete the ongoing test and learn activity around health and care workforce training and development around Poverty Awareness and Poverty Literacy and use the findings from this to implement a scaled-up programme of training and development across the GM health and care workforce as part of the Fairer Health for All Academy

- Complete the ongoing proof of concept activity exploring the application of 'poverty proofing' methodology in health and care (with an initial focus on pregnant women

during pregnancy and 12 weeks post-partum) in the 20% most deprived areas of GM) and use the learning from this to develop a GM approach

- Explore options to enhance the provision of welfare and debt advice and guidance services in health and care settings

- Complete ongoing activity with energy providers aimed at mitigating the potential adverse impact of high energy costs on people who have high energy consuming medical devices within their home

Measuring our Delivery

In the long term, the impact of our activity will be measured by:

- A reduction in the gap in life expectancy and healthy life expectancy between the most deprived and least deprived areas of Greater Manchester.

In the shorter term, the impact of our activity will be measured by:

- 500 NHS GM or provider staff completing poverty awareness training by the end of 2023/24 and at least 50% of all NHS GM staff completing poverty awareness training by the end of 2028/29.
- Evidence of poverty-proofing activity taking place and the development of a GM approach to poverty-proofing health and care.
- The impact of the cost of living on individuals with health and care needs, in particular:
  - Reduction in the % of GM residents who are not in work due to ill health or disability who are significantly more likely to feel very / somewhat worried about the rising cost of living (GM Residents Survey)
  - Reduction in the % of GM residents who are diagnosed with mental ill health who are significantly more likely to feel very / somewhat worried about the rising cost of living (GM Residents Survey)
  - Reduction in the % of Gm disabled respondents (including those with a learning disability or diagnosed with a mental ill health need who are struggling to manage their debt levels (GM Residents Survey)
  - Reduction in the number of Personal Independence Payment (PIP) claimants who need to access support via Citizens Advice Bureau (CAB Data Portal via GM Cost of Living Dashboard)

Accountability

- Locality Boards
- Population Health Board

- Reform Board

4.1.4 Action: Expand Community-Based Adult Mental Health Provision

As part of our neighbourhood model, we will expand provision of multi-disciplinary, strengths-based teams for mental health. We will aim to build resilience in people and communities and intervene earlier before people reach a point of crisis. Our approach is based on addressing historic under-investment in mental health, learning disability and autism.

Our Mental Health and Well Being Strategy sets out our aim to provide clear, accessible care pathways for people, integrating mental wellbeing, social care and physical health. We will further integrate mental health offers into Early Help, family support, housing and schools.

In line with the national Community Mental Health Transformation Framework, we are working across all ten localities to develop new and integrated models of primary and community mental health care which will support adults and older adults with severe mental illnesses and reach over 20,000 more people. A key area of work is scaling up the Living Well model across all GM localities which was successfully piloted in Salford and Tameside between 2018-2021.

Our ambition is to increase our community Mental Health offer so that fewer people escalate to crisis point. We will know we have achieved this when we are able to reduce our crisis offers and reduce the number of inpatient beds in GM without adversely impacting our communities.

Over the next five years, we will:

- Continue to develop, embed and enhance Living Well models and integrated specialist community pathways in each of the ten localities
- Engage in meaningful co-production and co-design with people with lived experience and wider stakeholders
- Improve the quality of person-centred care by developing our multi-agency teams
- Working with a shared practice model that is strengths based, trauma-informed and solutions focused
- Providing increased access to evidence based psychological therapies, social support and community connections

Measuring our Delivery[5]

- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Number of women accessing specialist community perinatal mental health services
- NHS Talking Therapies access: number of adults entering NHS funded treatment
- Access and waiting times for Children and Young People (CYP)
- Improving access (CORE 20 PLUS 5 groups) for CYP with long-term conditions to mental health services including Child and Adolescent Mental Health Services (CAMHS), eating disorders and talking therapies.
- Better support offer for CYP with mental illness/emotional/behavioural needs presenting in acute settings – including growing the number of mental health champions in acute settings

Accountability

- Locality Boards
- GM Mental Health System Board

4.1.5 Action: Living Well at Home

Adult Social Care in Greater Manchester is rooted in the power of co-production with people, carers and families to enable better outcomes for people. The primary focus is on supporting people to live well at home, as independently as possible, making sure that the care and support people experience is built on their own strengths and those within the community, and is of the best quality.

The key elements of the programme are:

Workforce

- RECRUIT-implementation of the GM Care academy, delivery of the GM Social Care Workforce strategy, the GM International Recruitment Programme implementation, and the recruitment strategy for social workers and nurses

[5] 2023/24 is the final year of Mental Health Long Term Plan Indicators and we will review the metrics in this plan as the new national indicators are published

- RETAIN - expand blended roles to enhanced care workers, expand the person-centred care and support Trailblazer
- GROW – continual professional development training for nurses and Occupational Therapists (OTs), succession planning, leadership development and mentoring

Market Development and Sustainability

- A diverse and sustainable market with great quality and supporting better outcomes and better lives
- Continuous improvement of the quality of social work
- Better commissioning models that support better outcomes and attract the best providers to the market

Digital

- Explore more collaboration, focussing where we can pool funding to deliver shared outcomes
- Improve number of providers using digital social care records as set out in our digital strategy
- Better utilisation of technology enabled care solutions

Safeguarding

- Working in partnership across all aspects of safeguarding to enable the best outcomes for people, especially in relation to complexity, prevention and sharing learning

Learning Disability

- Continued commitment to the Learning Disability strategy and the Autism Strategy
- Development of 3-year LeDeR (Learning Disabilities Mortality Review) strategy
- Develop apprenticeships programmes
- Continue roll out of the Keyworker workstream
- Roll out PACT (Paediatric Autism Communication Therapy) and Riding the Rapids training
- Continue to implement the GM justice plan
- Continue to the roll out of the CYP Keyworker workstream
- Review advocacy – GM exemplar model

Measuring our Delivery

- Workforce – increase in recruitment and retention of individuals successfully employed through the developing GM care academy
- Market shaping – more people living well at home (reduction in long term residential care)
- Quality – either a maintenance of existing or improvement of Care Quality Commission (CQC) ratings for providers, LAs and GM ICS (new single assurance framework)

Accountability

- Locality Boards
- GM Directors of Adult Social Care

4.1.6 Action: Take an inclusive approach to digital transformation to ensure equity for all

GM has significantly advanced the use of digital approaches across health and care, but there are still many people who cannot easily access or benefit from digitally enabled services and tools. In an increasingly digital world, people who are digitally excluded are at risk of worse access to services and poorer health outcomes, deepening inequalities.

People who are most likely to experience digital exclusion are:

- People living in deprived areas
- Inclusion health groups including people who are homeless, rough sleepers, asylum seekers and the travelling community.
- Protected groups according to age, disability and ethnicity.

A lack of digital access and skills can have a huge negative impact on a person's life. As many as 1.2m residents in Greater Manchester could be excluded in some way to access the benefits digital brings.

The GM Digital Inclusion Action Network (DIAN) has been established by the Greater Manchester Combined Authority to ensure digital inclusion is built into the transformation of public services, place-making and economic growth. It is focused primarily on getting all under-25s, over-75s and people with disabilities online.

NHS GM will continue to work in partnership with the DIAN and Health Innovation Manchester to build inclusion into the design and development of digitally enabled services and pathways, develop targeted approaches for key communities and boosting digital capabilities and awareness of inclusion barriers.

Measuring our Delivery

- Develop and deliver a series of pan-GM projects to address digital exclusion in key service areas including virtual wards, digital GP practices and the use of remote monitoring technologies
- Monitor uptake and access to digitally enabled services according to key demographics, including over-75s, under-25s and people with disabilities
- Develop and deliver a programme to improve health and care staff awareness of digital inclusion and build skills needed to spot and support people who may be impacted – number of staff participated, % increase in awareness and competence

Accountability

- GM Digital Inclusion Action Network
- GM Health and Care Digital Transformation Board

4.2 Area of Focus: Develop collaborative and integrated working

4.2.1 Action: Embed the VCSE Accord

Voluntary, Community and Social Enterprise (VCSE) sector providers are part of a three-way agreement (the VCSE Accord) between the GMCA, NHS Greater Manchester and the VCSE sector.

The VCSE Accord delivery plan for 2023 to 2026 sets out the future of the Accord over the next three years. The central themes of delivery are:

- Scaling up the VCSE role in addressing inequality, population health delivery models, and in creating a more inclusive economy
- Supporting the effective Commissioning and Investment of GM VCSE action
- Helping to develop a resilient ‘VCSE Ecosystem’ in the face of current challenges
- Ensuring powerful VCSE representation and voice
- Finding ways to support Greater Manchester’s 75,000-strong VCSE workforce, 500,000 volunteers and 300,000 informal carers

Measuring our Delivery

- Three VCSE data targets met: contributing to system, access to collective data and VCSE intelligence built into decision-making
- Propositions for VCSE role in addressing wider determinants of health built into GM programmes and asks and VCSE at the heart of social and economic action in all ten localities and at GM-level
- Co-design and Co-production via VCSE sector defined and resourced
- VCSE accessing funding and investment across GM and across VCSE sector (equalities, providers, grassroots)
- All employees in the VCSE sector receive at least the Real Living Wage
- VCSE workforce at all levels (including leadership and management) is reflective of the diversity of the communities of Greater Manchester

Accountability

- VCSE Leadership group

4.2.2 Action: Deliver a GM-wide consolidated programme for those experiencing multiple disadvantage

Through the Devolution Trailblazer Deal in early 2023, the Government confirmed its support for GM's ambition to develop a city region-wide approach to supporting people and families experiencing multiple – social, economic and health –disadvantages. To support this work, the Government has agreed to review the secondary legislation that underpins pooled and aligned budgets (section 75 of the National Health Service Act 2006), with a view to amending the scope and simplifying the regulations where needed.

Demand on public services, including health and care, is often driven by cohorts of residents who are in contact with multiple agencies – for instance, people with drug and alcohol problems; people who are homeless; people with a range of complex long-term conditions who frequently present to acute services through A&E and other routes.

They are among the most vulnerable in our communities, and often experience entrenched disadvantage, long term unemployment, trauma and health inequalities. The most at-risk adults and children and young people in this situation are estimated to cost the public purse five times more than the average citizen per year.

These plans will support our aim to move from a system characterised by responses to cycles of chronic illness and exacerbation to one focused on a proactive model that keeps people well at home and in their communities. They build on learning from the Supporting Families (Troubled Families) programme, Rough Sleeper Initiative, Housing First, Changing Futures and Working Well.

Our key actions in 2023/24 are:

- Define a cohort
- Demonstrate the demand reduction opportunities
- Draw together a blueprint for programme delivery

Measuring our Delivery

For the identified cohort:

- Reduction in crisis presentation and presentation to acute services

Accountability

- Locality Boards
- Reform Board

4.2.3 Action: Embed the GM Tripartite Housing Agreement

The home is a driver of health inequalities. Inadequate housing causes or contributes to many preventable diseases and injuries. Direct effects of an inadequate home on a person's health can include heart attacks, stroke, respiratory disease, flu, falls and injuries, hypothermia and poor mental health. Poor quality housing is estimated to cost the NHS at least £1.4 billion per year in first year treatment costs alone.

The GM Tripartite Agreement 'Better Homes, Better Neighbourhoods, Better Health', is a collaboration between Greater Manchester Housing Providers, Greater Manchester Combined Authority and NHS Greater Manchester Integrated Care to deliver positive change across the city region. The Agreement sets out a collective vision to work alongside local people, neighbourhoods and stakeholder organisations to create lasting solutions to complex issues and challenges centred on housing and health.

Measuring our Delivery

- Increase supply of supported and specialist homes to support delivery of health and care system priorities
- Integrating housing pathways and models of joint working into place-based delivery via PCNs
- Delivery of the action plan on Damp, Mould and Condensation
- Delivery of the GM Good Landlord Charter to drive up standards in rented homes
- Activity to make our homes warmer and reduce fuel poverty, including domestic retrofit measures, delivery of Truly Affordable Net Zero homes, NHS GM Warm Homes pilots
- Acting on the GM Healthy Homes framework to deliver consistent Home Improvement Agency services and policies
- Private rented sector interventions, including Good Landlord Scheme
- Responding to homelessness and rough sleeping - including embedding Inclusion Health principles in commissioning and delivery and ongoing health system investment

Accountability

- Locality Boards
- Population Health Board
- Tripartite Agreement Core Group

4.2.4 Action: Giving every child and young person the best start in life

Greater Manchester is passionate about ensuring that all our children and young people get the best start in life and are cared for, nurtured and supported to grow up well and achieve their ambitions in life.

We will support our children and young people to get the best start in life through a joined-up approach to their early years' development. We will wrap support around our most vulnerable young people to give every child the opportunity to live their best life through access to quality education and opportunities that respond to their needs. We will give young people a voice in how we develop policy and make decisions that affect their lives.

There are strong foundations to build on. This includes work over the last decade to develop common practice standards for groups of young people (for example Children with Special Educational Needs and Disabilities and Care Leavers). The specific

health case for investment in children is extremely strong. The life course costs of late intervention have been estimated at £17bn across England and Wales (including nearly £4bn borne by the NHS).

Around 1 in 4 children and young people continue to live in poverty, according to Department of Work and Pensions (DWP) data on the percentage of children age 0-15 living in low-income households. There are disproportionately high numbers of children and young people across GM who are at risk, vulnerable or have complex needs.

GM partners (health education, voluntary, criminal justice sectors, GMCA and local authorities) have adopted a system-wide approach, delivered through a combined Children and Young People Plan. The GM Children Board, reporting to the Integrated Care Partnership, and GMCA acts as a system board that represents the range of accountabilities brought together to deliver on the priorities in the Children and Young People Plan.

We have set out our priorities for children and young people:

- Early years – Taking an integrated approach to early years recognising the importance of 1,001 critical days and responding to the detrimental impact of Covid-19 on the development of children age 0-5
- Children and young people with long term conditions – Taking a preventative approach to tackling issues that may contribute to longer term conditions such as obesity and asthma and ensuring those with long term conditions get the high-quality treatment they need in their communities
- Family help (including family hubs) – Working towards a shared vision of family help where families can get the help they need from the right places and people in their communities including health professionals
- Education outcomes – With particular focus on tackling the issues that impact on school attendance/absence
- Mental health and wellbeing – Responding to the rise in the number of children and young people being referred to CAMHS through a focus on earlier support and preventing escalation in the community whilst also having the right

pathways in place for those in crisis. This includes responding to #Beewell[6] as an important piece of insight into the wellbeing of GM children

- Care for / care experienced young people – Understanding and responding to the specific health needs of this important group of young people recognising including those placed in specialist residential care units
- Children and young people with SEND – Work together to improve the experience of children and young people with SEND (and their carers) through common standards, joint commissioning and a commitment to addressing inconsistencies in the offer across GM
- Adolescents –Improve the way we work with Adolescents in GM including the implementation of a GM Adolescent Safeguarding Framework
- Children and Young people in the Criminal Justice System – responding to the health needs of young offenders recognising that many of these young people have unidentified needs until they enter the youth justice system
- Domestic Abuse – recognising the significant impact domestic abuse has on the lives of children and young people and the need for a cross sector response to tackling these issues in our communities
- Speech, Language and Communications – Responding to emerging evidence of delayed early language development in under 5s early years due to the impact of children missing out on early education and normal social interactions during Covid-19 in addition to challenges on workforce and waiting times
- Trauma Responsive Care – implement our system plans to become an Adverse Childhood Experience (ACE) and Trauma Responsive system
- Workforce –We must look at how we tackle common challenges across the children's workforce including recruitment and retention in addition to training around core competencies. Continued focus on a Trauma responsive workforce and the importance of neurodiversity

To give every child the best start in life, we will continue to improve maternity services. In doing so, we will:

[6] A GM youth-led survey of young people's wellbeing and experiences

- Address inequalities within maternity services through delivery of the Greater Manchester and Eastern Cheshire Maternity Equity and Equality Plan 2022-2027. This includes meeting the national priority to reduce workforce vacancies in maternity
- Implement Saving Babies Lives version 3 within our maternity providers with the intention to reduce still birth rates, early neonatal deaths and maternal deaths
- Fully embed the Smoke Free Pregnancy (SFP) programme into the mainstream maternity journey to achieve the high-level performance seen pre-pandemic (see section 5.2.1)
- Standardise pathways to prevent alcohol harm in pregnancy across all the GM maternity providers
- Continue rolling out the 'As Soon as You're Pregnant' campaign to encourage early booking and to increase timely uptake of screening tests, including those for sickle cell and thalassaemia

Measuring our Delivery

- 83% of children to reach the expected level of development by 2024
- Improved access to speech and language therapy services
- Increase the uptake of funded childcare and early education places for 2-year-olds by April 2024
- Improve vaccination uptake for routine immunisations
- Continue to deliver the Long Term Plan (LTP) ambitions through the three-year delivery plan for maternity and neonatal services to deliver safer, more personalised, and more equitable care, including mental health care, for women, babies and families
- SATOD (Smoking at Time of Delivery) rate to be reduced to 4% or less by 2026
- School readiness: Increase in the percentage of children achieving a good level of development at the end of reception
- Reduction in the neonatal mortality and stillbirth rates
- Reduction in the infant mortality rate

Accountability

- GM Children and Young People's Board
- Population Health Board
- Locality Boards
- GM Maternity and Neonatal System Board

4.2.5 Action: Ageing Well

The pursuit of an age-friendly Greater Manchester is in line with the UN Decade of Ageing and the WHO (World Health Organisation) Age-friendly cities and communities' programme. Our approach focuses on improving financial security, tackling inequalities, and creating places for people to age well through healthy, active, and connected lives. We do this by championing the voice of older people, challenging ageism, growing the GM age friendly movement, and delivering changes across our city region to improve later life. The key themes within the Greater Manchester Age-Friendly strategy are work and money (financial hardship), places, ageing well, and working together.

A unique cross-sector Ageing Hub partnership brings together the Greater Manchester system leadership at the Ageing Hub Executive Group and a range of task groups, to collectively deliver on the strategy, supported by the Ageing Hub team at GMCA. The Ageing Hub works alongside the 10 districts of Greater Manchester to integrate age-friendly approaches at a neighbourhood, district, and Greater Manchester level.

The Greater Manchester Ageing in Place Pathfinder is a £4 million investment (2022-25) by partners, led by GMCA, in eight neighbourhoods to create strong and supportive neighbourhoods to improve connection, health and wellbeing of residents over 50 years of age. The Pathfinder is designed to support the GM, district and neighbourhood partners to test evidence-based approaches and learn to sustain and scale this work across Greater Manchester.

Measuring our Delivery

- Number of neighbourhoods with identifiable Ageing Well Action Plans
- Number of neighbourhoods with identifiable Ageing Well Action Plans
- Demonstrable evidence of the voice and lived experience of older people informing action in the places they live.
- A shared outcomes framework for Ageing Well across all partners to support commissioning (both for older people and the system)
- Age-friendly plans for each district supported by a system-wide partnership for ageing

Accountability

- Greater Manchester Ageing Well Steering group
- Ageing Hub Executive Group
- Greater Manchester Reform Board

- GM Population Health Board

4.2.6 Action: Increase identification and support for victims of violence in all health care settings

We are working collaboratively with partners to develop community-led, whole system approaches to violence reduction, and to refine our ways of working through a Trauma Informed and Responsive lens to enhance wellbeing and prevent the cyclical nature of Adverse Childhood Experiences (ACE).

In response to our statutory safeguarding duties and legal duties (Serious Violence Duty and Domestic Abuse Act) and to fulfil the NHS commitments in the GM Gender Based Violence Strategy[7] and emerging Violence Reduction strategy we will:

- Provide inter-generational support for parents, families, adults and children to prevent ACEs.
- Develop adversity and trauma-informed workforce and services and systems
- Increase societal awareness and supporting action across communities and create a social movement for change to develop as a Trauma responsive City Region
- Develop community-led solutions to violence reduction through culture and sport as part of social prescribing pathways
- Increase identification and support for victims of violence in health care settings, including development of primary care and sexual health services pathways for victims of gender-based violence and Community Navigator pilots in Urgent care
- Develop integrated pathways for victims of sexual assault who have complex mental health problems
- Develop tailored health and well-being pathways for children and young people and women in contact with police, custody, court and probation services and on release from prison
- Establish clear relationships between Community Safety Partnerships, Locality Boards and Health and well-being boards
- Review trends in Domestic Homicide, key themes emerging for the health and care system and mechanisms to ensure learning is applied across the health and care system and built into performance and governance systems

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[7] Gender Based Violence Strategy - Greater Manchester Combined Authority (greatermanchester-ca.gov.uk)

- Complete Serious Violence Needs Assessments in all ten Localities and ensure violence reduction is embedded within neighbourhood, Locality and GM strategies and plans

Measuring our Delivery

- Number of trauma leads and champion roles across third and public sector organisations
- Number of trauma/ACE recognised trainers and professionals working in the health and care system
- Trauma/ACE embedded within communities of practice at neighbourhood, Locality and GM level
- Referrals from urgent and primary care into the Violence Reduction Community navigator programme
- Referral from health and care settings into domestic and sexual violence advocacy services.

Accountability

- Population Health Board
- Locality Boards
- GMCA Gender based Violence Board and Violence Reduction Board

4.3 Area of Focus: Develop a sustainable environment for all

4.3.1 Action: Delivering the NHS Green Plan

Climate change is the greatest global health threat facing the world in the 21st century, but it is also the greatest opportunity to redefine the social and environmental determinants of health (Lancet Commission, 2009).

In May 2022, we published our Green Plan 2022-2025, aligning priorities and carbon budgets with the national NHS Delivering a 'Net Zero' National Health Service report and the GMCA 5 Year Environment Plan. Two overarching goals are outlined:

- To achieve a net zero NHS GM Integrated Care Carbon Footprint by 2038 – this target is the science-based approach outlined in the GMCA 5-Year Environment Plan. We will seek assurance that providers are delivering against their own plans, whilst focusing on priorities that we can deliver most effectively by working together.

- To achieve a net zero NHS GM Integrated Care Carbon Footprint Plus by 2045 – this is a national NHS target to eliminate the carbon impact of the goods and services we buy. We will work closely with national and regional partners to achieve this

Over the next five years we will focus on delivering and scaling up activities outlined in the Green Plan, refreshing this as necessary to ensure it remains current, and maximising the opportunities from collaboration.

We will:

- Ensure all Trusts have robust travel plans in place and work closely with Local Authorities and TfGM (Transport for Greater Manchester) to improve access to sites by active travel and public transport,
- Consider carbon emissions from procurement
- Harness the carbon reduction opportunities presented by digital transformation
- Engage the system-wide workforce with the net zero agenda by developing comprehensive training, awareness and behaviour change programmes
- Embed net zero into commissioning processes and across more clinical services
- Work closely within the NHS GM Anchors Network to drive a more strategic and aligned focus across trusts and localities
- Ensure appropriate prescribing by supporting social and low carbon options, with support for patients to reduce medicines waste

Measuring our delivery

- Total carbon footprint and carbon footprint normalised against activity
- Inhalers carbon footprint
- Increase in active and sustainable travel by staff and patients (as demonstrated through % modal shift in survey responses)

Accountability

- Population Health Board
- GM Net Zero Delivery Board

5 Helping people stay well and detecting illness earlier

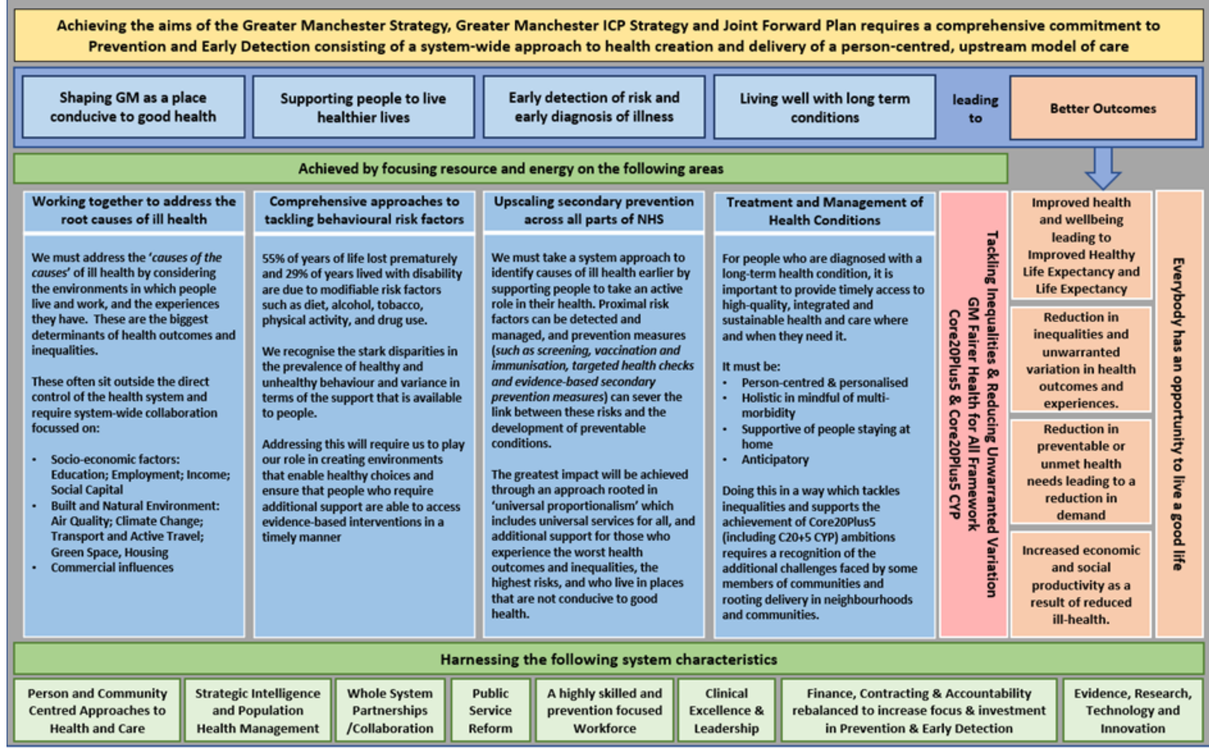
There is a strong rationale for the NHS to increase its focus on prevention and improving population health outcomes. For the past decade, improvements in life expectancy and healthy life expectancy have stalled, and inequalities have widened.

Life expectancy and healthy life expectancy for people born in GM is significantly lower than the England average. Importantly, much of this burden of poor health and early death (borne disproportionately by the most deprived and marginalised communities) can be attributed to conditions that are preventable through coordinated action across the health and care system.

Helping people stay well and detecting illness earlier Delivery Leadership: Locality Boards System Leadership: Clinical Effectiveness and Governance Committee (CEG); Population Health Board	
Areas of Focus	**Actions**
Tackling inequalities	Implementing a GM Fairer Health for All Framework
	Reducing health inequalities through CORE20PLUS5 (adults)
	Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)
	Implementing GM Women's Health Strategy
Supporting people to live healthier lives	A renewed Making Smoking History Framework
	Reducing Harms from Alcohol
	Enabling an Active Population
	Promoting Mental Wellbeing
	Food and Healthy Weight
	Improving Sexual Health Services
	Eliminating New Cases of HIV and Hepatitis B and Hepatitis C
	Increasing the uptake of vaccination and immunisation
Upscaling secondary prevention	Early Cancer Diagnosis
	Early detection and prevention of cardiovascular disease
	Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry
	Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness
Living well with long-term conditions	Managing Multimorbidity and Complexity
	Optimising Treatment of long-term conditions
	Expansion of the Manchester Amputation Reduction Strategy (MARS) across NHS GM
	The GM Dementia and Brain Health Delivery Plan
	Taking an evidenced based approach to responding to frailty and preventing falls
	Anticipatory Care and Management for people with life limiting illness

The complexity and breadth of activity that is required to drive change through prevention and early detection is set out in our GM Framework for Prevention below:

Figure 4



For the purposes of the framework, we have used the broader definition of secondary prevention, used by the UK chief medical officers, to include "evidence based, preventive measures to help stop or delay disease, taken during an interaction between an individual patient and a clinician" [8].

Our framework has four distinct areas of focus:

1. Tackling inequalities and reducing unwarranted variation through Core20Plus5 and the GM Fairer Health for All Framework
2. Supporting people to live healthier lives by implementing comprehensive approaches to tackling behavioural risk factors for illness
3. Upscaling secondary prevention across the NHS (including the early identification of risk and diagnosis of illness, and the effective management to prevent progression).
4. Supporting people to live well with long term conditions through the equitable, effective, and efficient management of diagnosed health conditions

[8] Restoring and extending secondary prevention | The BMJ

We need to put in place more upstream models of care and integrated neighbourhood models that better address the needs of those at higher risk of illness, and those not currently in contact with services. This will require increased population health management capability.

Secondary prevention must be an integral part of all patient care pathways. All medical and allied professionals have an opportunity to 'make every contact count'. Prevention activities also need to be extended to population groups with historically low uptake, and those not in contact with NHS services, to ensure delivery within communities and neighbourhoods.

As set out in the GM Prevention Framework, the NHS also has an important role to play in working across the system with partners to address the root causes of ill health (relating to factors such as poverty, education, work, and housing), and to shape GM as a place that is conducive to good mental and physical health.

5.1 Area of Focus: Tackling health inequalities

5.1.1 Action: Implementing a GM Fairer Health for All Framework

Health inequalities mean that some groups have significantly worse health outcomes and experience than others. These inequalities are avoidable, unfair, and systematic.

Reducing health inequalities is a priority for NHS GM and we continue to work in partnership across the NHS, local government, and voluntary sector to take comprehensive approaches to address the socio-economic causes of poor health. In doing so, we must ensure that we address the profound inequalities experienced by those communities that face specific challenges in accessing health and care services and those at greatest risk including rough sleepers, migrants and people in prescribed places of detention.

We have worked with system partners and communities to codesign a Fairer Health for All Framework to ensure that health equity and equality and sustainability are embedded systematically at the heart of our decision making, system leadership and governance. The Framework outlines our shared principles and provides a set of intelligence, workforce development and leadership tools in the Academy and Intelligence hub which will enable coordinated action to reduce inequalities.

Figure 5

Fairer Health for All Principles

People Power	Proportionate Universalism	Build Back Fairer is everyone's business	Representation	Health Creating Places
• We will work with people and communities, and listen to all voices – including people who often get left out. • We will ask 'what matters to you' as well as 'what is the matter with you' • We will build trust and collaboration and recognise that not all people have had equal life opportunities	• We will co-design universal services (care for all) but with a scale and intensity that is proportionate to levels of need (focused and tailored to individual and community needs and strengths) • We will change how we spend resources – so more resource is available to keep people healthy and for those with greatest need	• We will think about inclusion and equality of outcome in everything we do and how we do it. • We will make sure how we work makes things better, and makes our environment better, for the future. • We will tackle structural racism and systemic prejudice and discrimination	• The mix of people who work in our organisations will be similar to the people we provide services for. For example, the different races, religions, ages and sexuality, and including disabled people. • We will create the space for people to share their unique voice and be involved in decision making.	• As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies • We will focus on place and work collaboratively to tackle social, commercial and economic determinants of health

The Fairer Health for All Academy is creating opportunities for partners to share learning on how they are developing social models for health that go beyond clinical intervention and create upstream models of care that are

- **Person-centred** - involving patients in decision-making and planning their health and social care that shifts the balance of power between patient and clinicians/care givers
- **Trauma-responsive -** promoting the use of non-blaming, non-shaming language that recognises and responds to the patient's experiences of violence, trauma, and adverse experiences
- **Health promoting –** health and care settings that create opportunities for people to eat well, stay active, connect, and access support to live well.
- **Integrated with broader welfare, financial, emotional and social support**, - clear referral pathways into housing, skills, and employment support as wider wrap around support to clinical care.
- **Serving neighbourhoods and communities -** Targeted, inclusive and proportionate to the needs and assets in different neighbourhoods and communities of interest and identity
- **Environmentally sustainable** - maximise access to green spaces and to active travel while minimising the green impact of health and care interventions.

The GM Health and Care Intelligence Hub is a web-based portal that is being co-designed to bring together data, community insight, web-based tools, guidance,

shared learning and workforce development resources to support people working in health and care to better understand health inequalities and variation in care in their areas and implement upstream models of care.

Cross-sectoral intelligence (data and insight from public and VCSE partners accessed via the GM Health and Care Intelligence Hub), supports a shift in how we understand health inequalities across the life course and for people with multiple conditions to inform allocation of resources according to need. This cross-sectoral approach is facilitated through a GM VCSE intelligence group, and investment in VCSE capacity and skills to collate and analyse data and insight.

The Intelligence Hub contains Population Health Management tools which facilitate a shift in how we understand health inequalities across the life course for people with multiple conditions and how we understand the inter-section between different protected characteristics. These tools will support people planning and delivering care to identify and enrol individuals onto acute and chronic disease remote monitoring programmes; mitigate risks of health deterioration; and support the identification of appropriate population level or prevention interventions.

Our key delivery actions are:

- To continue to build and sustain our adaptive capability (analysis, people, and systems) within NHS GM for population health management and strategic intelligence. In years 1 and 2, we will continue the development and application of the record-level longitudinal linked dataset across health and care.We will capture best practice for population health management and design and implement targeted development programmes aligned to major system programmes, including CORE20PLUS5 clinical areas and primary care blueprint priorities. In addition, we will establish a strategic intelligence business 'unit', to support the NHS GM and specifically the PH Board to determine whether the system is going the right things and at the right scale to maximise our city region's health, including a focus on the economics of prevention i.e. what prevention brings to economic growth and health and care demand.

- To launch Fairer Health for All Academy. The Priority learning and development programmes in 2023/24 for the Fairer Health for All Academy include: co-production of a leadership programme, a fellowship programme for people working in the VCFSE sector, primary and secondary care, and establishing at least three communities of practice supporting Live Well, Population Health Management and integrated neighbourhood working.

- To further develop VCSE-primary care partnerships to address the CORE20PLUS5 clinical priority areas. In 2023/4, as part of the implementation of the primary care blueprint we will synthesise the learning from the

CORE20PLUS5 community connector pilot led by the Caribbean African Health Network and the VCSE-PCN partnership pilots into a series of practical guides and tools.

Measuring our Delivery

- Narrow the gap in healthy life expectancy between men and women living in GM and between all ten Localities and the England average
- Reduction in avoidable mortality
- Reductions in health inequality in the onset of multiple morbidities

Accountability

- Population Health Board

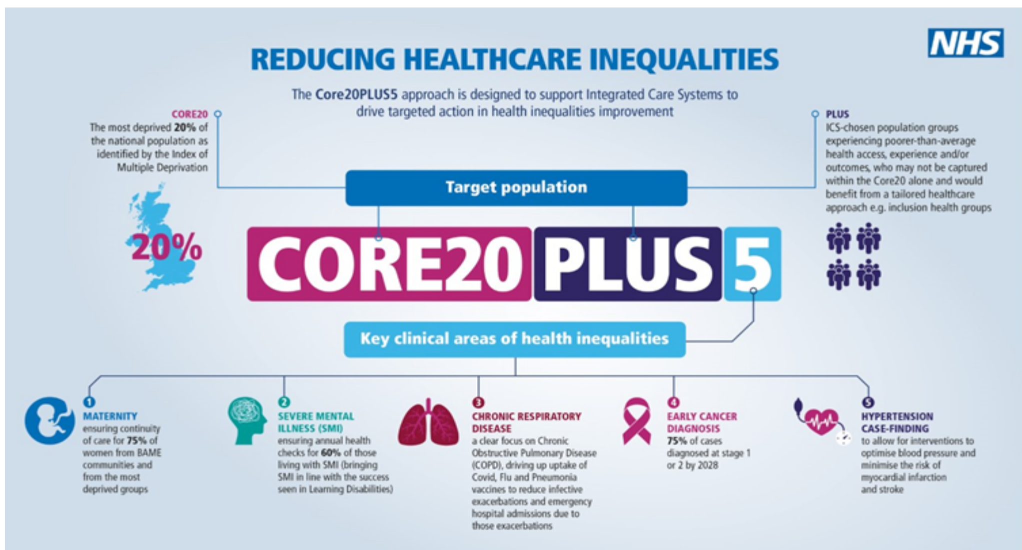
5.1.2 Action: Delivery of CORE20PLUS5 (adults)

The CORE20+5 framework for adults (5.3.

Figure) outlines the key clinical areas that should be targeted to reduce health inequalities.

Of the five clinical areas of health inequalities, severe mental illness annual health checks, chronic respiratory disease, early cancer diagnosis and hypertension case finding are covered in section 5.3.

Figure 6



Maternity

We have developed a Maternity Equity and Equality Action Plan. The plan has been carefully co-designed and co-produced with the people we serve. It is an ambitious and dynamic plan with particular focus on those areas that make the biggest impact:

- Preconception care
- Early access to antenatal services
- Enhanced Midwifery Continuity of Carer
- Personalised Care and Support Planning
- Black and Asian Maternity Equity Standards
- Universal and Targeted vitamin D supplementation
- Embedding of Saving Babies' Lives Care Bundle, including the Smokefree Pregnancy programme
- Addressing raised BMI
- Establishment of Family Hubs across GM

In 2022 the GM Equity and Equality steering group was established which brings together clinical, VCSE, education colleagues to oversee and deliver the Maternity Equity and Equality Action Plan.

The group have already delivered on improvements identified in the plan including the development of Black and Asian Maternity Equity Standards, public facing information materials, working with Maternity Action to support pregnant women at work and the commencement of a student mentor scheme.

Cancer

GM Cancer Alliance established a Cancer Health Inequalities Working group in 2021, and it leads on the health inequalities work programme for the cancer system in GM.

Examples of work include:

- A report commissioned by the Cancer Alliance and undertaken by GMCVO into the inequalities in cancer prevention, diagnosis and care
- A review of GM Cancer's User Involvement Programme assessing what a successful and effective programme looks like and how can it be more diverse and work for everyone

The strategy and implementation plan for 2023-24/5 was approved by the GM Cancer Board in May 2023.

Key priorities are:

- Make health inequalities everyone's business. For the cancer system to achieve its overall goals around early diagnosis, operational performance and personalised care and treatment, health inequalities must be addressed
- Better use of data, understanding health inequalities in the cancer system and the impact we are having
- Target all cancer innovation and improvement to tackle health inequality groups as set out in CORE20PLUS5
- Funding of two health inequalities pieces of research, one to look at how inclusive our cancer research population is and one to increase up take from our ethnic minority communities in cancer clinical trials

Measuring our Delivery

- Ensuring Continuity of Maternity Care for 75% of women from BAME communities and the most deprived groups
- Achieve 75% of cancers being diagnosed at stage 1 or 2 by 2028

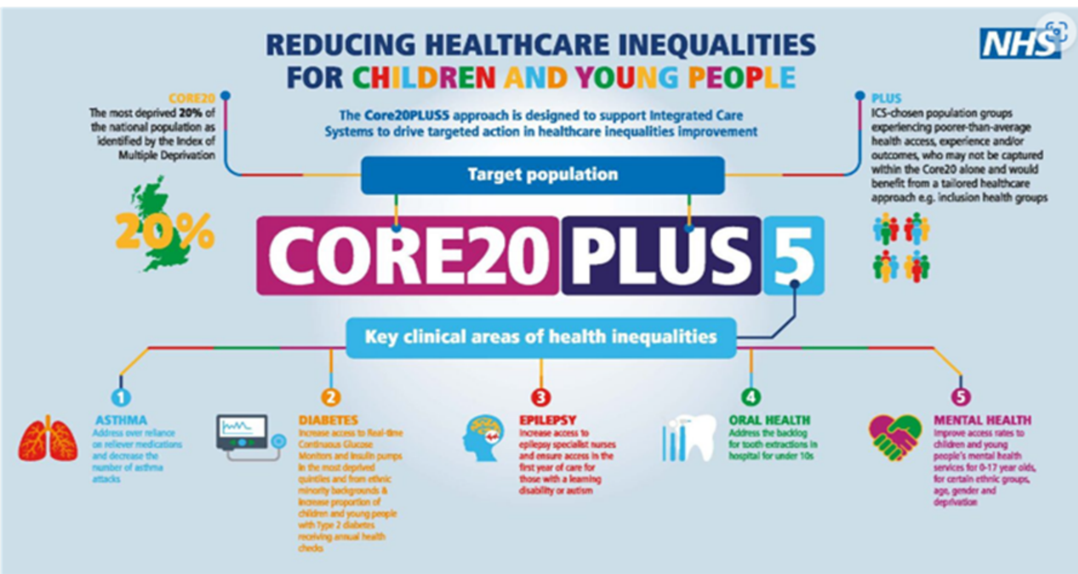
Accountability

- Locality Boards
- Clinical Effectiveness and Governance Committee (CEG)
- Population Health Board
- Quality and Performance Committee
- GM Cancer Board
- GM Maternity Board

5.1.3 Action: Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)

The national CORE20PLUS5 framework for children and young people (CYP) outlines the key clinical areas relating to secondary prevention that should be targeted to reduce health inequalities

Figure 7



Over the next five years, we will:

- Build on the existing partnerships and cross-sectoral leadership in GM, through the newly established GM Childrens Board, to enable a social model of care for CYP so that equity, inclusion, and sustainability are at the heart of all care pathways.
- Asthma - Test out population health approaches to asthma prevention and management through asthma friendly schools' pilots, programmes to develop CYP asthma peer mentors in primary and secondary schools and integrated care pathways
- Diabetes – Implement a whole system approach to enabling CYP and their families to eat well, move more and achieve a healthy weight
- Epilepsy – Review access to Epilepsy Specialist Nurses and epilepsy tertiary services
- Dental and Oral Health – Reduce tooth decay in children by delivering a GM Oral Health Improvement Programme to increase the number of children brushing their teeth every day; improve access to dental services for children; increase the dental practices that are in the Child Friendly Dental Practice (CFDP) Network; develop the dental care pathway for looked after children; and raise the number of sessions for children who need dental extraction(s) in a hospital setting.
- Mental Health – increase access to community and crisis services through support teams working with education settings and implement a core mental health offer for Cared For/Care Leavers including Speech and Language support and Trauma Informed Care

We will draw on the #BeeWell survey to inform and develop our priorities. #BeeWell, the youth-led survey of young people's wellbeing and experiences, was co-designed with 150 young people to provide an insight into how pupils in schools across Greater Manchester. Almost 40,000 pupils in Years 8 and 10 responded to the survey when it was launched in 2021. The survey is the largest of its kind in the country and we plan to expand it further.

Measuring our Delivery

- A reduction in avoidable admissions and emergency attendances for relevant clinical conditions
  - Reduction in rate of emergency admissions for asthma for CYP aged 18 years and under from 180.1 per 100,000 population to 137.12 per 100,000 in line with the North West average by March 2024.
  - Reduction in rate of emergency attendances at hospital for asthma for CYP aged 18 years and under
  - Reduction in rate of emergency hospital admissions for diabetes for CYP aged 18 years
  - Reduction in rate of emergency attendances at hospital for diabetes for CYP aged 18 years and under
  - Decrease in rate of epilepsy-related emergency admissions for CYP aged 18 years and under from 31.98 per 100,000 population
  - Reduction in rate of emergency attendances at hospital for epilepsy for CYP aged 18 years and under from 163.4 per 100,000 population

CYP Asthma
- Year on year reduction in prescription of oral steroids

CYP Diabetes
- Increase access to CGM (Continuous Glucose Monitoring) from 10.9% to 20.9% in the most deprived quintile
- Increase access to insulin pumps from 23.5% to 27.7% in the most deprived quintile
- Minimum of 60% of CYP with diabetes received all 7 care processes.

CYP Epilepsy
- % of children and young people with epilepsy, with input by epilepsy specialist nurse within the first year of care (Minimum 85%)
- % of children and young people with epilepsy after 12 months where there is evidence of a comprehensive care plan that is agreed between the person, their

family and/or carers and primary and secondary care providers, and the care plan has been updated where necessary. (Minimum 74%)
- % of children and young people meeting defined criteria for paediatric epilepsy surgery
- Referral criteria with evidence of epilepsy surgery referral (Minimum 50%)

CYP Oral Health
- Increase the number of settings recruited to the GM Oral Health Improvement Programme
- Reduce the waiting times for proportion of children waiting more than 18-weeks for dental extractions in a hospital setting
- Increase proportion of children and young people (aged 0-18-years) accessing routine and urgent NHS General Dental Service

CYP Mental Health
- Improved access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- The Greater Manchester Assessment and In-reach Centre (GMAIC) available 7 days a week with a 24/7 consultation service to support the wider system with young people presenting in crisis to urgent and emergency settings.
- GM-wide, 24/7 single point of access for all CYP crisis services to improve accessibility and system navigation for referrers and specialist pathways to support looked after young people experiencing emotional distress

Accountability

- Children's System Board
- Population Health Board
- Mental Health and Wellbeing Board
- Quality and Performance Committee
- Clinical Effectiveness and Governance Committee (CEG)

5.1.4 Action: Implementing the Greater Manchester Women's Health Strategy

Inequalities interact in complex ways with socio-economic position in shaping women and girls' health status. We also know that there are systematic gender differences in health outcomes and gender stereotyping impacting on individual decision-making processes regarding health.

In early 2023, we finalised the Greater Manchester Women's Health Strategy. This was a response to the National Women's Health Strategy (2022). The purpose of the strategy is to consolidate all contributions towards advancing women's health outcomes across Greater Manchester in one overarching 10-year strategy.

Measuring Our Delivery

- Create a more collaborative, person-centred, trauma informed approach across different public services to respond collectively to the range of circumstances that contribute to women's disparities across their life course

Accountability

- Population Health Board

5.1.5 Action: Monitoring and targeting of unwarranted variation in outcomes

Pivotal to the system approach to reducing health inequalities is access to cross-sectional data through the GM Advanced Data Science Platform (ADSP). The ADSP has been created to ensure that we have a wide range of interoperable and specialist capabilities to support the creation of insight for clinicians and multidisciplinary teams and intelligence to support service optimisation and population health.

Cross-sectoral intelligence (data and insight from public and VCSE partners accessed via the GM Health and Care Intelligence Hub), supports a shift in how we understand health inequalities across the life course and for people with multiple conditions to inform allocation of resources according to need. This cross-sectoral approach is facilitated through a GM VCSE intelligence group, and investment in VCSE capacity and skills to collate and analyse data and insight.

The GM Health and Care intelligence hub is a web-based portal that is being co-designed to bring together data, community insight, web-based tools, guidance, shared learning and workforce development resources to support people working in health and care to better understand health inequalities and variation in care in their areas and implement upstream models of care.

These technologies enable the development of a record-level longitudinal linked dataset which combines primary, secondary, mental health, social care and community data held in our GM shared care record with other health and care data that is available nationally and via local flows from providers. Using this combined data, we can support clinicians to identify and enrol individuals onto acute and chronic

disease remote monitoring programmes; mitigate risks of health deterioration; and support the identification of appropriate population level or prevention interventions.

Measuring our Delivery

- Continued development and application of the record-level longitudinal linked dataset across health and care

System Leadership

- Population Health Board

5.2 Area of Focus: Supporting People to Live Healthier Lives

We know that if Greater Manchester was a place that enabled people to smoke less, drink less alcohol, do more exercise, and eat better food, it would have a major impact on health and wellbeing. There are also stark disparities in the prevalence of healthy and unhealthy behaviour and variance in terms of the support that is available to people, which in turn drives unacceptable levels of health inequality. We also know that unhealthy behaviours are a symptom of the presence of deep-seated societal and commercial causes of poor health.

5.2.1 Action: A renewed Making Smoking History Framework to deliver our smokefree ambition

We are committed to becoming the first global city region to be smokefree and since 2017 has been delivering the evidence-based Making Smoking History (MSH) Strategy.

Reducing smoking prevalence is integral to GM's approach to tackling inequalities. Becoming a smokefree city region by 2030 creates a unique opportunity to reduce health inequality and increase healthy working life expectancy with ONS estimating that overall healthy life expectancy would increase by just over 6 years for men and 7 years for women if GM becomes smokefree by 2030 (a prevalence of <5%).

An updated Making Smoking History (MSH) five-year framework will be published in Autumn 2023. The refreshed framework will further strengthen our reputation as national leaders in tobacco control through a strong commitment to innovation and research and delivering behaviour change. Over the next five years we will deliver our **GMPOWER** approach:

- **G**rowing our social movement with communities to create change culture, denormalise smoking and turn off the tap of new young smokers. This includes working with housing providers and communities on smoke free homes

- **M**onitoring and evaluating prevalence through the national Smoking Toolkit Study and through increasing research collaboration with academia.
- **P**rotecting people from secondhand smoke. Work will continue through the WHO Bloomberg Partnership for Health Cities to deliver more outdoor smokefree spaces.
- **O**ffering every smoker support to quit, targeted at the most disadvantaged. This includes comprehensive programmes within acute and community services (CURE, Smoke Free pregnancy, SMI mental Health, Targeted Lung Health Checks), as part of a wider model of support delivered through pharmacy, community, and digital.
- **W**arning of the dangers of tobacco through insights driven, multi-media behaviour change
- **E**nforcing regulation across the full range of tobacco and nicotine regulation including action to protect young people from vaping products
- **R**aising the price of tobacco is achieved both through advocacy for national tax increases and GM coordination of a Tackling Illicit Tobacco programme

Measuring our Delivery

- Reduced smoking prevalence in overall population – GM and locality targets
- Reduced smoking prevalence in Routine and Manual groups - GM and locality targets
- Reduced smoking at time of delivery/during pregnancy
- SOF metrics for NHS LTP Treating Tobacco Dependency Programmes

Accountability

- Population Health Board

5.2.2 Action: Reducing Harms from Alcohol

Alcohol is a significant cause of health harms and Greater Manchester residents experience this disproportionately, which culminates in demand for health and care services.

Reducing alcohol harm at a pace which meets our ambitions will require a scaling up and acceleration of our current whole system efforts and extensive collaboration with a range of partners.

Over the next five years we will:

- Develop the independent evaluation of an evidence-based and co-produced NHS GM plan to tackle the health harms associated with alcohol, as a constituent part of a refreshed overarching GM Drug and Alcohol Strategy
- The development of this plan will be underpinned by a strategic evidence and research partnership with the NIHR Applied Research Collaboration (Greater Manchester); comprehensive primary research into the alcohol consumption behaviours of children and young people in Greater Manchester; and focused engagement with high-risk cohorts
- Commission a community-led 'Ambition for Alcohol' aimed at accelerating a social movement for change in Greater Manchester
- Build on our activity to date on tackling the harms associated with alcohol consumption in pregnancy by fully implementing the NICE Quality Standards for Foetal Alcohol Spectrum Disorder (FASD)
- Continue to monitor and evaluate our existing Alcohol Care Teams (ACTs) and improve quality, and reduce variation through the development of a GM Community of Practice

Measuring our Delivery

The impact of our activity will be measured by closing the gap to the national average for:

- Alcohol specific mortality
- Admission episodes for alcohol specific conditions
- Admission episodes for alcohol specific conditions – Under 18s

Accountability

- Population Health Board
- Drug and Alcohol Programme Board

5.2.3 Action: Enabling an Active Population

Greater Manchester Moving is our social movement of people, communities, and organisations, from every sector and place across the city region, with a shared goal of enabling Active Lives for All, aligned behind the knowledge and belief that:

- Moving matters to us all
- We need to design movement back into our lives
- Everyone has a role to play

'GM Moving in Action 2021-31' sets out our collective strategy and system approach for achieving this mission, making it easier for people to move more and a natural part of how we all live, travel, work, and play.

Approximately 30% of the GM population are still not experiencing the health benefits of physical activity and the patterns in the data reflect the social determinants of health and point to a need for culture, systems, and behaviour change. We have identified where GM Moving can support the missions of the ICP strategy These are outlined below and will be the focus of our collective efforts in this area in the next three to five years.

- While You Wait – supporting people waiting for hospital treatment
- Deconditioning and Falls Prevention
- Mental Health and Wellbeing
- Health and Care Workforce Wellbeing
- Priority Clinical pathways (Respiratory, CVD and Cancer)
- Healthy Active Places
- Women's Health

We will:

- Embed GM Moving (movement, physical activity, and sport) across the health and care mode through a universal and targeted approach to tackle inequalities in inactivity
- Continue to connect with national and international networks such as the Active Partnership Network and the Global Community of Practice, to learn from, and share our understanding of whole system approaches to physical activity

Measuring our delivery

- Reduce inequalities by increasing physical activity rates amongst the groups most likely to be physically inactive, with a specific focus on lower socio-economic groups; culturally diverse communities; disabled people; people with long-term health conditions
- Reduce whole population inactivity rates as measured by the active lives survey and close the gap to the national average

Accountability

- Population Health Board

5.2.4 Action: Promoting Mental Wellbeing

It is our ambition to create a unified, integrated, and equitable system in which every child, adult, and place matters. We aim to achieve this through our new GM Mental Health and Wellbeing Strategy.

The strategy recognises a need to focus on early intervention and prevention. Poor mental health and ill health has its roots in our experiences and opportunities in early life and throughout the life course. We know that some individuals, communities, and cohorts are at greater risk and are underserved by the support that exists.

Our key workstreams include:

- Tackling inequalities through the allocation of grant funding to the VCSE sector to focus on those individuals, communities, and cohorts who are at greater risk
- Delivering training and development to boost the understanding, confidence and skills of the wider health and social care workforce in relation to responding to poor mental wellbeing and building positive mental wellbeing
- Raise population level awareness to enable more people to identify and access timely self-help, support and services if required that will improve outcomes and reduce the need to access clinical support.
- Continue to deliver workforce training, such as Connect 5, that is based on best practice and trauma informed evidence to inform and support our workforce to deliver better mental wellbeing outcomes for population
- Use the information and insight gathered in the #BeeWell survey of young people's wellbeing to inform and develop our priorities – including on mental wellbeing.

Measuring our Delivery

- Improved wellbeing, satisfaction, worthwhile, happiness and anxiety as measured through the national ONS survey questions and the supplementary data provided by the quarterly GM Residents Survey
- 10% reduction in population reporting they do not know how to access timely self-help and further support by the end of 2023/24 and a 100% reduction by the end of the 5-year period meaning that every person in GM knows how to access self help and support if they require it

Accountability

- GM Population Health Board
- GM Mental Health Programme Board

5.2.5 Action: Food and Healthy Weight

Obesity and poor diet are linked with numerous health conditions. In GM, nearly two-thirds of adults (65.8%), and 40% of children in year six, are classified as overweight or obese (significantly higher than the England average)[9].

There is a strong relationship between obesity and deprivation, and rates are higher in some ethnic minority groups. Creating opportunities for people to be a healthy weight requires a whole system approach, and policies and programmes at neighbourhood, city-region, national and international levels. We will:

- Initially focus on supporting a whole system approach to food and healthy weight for pregnant women, children and young people and families
- Further develop primary care pathways into weight management services that align the local well-being offer with the national digital weight management programme.

Measuring our Delivery

- Increase in healthy weight prevalence for Y6 pupils across GM from 58.4% (latest GM data for 2021/22) to 60.8% (latest England average for 2021/22).
- Reduction in prevalence of overweight (including obesity) for Y6 pupils across GM from 40% (latest GM data for 2021/22) to 37.8% (latest England average for 2021/22).
- Reduce the prevalence of overweight and obesity in adults

Accountability

- GM Population Health Board

5.2.6 Action: Improving Sexual Health Services

A high-quality system for sexual and reproductive health across Greater Manchester will ensure that everyone living in GM is able to exercise personal choice and self-management regarding sexuality, sexual health, and contraception, so they can access the right support where and when they need it. It should offer open access high quality, confidential services, and the pathways between primary and secondary care should be clear. Schools and services focused on young people play an important

[9] Obesity Profile - Data - OHID (phe.org.uk)

role in ensuring they have access to education and support to enable them to build healthy relationships and protect themselves from sexual exploitation.

To this end, the Greater Manchester Sexual Health Network (GMSHN) is currently updating the GM Sexual Health Strategy and this work will be completed in 2023/24.

Measuring our Delivery

- Diagnosis rate of STIs (syphilis, gonorrhoea, chlamydia)
- Under 25s repeat abortions
- Abortions under 10 weeks
- Total prescribed LARC (Long Acting Reversible Contraception)
- Under 18s conception rate

Accountability

- GM Population Health Board
- GM Sexual Health Network

5.2.7 Action: Eliminating New Cases of HIV, Hepatitis B and Hepatitis C

GM has some of the highest diagnosed prevalence rates of HIV in the country, and The prevalence of HIV in GM is among the highest in the country, and over a third of diagnoses are made at a late stage. Preventing HIV, hepatitis C (HCV) and hepatitis B (HBV) virus infection, diagnosing them early, engaging people in care and starting treatment at an early stage are all critical to preventing the associated health consequences, including premature death, and to preventing onward transmission.

Towards Zero – the HIV action plan for England outlines plans to reach zero new transmissions of HIV by 2030, with an interim target of an 80% reduction in HIV transmissions by 2025. For GM, this means a target of under 35 new diagnoses a year by 2025. NHSE has also set out its ambition to eliminate HCV by 2025; five years earlier than WHO targets for hepatitis. In 2018, the Mayor of Greater Manchester and all 10 Council leaders signed the Paris Declaration and Greater Manchester joined the Fast-Track Cities Initiative, committing to achieve the UNAIDS targets for HIV (which GM has now reached and exceeded). In the same year, a transformation programme (‘ending all new cases of HIV in Greater Manchester within a generation’ - HIVe) was launched.

Over the next five years, we will:

- Continue to support the delivery and development of HIV and HCV opt-out testing at Manchester University NHS Foundation Trust (MFT)
- Support mobilisation and development of HIV and HCV opt-out testing at Salford Royal Hospital
- Work towards including HBV in ED opt-out testing projects (as done in Greater London) and scope out the feasibility of extending blood-borne virus testing to additional sites in GM, aiming for a GM-wide testing approach
- Continue investment and activity in the HIVe programme, and co-design of proposals for the next phase. This will be informed by community insights work, commissioned to identify populations not reached by HIVe activities to date, and to identify the barriers and facilitators to accessing care and support, by increasing education, tackling stigma, and supporting activities aligned to Greater Manchester's Fast Track City status
- Continue coordinated activities to end new cases of HCV and HBV through prevention (including good IPC, health improvement messaging and HBV vaccination), harm reduction, and testing and treating target populations

Measuring our Delivery

- Increase in the proportion of eligible people attending participating emergency departments who are tested for HIV and/or HCV/HBV on an opt-out basis
- Reduction in the proportion of diagnosed HIV made late (among people first diagnosed in the UK).
- Increase in the proportion of people living with HIV who have a diagnosis, are on treatment and who maintain a fully supressed virus.
- Reduce new infections of HCV and HBV by 90% by 2030.

Accountability

- GM Population Health Board
- GM Sexual Health Network
- GM Blood Borne Virus (BBV) Opt Out Testing Steering Group

5.2.8 Action: Increasing the uptake of vaccination and immunisation, particularly amongst groups with the lowest uptake and the worst health outcomes.

High immunisation rates are key to preventing the spread of infectious disease, the associated complications, and premature death[10]. However, there are avoidable inequalities in immunisation rates between population groups, and the likelihood of complete and timely vaccination is influenced by variables such as where people live, their socio-economic status and their ethnic group[1].

Since the COVID-19 pandemic, vaccine uptake rates for routine childhood programmes have fallen globally. Coverage for the measles, mumps, and rubella (MMR) vaccination programme in the UK has also fallen to the lowest level in a decade. Uptake of the first dose of MMR by two years of age, and uptake of both doses of MMR by five years of age is below the 95% threshold across GM and has dropped in almost all locality areas compared with pre-pandemic.

Over the next five years, we will:

- Finalise and implement the GM winter vaccination strategy for COVID and flu once the upcoming national immunisation strategy is published
- Aligning with national plans, bring forward the second dose of the MMR vaccine from 3 years 4 months to 18 months of age (implementation by 2024/25) to improve coverage
- Review, refresh and then implement (Q2-4 2023/24) the GM measles and rubella elimination strategy action plan in collaboration with stakeholders across the system
- Commission behavioural insight work to understand the motivators, drivers, situational changes, nudge factors and steps that lead to positive attitudinal and change in members of communities where vaccine uptake is low and implement strategies to effect change
- Support catch up vaccination in response to health protection incidents

Measuring our Delivery

- Achieve and sustain ≥ 95% coverage with two doses of the MMR vaccine in the routine childhood programme (<5 years old)

[10] PHE Immunisation Inequalities Strategy (publishing.service.gov.uk)

- Increase the proportion of people over 65 receiving a seasonal flu vaccination to ≥ 85
- Demonstrate improvements in flu and COVID-19 uptake, and reduce inequalities in uptake in specified cohorts

Accountability

- GM Population Health Board
- Screening and Immunisation Oversight Committee

5.3 Area of Focus: Upscaling Secondary Prevention

Secondary prevention refers to a wide range of the activities included throughout this mission: from supporting people to take an active part to improve their own health by promoting healthier behaviours; to earlier detection and diagnosis of illness; to high impact interventions for the prevention and treatment of cardiovascular disease, diabetes, and respiratory disease

5.3.1 Action: Early cancer diagnosis through screening and early detection

Cancers are a significant driver of avoidable mortality. Effective cancer screening programmes and other activities that increase the proportion of cancers diagnosed at an early, more treatable stage have a central role to play in reducing premature mortality and morbidity.

The NHS Long Term Plan outlines the ambition for 75% of people with cancer to be diagnosed at an early stage (stage 1 or 2) by 2028. Research shows that eliminating socioeconomic inequalities in stage at diagnosis across several different cancers could result in a 4% shift to early-stage cancer diagnosis[11] .

Over the next five years, we will implement improvements to cancer screening programmes to improve access and maximise uptake. These include:

- Continue staged roll-out of the NHS Bowel Cancer Screening Programme to younger age groups in line with the NHS Long Term Plan ambition to lower the starting age to 50. During 2023, we will continue the rollout to 54-year-olds, and then progress to 50- and 52-year-olds in 2024/25

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[11] Socio-demographic variation in stage at diagnosis of breast, bladder, colon, endometrial, lung, melanoma, prostate, rectal, renal and ovarian cancer in England and its population impact - PubMed (nih.gov)

- Remodel regional breast screening services for GM to deliver the infrastructure and integrated models of care to provide a high quality, efficient, sustainable service for all patients
- Implementing 5-year screening intervals for women aged 25 to 49 testing HPV negative on a routine screen
- Commission bowel, cervical and breast screening behavioural insights work to improve understanding of the barriers and motivators to accessing cancer screening for populations across GM. This will be completed in Q1 and 2 of 2023/24 and inform a GM wide communications campaign and future commissioning approaches

We will implement the GM Cancer Alliance 2023-24 programme of work on early diagnosis. This is overseen by the Early Diagnosis Programme Board. The work includes:

- Patient and public awareness to promote timely presentation – ongoing programme of communication with locality support and involvement. Funding to be allocated to support this in 2023-24, at a GM and locality level
- Primary Care Pathways – primary care engagement and education to support delivery of the Early Diagnosis Primary Care Network Direct Enhanced Service. Testing new referral pathways, including the national pharmacy referral pilot – GM is one of three national pilot sites
- GP Direct Access Diagnostics – ensuring GP have access to the appropriate range of pre-referral diagnostics and encouraging use of the established 'non-specific symptoms' (NSS) pathways.
- Targeted Lung Health Checks (TLHC) – continued delivery and further expansion of this programme across Greater Manchester. This project is supported by additional targeted funding allocated to the Cancer Alliance
- Cancer Screening Programmes – joint work with the NHSE/I Screen and Immunisation Team and colleagues in primary care to improve uptake of the three cancer screening programmes and reduce inequalities in access, experience and outcomes.

Measuring our Delivery

- Increasing and maintaining breast cancer screening coverage to ≥70% and reduce inequalities between specified cohorts.
- Increasing and maintaining cervical screening coverage (under and over 50) to ≥80% and reduce inequalities between specified cohorts.
- Increasing bowel cancer screening coverage in all age cohorts (aged 50-74 years) and reduce inequalities between specified cohorts.

- Reduction in the under 75 mortality rate from cancer considered preventable
- Increase the proportion of people with cancer diagnosed at an early stage (1 or 2) to ≥75% by 2028
- Meet the Faster Diagnosis Standard (FDS) Standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days

Accountability

- Population Health Board
- Cancer Board
- Locality Boards
- Primary Care System Board
- Screening and Immunisation Oversight Committee

5.3.2 Action: Early detection and prevention of Cardiovascular Disease

We will improve earlier detection of undiagnosed illness and earlier identification will enable earlier initiation of treatment. Given the inequity in health outcomes we currently see across GM, these key activities will focus on reducing inequalities in access and experience of healthcare and in reducing unwarranted variation in earlier diagnosis rates.

Earlier diagnosis of CVD

Whilst Cardiovascular disease (CVD) Prevention involves optimising and streamlining clinical pathways and areas, the underlying complexity and overlap with social and wider determinants of health means that a concerted system response is required. This needs to be combined with new ways of working with and for our communities: starting to change the dialogue from one about patients to people.

CVD has been identified as the single biggest area where our NHS can save lives over the next 10 years. The NHS Long Term Plan aims to prevent up to 150,000 heart attacks, strokes, and cases of dementia over 10 years. Key areas of focus include:

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

Modifiable risk factors explain 90% of CVD incidence and up to 80% of premature deaths from CVD are preventable[4]. Many people are living with common, treatable risk factors that significantly increase the risk of developing CVD:

- High blood pressure affects 1 in 4 adults, of whom half are undiagnosed or not receiving treatment. In GM, only 61% of adults with hypertension are treated to target.
- Nearly half of adults have cholesterol above recommended guidelines. In GM, 62% of people with no CVD, but a QRISK (Heart Attack and Stroke Risk Calculator) score of 20% or more are on lipid lowering therapy
- An estimated 1.4 million people have atrial fibrillation (AF), of whom almost 500,000 are undiagnosed and untreated12. In GM, around 89% of adults with AF and a CHA2DS2-VASc (Score for AF Stroke Risk) score of 2 or more are currently treated with anticoagulants

In general, GM figures are lower or worse than the England average, with variation between local authority areas in terms of both the prevalence and management of these risk factors.

NHS health checks are a crucial part of our prevention plans. We will continue to drive uptake of health checks across GM by:

- Focusing NHS Health Check recovery on high-risk priority people and explore mixed models of delivery to increase engagement
- Maximise impact of the programme by increasing prescribing of hypertensives and statins, referral into prevention programmes and links into wider welfare and support
- Explore a GM training approach which supports consistent and high-quality delivery and performance with a strong focus on effective behaviour change which is strength based and aligns to approaches to social prescribing and personalised care.

We will improve the identification and treatment of people with Hypertension by:

- Community pharmacy blood pressure case finding service. We have 456 community pharmacies providing a blood pressure (BP) case-finding service. These will be supported by the development of guidance for primary care around collaborating with community pharmacies.

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[12] Prevalence | Background information | Atrial fibrillation | CKS | NICE

- Supporting opportunistic blood pressure screening across all health and social care settings, making every contact count. Following the national rollout of the BP@home scheme, GM distributed over 10,000 BP machines across GP surgeries throughout so that patients can record their own blood pressure and send their readings to their GP practice to review

Measuring our Delivery

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Reduction in prevalence gaps across our localities
- Reduction in inequalities in outcomes
- Improvement in the expected vs recorded prevalence of illnesses across differing socio-economic and ethnic groups
- Increased use of Community Pharmacy blood pressure case finding service
- Increased recorded prevalence of NDH (Non-Diabetic Hyperglycaemia) diabetes, hypertension, high cholesterol, obesity and behavioural risk factors

Accountability

- GM CV Prevention and Cardiac Board
- GM Clinical Effectiveness Group
- Locality Boards
- Primary Care System Board

Lipid management: Improve the identification and treatment of people with high cholesterol

Currently in GM we have approximately 11,000 patients who have had a CVD event, known to need basic statin medication to manage their cholesterol but who are not receiving this medication (cohort 1), plus a further 8,000 patients who are maximised for statin medication and yet their cholesterol levels remain unmanaged (cohort 4). These two cohorts are the two highest risk patient cohorts for our populations in terms of developing further cardiovascular events (such as a stroke or a heart attack). Our key actions in this area include:

- Development of a GM bespoke risk stratified case management tool Enabled on the Greater Manchester Shared Care Record, allowing system level data insight – shared with localities

- Development of lipids educational and training resources, including webinars, case management tool, medication pathway.
- An enhanced clinical pharmacist third-party review service for primary care supporting the optimisation of lipid lowering therapies for high-risk patients

Measuring our Delivery

- Improvements in the numbers of patients across the highest risk cohorts who are initiated on therapy against pathway criteria 1 and 4
- We conservatively estimate that optimising these patients will realise a 17% reduction on Major Adverse Cardiovascular Events (MACE) + events, 15% in MACE events and a total of 1,067 non-fatal events avoided
- Improvements in the proportion of patients who are optimised against the Accelerated Access Collaborative medication pathway

Accountability

- GM CV Prevention and Cardiac Board
- GM Clinical Effectiveness Group
- Locality Boards
- Primary Care System Board

5.3.3 Action: Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry

There are thousands of people in GM who have COPD but are undiagnosed. NHS RightCare estimate this to be around 19,000. Spirometry is essential for the diagnosis of respiratory conditions such as COPD and asthma. Limited spirometry has been provided across Greater Manchester since COVID-19 due to infection prevention and control measures. Spirometry restart is necessary for the diagnosis of patients presenting with new symptoms but also to catch up on the backlog of people who have been unable to access spirometry over the past three years. Spirometry provision will be embedded in the community so it can be aligned with Community Diagnostic Centres (CDCs). Spirometry is best delivered to patients close to their home and in

General Practices within Primary care networks, and the provision of it should be quality assured. FeNO[13] is also an integral part to make a diagnosis of asthma.

Our focus is on achieving the following outcomes:

- To increase the number of people accurately diagnosed with COPD, asthma
- To increase the proportion of people diagnosed with COPD confirmed using post bronchodilator spirometry that is quality assured
- To increase the proportion of people with COPD who are diagnosed compared to predicted prevalence
- To reduce the risks related to inappropriate treatment of individuals misdiagnosed, and the associated medicines waste and environmental impact

Measuring our Delivery

- Decrease Backlog in Spirometry
- Reduce respiratory referrals into secondary care
- Increase in diagnostic spirometry for children
- Increase the number of people who have been diagnosed with Asthma/COPD and have a quality assured spirometry on record

Accountability

- Primary Care System Board
- GM Clinical Effectiveness and Governance Group

5.3.4 Action: Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness (SMI)

Learning from lives and deaths - people with a learning disability and autistic people (LeDeR) is an NHS England service improvement programme. Its purpose is to improve the quality of health and social care for people with a learning disability by requiring a review of the care received by a person after their death. The role of health checks is key in supporting earlier access to healthcare and earlier detection of unmet health needs.

[13] Medical technology used to aid in the diagnosis of asthma. FeNO devices measure fractional exhaled nitric oxide in the breath of patients.

We are committed to increasing the number of people with SMI having an annual physical health check. We know that people living with severe mental illness face one of the largest equalities gaps in England. The life expectancy for people with SMI is 15-20 years lower than the general population and this disparity is partly due to physical health needs being overlooked. Smoking is the largest avoidable cause of premature death, with more than 40% of adults with SMI smoking. By ensuring that people with SMI have access to annual physical health checks, we can address this inequality and help people to live healthier lives for longer.

The CORE20PLUS5 Framework sets out the ambition for at least 75% of those living with a Learning Disability and at least 60% of those living with SMI to receive an annual health check.

Over the next five years, in partnership with experts by experience, we will:

- Work with General Practice to increase the numbers of people with Learning Disability on the General Practice Learning Disability register to reduce the numbers of those ‘missing’ from the register
- Increase both the uptake and quality of LD Annual Health Check (AHC), including provision of meaningful Health Action Plans (HAP) to meet (or exceed) national target of 75%
- Develop and provide quality information for people with Learning Disability, families, health, and social care providers
- Deliver health cafes, providing a structured platform to share accessible evidenced based information to people with Learning Disability
- Continue to co-produce and embed innovative models to improve access for SMI patients and their physical health checks using principles of Making Every Contact Count
- Ensure people are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvements in their physical health through personalised care planning. This will address the full needs of the person taking steps to combat loneliness, isolation and promoting wider engagement in self-care, exercise, healthy eating and lifestyle
- Ensure that primary care teams continue to carry out annual physical health assessments and follow-up care for patients who are not in contact with secondary mental health services and patients with SMI who have been in contact with secondary care mental health teams for more than 12 months and /or whose condition has stabilised

- Ensure that secondary care teams continue to carry out annual physical health assessments and follow-up care for patients with SMI under the care of a mental health team for less than 12 months and/or whose condition has not yet stabilised

Measuring our Delivery

- Achieving 75% uptake rate for annual health checks for those with Learning Disability across NHS GM
- Increase in those from ethnically diverse communities on register and having an LD AHC/HAP
- Increase in young people aged 14-25 on GP register and having an LD AHC/HAP
- Increase in LeDeR reviews identifying positive impact of AHC/HAP (and decrease in those not having one)
- Achieving 60% uptake rate for annual health checks for those with Severe Mental Illness across NHS GM

Accountability

- The GM LD&A delivery Group
- The GM Good Health Group
- The GM LDA Strategic Group
- GM Mental Health Board
- GM Clinical Effectiveness and Governance Group

5.4 Area of Focus: Living Well with long-term conditions

We have described the actions to prevent the worsening of disease, particularly of CVD, Diabetes and Respiratory disease. We now move focus to consider how we can support those with established long-term conditions to live well. The focus on prevention at every stage of the patient journey is to improve health and reduce severity of illness and to shift the balance away from care in hospitals towards care at home, with appropriate support.

5.4.1 Action: Managing Multimorbidity and Complexity

Multimorbidity is a term used to describe the presence of two or more long-term health conditions, and includes both physical and mental health conditions, ongoing

conditions such as learning disability, symptom complexes such as frailty or chronic pain, sensory impairment such as visual loss and alcohol/substance misuse[14].

Over the next five years, we will:

- Obtain the data to understand the prevalence of those living with multimorbidity in Greater Manchester, with a particular focus on identifying inequity and unwarranted variation
- Develop a strategic multi-morbidity approach to long term conditions, which will include person centred care and shared decision making aligned with the national Major Conditions Strategy.
- Establish a systemwide approach to Chronic Musculoskeletal Conditions (including back pain), Chronic Pain and Chronic Fatigue

Measuring our Delivery

- We will design/develop an approach to multimorbidity in years 1-2 of the Joint Forward Plan
- We will evidence delivery of this over years 3-5

Accountability

- GM Clinical Effectiveness and Governance Group
- GM Population Health Board

5.4.2 Action: Optimising treatment of long-term conditions

The focus here is the optimal treatment of the three main conditions driving preventable disability and mortality - cardiovascular disease, diabetes and respiratory disease

Cardiovascular Disease

Following a cardiac event, such as a heart attack, research shows that cardiac rehabilitation has a positive impact on wellbeing and quality of life and can also reduce the risk of being re-admitted into hospital with subsequent cardiac events.

Measuring our Delivery

Our aims are:

[14] Recommendations | Multimorbidity: clinical assessment and management | Guidance | NICE

- 85% of eligible Acute Coronary Syndrome patients attending cardiac rehab
- 33% of eligible and newly diagnosed Heart Failure patients completing a personalised cardiac rehabilitation programme by 2028/29

Accountability

- Quality and Performance Committee

Improving access to diagnostics for people with Heart Failure

People with Heart Failure are often admitted to hospital due to limited access to diagnostics and treatments in the community. Improving access could prevent up to 230,000 hospital admissions and 30,000 deaths from heart and circulatory diseases over the next decade in England.

We will use digital services to support improvements. These include:

- GM heart failure digital care plan. We are working together to transform care planning in HF to a standardised digital heart failure care plan that can be utilised across care settings via the GM Care Record. It will support patients to be managed more effectively within the community while also empowering patients to take greater control and be more informed. It is currently being piloted in Rochdale and Tameside with a view to spread across the whole of GM.
- Remote Monitoring for Heart Failure. We are testing out a remote monitoring platform that allows people with heart failure to be monitored remotely

Measuring our Delivery

- Roll out of standardised digital heart failure care plan

Accountability

- Quality and Performance Committee

Improving survival rates for Out of Hospital Cardiac Arrest

Cardiopulmonary resuscitation (CPR) is attempted in nearly 30,000 people who suffer out-of-hospital cardiac arrest (OHCA) in England each year, but survival rates are low and compare unfavourably to other countries.

Many lives can be saved if:

- CPR and early defibrillation are undertaken promptly and more often
- The whole pathway of care from successful resuscitation to subsequent rehabilitation were improved.

We will work with the British Heart Foundation to roll out training initiatives to support education on the use of defibrillators.

Measuring our Delivery

- Our ambition in GM is to increase the survival rates for our patients to 25%.

Accountability

- Quality and Performance Committee

Diabetes

Over 170,000 people are living with Diabetes in GM and many others are at risk of developing the condition. We reviewed and refreshed the GM Diabetes Strategy in 2022.

Our main areas of delivery include:

- Structured Diabetes Education is being in adapted to offer it in more culturally appropriate formats for different communities (South Asian, Black and Afro-Caribbean, Deaf people, visually impaired people)
- The nationally commissioned BHS Type 2 Diabetes Pathway to Remission (formerly known as low-calorie diet) is being offered across GM, providing a 12 week total diet replacement course under clinical supervision
- Healthier You, the national diabetes prevention support offer, is being offered across GM with 14,000 places available each year
- A Diabetes Transition Strategy is being developed to set out the GM vision for improved transition for children living with diabetes into adult care services
- Diabetes My Way (www.diabetesmyway.nhs.uk) provides self-management support for people living with diabetes in GM by providing access to their own GP diabetes data dashboard, personalised advice, digital structured education, and support resources

Measuring our Delivery

Using the GM Diabetes Intelligence Dashboard, we will measure key metrics at practice, PCN, locality and GM level, including:

- The prevalence of diabetes in GM
- Number of referrals and programme starts in the National Diabetes Prevention Programme
- Number of patients completing all 8 diabetes care processes (and individual care processes)

- Number of patients achieving all 3 diabetes treatment targets (and individual treatment targets)
- Number of patients attending structured diabetes education
- Number of referrals and programme starts into the NHS Type 2 Diabetes Pathway to remission programme
- Number of diabetes patients living with additional risk factors and/or other long-term conditions

Accountability

- GM Diabetes Board
- GM Clinical Effectiveness and Governance Group

Respiratory Disease

In GM in 2019, 26.78% of all respiratory hospital admissions were due to influenza or pneumonia. Influenza and pneumonia are one of the highest areas of spend due to non- elective admissions (source NHS RightCare).

The uptake of influenza, covid and pneumococcal vaccination varies across GM localities and across risk groups and all age groups. Increasing uptake rates of these vaccinations for people with respiratory disease, will lead to avoidance or reduction in severity of winter respiratory illness for the individual and reduce avoidable unplanned admissions to hospital.

We will work with vaccination and immunisations teams (as described in section 5.2.8) to deliver a comprehensive and targeted offer of vaccination for those with respiratory disease

Measuring our Delivery

- Reduction in hospital admissions due to influenza and pneumonia

Accountability

- Quality and Performance Committee

COPD

Prevention of COPD by supporting people to stop smoking and earlier detection of COPD through quality assured Spirometry is considered earlier in this plan. Once COPD has been diagnosed, the priority turns to enabling a good quality of life by preventing progression and complications. Respiratory conditions are long-term

conditions, with stable periods and exacerbations, and many patients experience deterioration over time. This means the access to services is an important aspect of care.

We will enhance and expand the Pulmonary Rehabilitation (PR) programme across GM. We have established a GM PR collaborative to reduce variation in offer, standards and access. Over 2023/24, we will roll out the standardised PR educational booklet; work with community teams to provide early education sessions; continue to work towards national accreditation.

We will explore community based and led rehabilitation/ patient expert education group models and will work with other rehabilitation groups (e.g., cardiac rehabilitation) to provide a person-centred offer which encompasses other rehabilitation and chronic disease education.

Measuring our Delivery

- Achieve nationally recognised accreditation standards for all pulmonary rehabilitation services
- Reduction in waiting times for PR
- Increase in choice of delivery of PR

Accountability

- Quality and Performance Committee

5.4.3 Action: Role out the Manchester Amputation Reduction Strategy (MARS) across NHS GM

The Manchester Amputation Reduction Strategy (MARS) is an example of a 'whole systems' approach to a single clinical problem: *How do we reduce lower limb amputations secondary to chronic disease across Greater Manchester?* A multi-disciplinary team came together to co-design a solution.

The work began with understanding amputation inequalities across regional, gender, ethnic and diabetes groups. An amputation is often the result of an ulcer that is inadequately treated which itself is often the result of chronic disease that is, itself, poorly managed.

MARS has 4 programmes of work being developed and becoming ready to scale up;

- ***'Move More':*** Improve physical activity in the general and ulcer population by linking Public Health services with clinical pathways both face to face and digitally
- ***'Reduce Inequality more':*** Level up access for all lower limb ulcers to the diabetes standard
- ***'Diagnose more':*** Raise capabilities and confidence of community nursing and podiatry teams to perform more non-invasive vascular assessments
- ***'Make every contact count more':*** Use Public Health Screening programmes e.g., aneurysm screening to case-find undiagnosed conditions of concern e.g., depression, hypertension and peripheral arterial disease

Measuring our Delivery

- Enable equity of access to community podiatry services by patients with foot ulcers regardless of diabetes status
- Raise uptake levels of screening from areas with high levels of deprivation and ethnic minorities
- Raise capability of community nursing and podiatry teams to perform and interpret non-invasive lower limb vascular assessments and reduce referrals into vascular surgery by 25%

Accountability

- Cardiac SCN
- Clinical Effectiveness and Governance Committee (CEG)
- Locality Boards
- Population Health Board

5.4.4 Action: The GM Dementia and Brain Health Delivery Plan

Dementia is a priority for Greater Manchester. Our vision is to improve the experience of being diagnosed and living with dementia and make GM the best place to live for all those affected,

Our Strategic Aims are:

- Improving connections, quality of care and experience for everyone affected by dementia
- Promote brain health and help prevent avoidable cases of dementia, supporting wellbeing and independence
- Design, develop and facilitate education and training across all sectors

- Increase access to benefits of dementia research through awareness, involvement and participation
- Co-produce and develop a dashboard which will fully reflect lived experience, quality of care and quality of life for people affected by dementia

We are working hard to increase the dementia diagnosis rate (DDR) to pre-pandemic levels. The Greater Manchester DDR is currently above the national target (66.70%) with an average of 70% in 2022/ 2023. This is key to supporting people to live well at home for as long as possible and avoid care home or hospital admission.

Measuring our Delivery

- The longer-term ambition is for GM to recover pre-pandemic levels which reached 76% in 2018/2019. Immediate target to reduce variation across GM and to ensure that all boroughs have recovered the dementia diagnosis rate of 66.7%
- Annual Care plan reviews
- Diagnosis rates for people from BAME and LGBTQ+ community
- Qualitative experience of receiving a diagnosis

Accountability

- Dementia United Board

5.4.5 Action: Taking an evidenced based approach to responding to frailty and preventing falls consistently across GM

Frailty is an increasingly problematic long-term health condition characterised by declining resilience and increased vulnerability to events associated with, but not specifically caused by, ageing.

We have launched the Greater Manchester Falls Collaborative to oversee and deliver the priorities for falls prevention, integration and reconditioning.

Over the next five years, we will:

- Develop GM strategy and standards focused on ageing well, identify and reduce of unwarranted variation, improve key clinical outcomes and improve patient experience for older people
- Review the Framework for Resilience and Independent Living to produce a GM Frailty Prevention and Care Strategy and an agreed set of frailty care standards for implementation to drive frailty care quality improvement.

- Develop a frailty care outcomes framework dashboard. This will be designed to support place-based teams allowing them to review, develop and quality improve services to achieve better care for local people as they age
- Co-produce and develop a system-wide Falls Prevention action plan for Greater Manchester to respond to the key thematic areas as identified in the 'Greater Manchester Falls Prevention: Delivering Integration and Reconditioning' [arc-gm.nihr.ac.uk] report
- Deliver on the GM wide action plan for Falls Prevention, working with each of the ten localities to build on the 'opportunities for action' across key areas such as: equity, access and quality, evidence-based approaches, data improvement, insight, workforce development and digital technologies

Measuring our Delivery

- New care home admission
- Death in unplanned settings including in hospital
- ED attendance and admission resulting from a fall and/or fracture

Accountability

- GM Ageing Well Steering Group
- GM Clinical Effectiveness and Governance Group

5.4.6 Action: Anticipatory care and management for people living with, deteriorating and dying from life limiting illness

Individuals who are experiencing a life limiting illness should be supported to live as well as they can before they die. They should be empowered to make important decisions about their care and wishes. They should be treated with dignity, respect and conversations about their condition and care should be open and honest. Appropriate and culturally sensitive care should be available to all those who need it.

It is recognised that most of an individual's care in the last year of life will be provided in their usual place of care. However, many people in Greater Manchester die in hospital. Dying in hospital is usually the least preferred place to be.

Our focus is on:

- Delivering a palliative and end of life care transformation programme
- Ensuring that care is available to all those needing it, prioritising quality of life and living and dying well within existing legal frameworks

- Implementing a quality improvement plan against the GM Commitments and the National ambitions self-assessment
- The increased use and reporting of IPOS (Integrated Palliative Care Outcomes Scale) across Greater Manchester ensuring the transformational programme is in line with individuals' needs

Measuring our Delivery

- The availability of 24 hour/7 day a week specialist palliative care services in Greater Manchester
- Reduction in inappropriate admissions to secondary care in the last 90 days of life
- Increased use of the EPaCCS (Electronic Palliative Care Coordination System) Summary on the Greater Manchester Care Record
- Increased identification of people with palliative and end of life care needs

Accountability

- GM Palliative and End of Life Group

6 Helping people get into, and stay in, good work

One of the purposes of Integrated Care Systems is to support wider social and economic benefits from NHS investment. We will act on this by enhancing the Education, Work and Skills system, working with employers on improving the quality of work and employee wellbeing through adoption of the GM Good Employment Charter and developing social value through our network of anchor institutions.

Helping people get into, and stay in, good work Delivery Leadership: Locality Boards System Leadership: Population Health Board; GM Good Employment Charter Board, GM Employment and Skills Advisory Board	
Areas of Focus	**Actions**
Enhance Scale of Work and Health Programmes	Expansion of our Working Well System
Develop Good Work	Working with employers to deliver GM Good Employment Charter
Increase the contribution of the NHS to the economy	Developing the NHS as an anchor system
	Implementing the Greater Manchester Social Value Framework

The Integrated Care Partnership and the Combined Authority have been able to draw from shared evidence generated through publications such as Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives (2021), the GM Independent Prosperity Reviews (2019 and 2022) and the Greater Manchester Local Industrial Strategy (2019) which all reinforce the connection between health and an inclusive economy.

6.1 Area of Focus: Enhance scale of work and health programmes

6.1.1 Action: Expansion of our Work and Health Models

Jointly developed by GMCA and NHS GM, the Working Well System Model has been in place since 2018. A co-investment approach aims to support the long term unemployed and people with health conditions or disabilities into sustainable 'good work' across the city-region.

Within the 2023 Devolution Trailblazer agreement, there is a commitment to a co-design approach for all future DWP contracted employment support programmes in the city-region, with an assumption of a GM footprint and a delegated delivery model. This will allow GM to further shape and define the Working Well system, and bring the additional resource and opportunity created by the introduction of the UK Shared

Prosperity Fund (replacing European Social Fund) for those not in employment or training, over 50s and those with complex needs.

NHS GM and the Combined Authority will work together in 2023/24 to redefine and advance our future model including for the Working Well model, as well as the Working Well: Specialist Employment Service (SES) comprising Supported Employment (SE) for people with a learning disability and/or autism, and Individual Placement and Support (IPS) for both people with severe mental illness and those referred through the Primary Care route.

NHS Talking Therapies Employment Advisors are being introduced in GM from 2023/24 and will provide employment advice to people undergoing therapy for anxiety/depression.

6.1.2 Action: Expansion of our Working Well System

Working with GMCA, NHS GM will continue to evolve the Working Well System to ensure as many residents as possible are supported towards and into employment providing the right support at the right time to enable positive work outcomes. As funding and programme opportunities become available, a data and evidence led approach will be applied to ensure maximum impact. New services to be in place in 2023/24:

- Working Well: Individual Placement and Support in Primary Care service funded by the Department for Work & Pensions (DWP) to provide support for 1,500 GM residents running to March 2025. Delivery will be co-located with a range of primary and community NHS health services and professionals. Participants will come from two distinct cohorts: out of work participants who require assistance and support to move into competitive employment; and in work participants who are off sick or struggling in the workplace due to their disability / health condition
- A Working Well: Early Help service, building on leaning from our first pilot and further testing an early intervention primary care referral model for individuals with health conditions or disabilities at risk of falling out of work
- A programme of work delivered in partnership with The Health Foundation will improve health and reduce inequalities through scoping a system wide approach to addressing increasing economic inactivity resulting from poor health in those aged 50-64
- A response to the Joint Work and Health Unit’s new Work Well Hub and Partnership programme. The Hubs are expected to link jobcentres, health services and other local organisations and provide wraparound support for jobseekers, those on benefits and those at risk of falling out of work due to their health conditions.

- Additional commissioning linked to the UK Shared Prosperity fund is likely to focus on economically inactive people with complex needs (all age groups) many of which are likely to relate to health conditions. This programme will be delivered from late 2023 and aims to support over 8,000 people towards employment over coming years.

Measuring our Delivery

- Number of people supported into work
- Number of people supported to remain in work
- Number of people supported whose health conditions improve

Accountability

- Locality Boards
- Population Health Board
- GMCA Employment and Skills Advisory Partnership / new Integrated Education, Skills and Work Governance Board

6.2 Area of Focus: Develop good work

6.2.1 Action: Working with employers to on improving the quality of work and employee wellbeing through adoption of the GM Good Employment Charter

The Greater Manchester Good Employment Charter aims to develop diverse, equal and truly inclusive working conditions across Greater Manchester. By promoting the benefits of equality, diversity and inclusion in the workplace, we aim to support employers to create workplaces that embrace the characteristics of good employment in ways that ensure fair pay, opportunity and progression to all. This will include adoption of the Real Living Wage (RLW)

This action applies to all Greater Manchester employers, in partnership with GMCA, but also includes health and care organisations. Our key actions in this area are set out in the Supporting our Workforce and Carers Mission.

Measuring our Delivery

- Number of Health and Care organisations achieving Charter Accreditation
- CQC well-led rating
- Agency spending

Accountability

- People Board

6.3 Area of Focus: Increase the contribution of the NHS to the economy

6.3.1 Action: Developing the NHS as an anchor system

The Health Foundation describes anchor institutions as large organisations whose long-term sustainability is tied to the wellbeing of the people they serve[15]. This agenda is also linked to the 'fourth purpose' of ICSs, unlocking the NHS's social and economic potential.

These anchor organisations are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community. By strategically and intentionally managing their resources and operations, anchor institutions can help address local social, economic and environmental priorities in order to reduce health inequalities.

In Greater Manchester, we will move from an institutional perspective to one more akin to a social movement. The next stage of our journey will be to develop a more strategic and aligned focus on what it is the ICS wants to change, developed in partnership with the range of other anchors in the system, all pulling and participating in the same strategic direction for the economy.

This work will be developed by a GM NHS Anchors Network with representation from each trust as well as each locality. Agreed priorities for the GM Anchors Network include:

- Develop and implement vision, strategy and targets
- Develop and implement local supply chain opportunities
- Develop and implement collaborative approaches to the development of effective local employment pathways

Measuring our Delivery

- To be confirmed through GM Anchors Network development

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[15] The NHS as an anchor institution (health.org.uk)

Accountability

- Population Health Board
- Provider Federation Board

6.3.2 Action: Implementing the Greater Manchester Social Value Framework

The GM Social Value Framework sets out how our city region will deliver social value through commissioning and procurement activities. It describes the outcomes that GM is collectively working on to make an impact through the policy, including supporting more people into work and improving working practices through the Good Employment Charter; a reduction in poverty and health inequalities; and avoiding acute problems by investing in prevention.

Our key actions as NHS GM:

- Embedding Procurement Policy Note 06/20 (taking account of social value in the award of central government contracts) into business-as-usual activity
- NHS GM Integrated Care and Provider Trusts formally adopt GMCA approach to lever more social value from public sector spending
- Agree and embed standard social value evaluation questions with model answers for procurements
- Implement standard approach to measurement and reporting on social value delivered:
- Evaluate the impact of a 20% (or higher) social value weighting for procurements
- Identify relevant categories and/or contracts for local supply chain development

Measuring our Delivery

- Improvements against Social Value Reporting Tool metrics – being developed at national level

Accountability

- Population Health Board

7 Recovering core NHS and care services

Improving access to high quality, core services and reducing long waits (for both adults and children) is the main issue raised by Greater Manchester residents participating in the Big Conversation and this will be delivered through our approach to the recovery of services. The impact of the COVID-19 pandemic was profound and exacerbated many of the challenges which were already influencing delivery of core health and care services. We will strive to return to consistent delivery of NHS constitutional standards and ensure that our system is well-placed to respond to national strategy and frameworks on core service delivery.

Recovering Core NHS and Care Services Delivery Leadership: Locality Boards and PFB System Leadership: System Boards; Finance and Performance Recovery Board	
Areas of Focus	**Actions**
Improving urgent and emergency care and flow	Access to urgent care in the community
	Admission/Attendance Avoidance
	Improving discharge
	Increasing ambulance capacity
	Improving emergency department processes
Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard	Integrated Elective Care
	Improving productivity and efficiency
	Improving utilisation of the Independent Sector
	Improving how we manage our wait list
	Recovering children and young people's elective services
	Reducing waiting times in cancer
	Diagnostics
Improving service provision and access	Making it easier for people to access primary care services, particularly general practice
	Digital transformation of primary care
	Ensuring universal and equitable coverage of core mental health services
	Digital transformation of mental health care
Improving quality through reducing unwarranted variation in service provision	Improving quality
	NHS at Home – including Virtual Wards
Using digital and innovation to drive transformation	Implementation of Health and Social Care Digital Strategy
	Driving transformation through research and innovation
System Resilience and Preparedness	Supporting System Resilience

7.1 Area of Focus: Improving urgent and emergency care and flow

The GM Urgent and Emergency Care (UEC) Plan is based on a set of improvement priorities linked to the themes in the national UEC recovery plan.

7.1.1 Action: Access to urgent care in the community

Responsive urgent care services in our neighbourhoods and communities are a vital part of our system. Our priorities for these community-based services are:

- Fully implementing Urgent Treatment Centre (UTC) models consistently across GM. There are currently 10 accredited UTC sites open across GM that adhere to the guidance
- Improving 111 access and flow through reviews of community services and Directory of Services (DoS) accessibility
- Improving referral pathways for 999 access and response. Building on existing good work with North West Ambulance Service (NWAS) and system partners to increase “Hear and Treat” and “See and Treat” rates
- Continued GM Clinical Assessment Service (CAS) development, reviewing appropriate code sets and increasing options for 111 and 999 based on clinical appropriateness

Measuring our Delivery

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
- Reduction in A&E attendances
- Reduction in Ambulance conveyances

Accountability

- UEC Board
- Locality Boards
- PFB

7.1.2 Action: Admission/Attendance Avoidance

Admission/Attendance Avoidance includes initiatives to ensure the expansion of out of hospital services to avoid an admission or attendance. These include:

- Same Day Emergency Care (SDEC) – working with system partners on improving direct access pathways for NWAS and primary care. Reviewing consistency of models across GM, supporting improvement, and overcoming barriers to make the most effective use of the services
- Urgent Community Response (UCR). All localities have plans to offer full geographic coverage for a minimum of 08:00 – 20:00, 7 days a week for UCR. Where demand necessitates, there is flexibility for longer operating hours and covering all 9 clinical conditions or needs, including level 2 falls. This is done by ensuring there are multi-disciplinary teams operational during the required times
- Our localities are aiming to increase referrals in from 111 and 999. The NW regional team are working with NWAS and the DoS team to produce a standardised code set for across the region to ensure consistency of approach

Measuring our Delivery

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Greater use of urgent community response to reduce avoidable admissions
- Reduction in non-elective admissions
- Reduction in A&E Attendances

Accountability

- UEC Board
- Locality Boards
- PFB

7.1.3 Action: Improving Discharge

Improving Discharge and Flow focuses on reducing Length of Stay (LoS) and supporting patients leaving hospital in a timely manner including:

- In-hospital flow – working with providers to support flow improvement initiatives, benchmarking and sharing best practice
- Evidenced-based audit work to support improvement
- Out of Area (OOA) placement discharge improvement

We have been working with partners to introduce new schemes and enhance existing models to improve Discharge and Flow. Specific areas of focus include:

- Setting up a directory in GM of contacts, and a national directory, and streamlining these through localities
- Ensuring points of escalation are in place through the relevant groups including acute and mental health discharges
- Development of systems and processes across GM, further embedding of escalation processes
- Review of other ICS Transfer of Care Hubs, working closely with social care
- Working through the Better Care Fund to scale up capacity for intermediate care

The GM Directors of Adult Social Services have led on the development of additional schemes to support winter and surge capacity engaging all GM partners in the decision making. This includes the GM Independent Provider Network.

Measuring our Delivery

- Reductions in Length of Stay
- Reductions in the number of patients in hospital beds with no criteria to reside
- Reduce adult general and acute (G&A) bed occupancy to 92% or below
- Increasing the number of patients being discharged to their usual place of residence

Accountability

- UEC Board
- Locality Boards
- PFB

7.1.4 Action: Increasing ambulance capacity

Several "alternative to transfer pathways" are in place across Greater Manchester. These pathways include direct referrals into two-hour UCR and other community services, as well as falls lifting services, which are relieving some of the pressure on ambulance services. There is a dedicated mental health triage function developed between Greater Manchester Police (GMP), NWAS and mental health providers. In addition to these pathways, we must also improve baseline ambulance performance across all categories.

GM actions include:

- Ensure pathways to other services are clear on the DoS and Service Finder.

- Monitor ambulance referrals to other services - ensure consistency during busier and lighter periods
- System review of pathways across localities ensuring sufficient capacity is in place

Measuring our Delivery

- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24 with further improvement towards pre-pandemic levels in 2024/25

Accountability

- UEC Board

7.1.5 Action: Improving emergency department processes

We are working with partners to standardise care at the ED front door, including for mental health patients. Our focus is on improving patient flow in and out of hospitals, including embedding fully functional bed management and the GM system control centres.

Work to improve and standardise Same Day Emergency Care (SDEC) is part of this improvement plan, ensuring patients can access SDEC services as an alternative to the Traditional ED process, through referral from their GP or from NWAS. Our key priorities include:

- Ensure consistency of approach across each ED to avoid inequity of service
- Ensure systems can cope with the operational and monitoring challenges on a day-to-day basis
- Further development of the SCC (System Control Centre) and embedding of a sustainable model across the whole system

Measuring our Delivery

- Improving A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (also in the NHS Mandate)
- Reducing 12hr waits in the Emergency Department

Accountability

- UEC Board
- PFB

7.2 Area of Focus: Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard

The GM elective recovery and reform strategy has six pillars (Figure 8) and addressing health inequalities is embedded as a priority through the programme supported through board level equalities champions. Each recovery pillar also has an equality impact assessment

Figure 8

7.2.1 Action: Integrated Elective Care

The Integrated Elective Care Pillar aims to support the early stages of a patient pathway. The Integrated Elective Care Pillar will support the Primary Care and Secondary Care interface principles through improving utilisation and implementation of referral optimisation initiatives. This pillar of work will also support the system in delivering outpatient recovery and transformation initiatives to improve efficiency and patient experience including increased use of advice and guidance and Patient Initiated Follow Up (PIFU).

Measuring our Delivery

- Utilisation of advice and guidance
- % patients moved to PIFU pathways
- New to follow up outpatient appointment ratio

Accountability

- GM Elective Recovery and Reform Board

7.2.2 Action: Improving productivity and efficiency

Driving productivity and efficiency to release the capacity required to increase elective activity, reduce long waits and improve patient safety, outcomes and experience.

Plans are underpinned by a systematic data-driven approach for identifying productivity opportunities with the highest impact on improving elective care and reducing inequalities. This is supported by the adoption of GIRFT (Getting it Right First Time) and Right Care principles to reduce unwarranted variation and improve GM performance. The programme will focus on reducing DNAs; improving theatre utilisation; increasing day case rates; specialty specific focus on ophthalmology and orthopaedics

Measuring Delivery

- Increase in high volume low complexity procedures
- Theatre utilisation
- Day case activity as a percentage of overall activity
- Reduction in on the day cancellations
- Improvements in DNA rates

Accountability

- GM Elective Recovery and Reform Board

7.2.3 Action: Development of Surgical Hubs

Maximising the use of surgical hubs will ensure capacity for elective activity is protected and drive down the overall wait list in GM. We have a number of hubs in place with plans for more to come in the next few years. We are also engaging with the national surgical hub accreditation process which focuses on performance, utilisation and patients experience in hub settings. One of our GM hubs is currently going through national accreditation process with more to follow. The use of surgical hubs through the pandemic highlighted the importance of protecting elective activity and ensuring beds are available.

- We have developed a weekly GM surgical hub capacity report to review surgical hub utilisation and proactively manage surgical hub capacity using the 6-4-2 model, supporting the GM mutual aid approach, and the delivery of national targets.
- GM surgical hub sites will continue to work towards the achievement of 85% day case activity in 2023/24, and the development of Standard Operating Principles for

all GM hubs will reduce variation and improve equity of access to hub capacity for patients across GM
- Plans to extend GM surgical hub sites in 2023/24 will increase the provision of elective capacity, particularly for children and young people, and surgical hub sites will work towards gaining national GIRFT (Getting it Right First Time) accreditation.
- A GM wide communication and engagement approach for both patients and staff will support these developments

To support digital activity, we have an identified digital lead on the GM Elective Board with links back to the GM Chief Digital Officers network. This will enable us to identify digital opportunities relating to the pillars of the Elective Recovery Strategy.

Measuring our Delivery

- Meet the 85%-day case and 85% theatre utilisation national expectations, using GIRFT and moving procedures to the most appropriate settings
- Number of patients treated in surgical hubs
- Productivity of surgical hubs

Accountability

- Elective Care Recovery and Reform Board
- PFB

7.2.4 Action: Improved utilisation of the independent sector

Working with independent sector (IS) providers is critical to supporting our work to reduce the overall wait list and, in particular, those who have waited the longest. This programme of work will focus on a demand and capacity model for those patients that have waited over 65 weeks.

We will work in collaboration with IS providers to develop and implement a joint standard operating procedure and access policy for IS activity.

Measuring our Delivery

- Utilisation of available independent sector capacity
- Number of long waits with IS providers
- System spend against plan on IS activity

Accountability

- Elective Care Recovery and Reform Board

7.2.5 Action: Improving how we manage our wait list

We will work collaboratively to eliminate long waits over 78 and 65 weeks by the end of June 2023 and March 2024 respectively. This will be undertaken in an equitable way through targeted support and a focus on choice. In addition, we will further develop the While You Wait website to support people while they are on the wait list and through our work on the Myrecovery app.

We will agree and implement a consistent GM access policy and will pilot a GM approach to risk stratification and clinical prioritisation to support inclusion and reduce inequalities.

Through the Wait List Management Programme, we will also pilot alternative approaches to support patients through our Care Navigation Hubs.

Measuring our delivery

- Overall GM referral to treatment (RTT) wait list
- Number of patients waiting over 78 weeks
- Number of patients waiting over 65 weeks

Accountability

- Elective Care Recovery and Reform Board

7.2.6 Action: Recovering children and young people's elective services

Our focus on Children and Young People will consider five key areas of work: additional capacity opportunities; consistent clinical prioritisation; improved referral pathways; revised specialty pathways and shared productivity and efficiency opportunities.

Improvements have already been driven through our work on Walk In Walk Out approach to increasing day case activity and surgical hub funding has been allocated to children and young people. Recovery is however slower for children and young people, which is also being seen across the country. As a result, this is a particular focus as part of our cross-cutting work on health inequalities.

Measuring our Delivery

- Overall number of children and young people on the RTT wait list
- Number of children and young people waiting over 65 weeks
- Activity relating to children and young people as a proportion of overall activity

Accountability

- Elective Care Recovery and Reform Board

7.2.7 Action: Reducing waiting times in cancer

Cancer Alliance planning requirements aim to improve performance against the Cancer Waiting Times standards with a specific focus on delivering the Faster Diagnosis Standard (FDS). This requires 75% of patients to have cancer confirmed or excluded within 28 days.

The target of 75% is for March 2024 with incremental milestones at the end of each quarter at system and provider levels. There is a requirement to reduce the volume of patients from a two week wait referral source who are on an active PTL (patient tracking list) beyond 62 days. The target set by NHSE is 1,051 by the end of March 2024. GM has set a stretch target of 761.

To achieve this, our key areas of focus are:

- Focused work on first attendance 'offer' and 'day 7'
- Best Practice Timed Pathway (BPTP) project delivery and compliance monitoring
- Roll out of tele-dermatology and Faecal Immunochemical Testing (FIT) and compliance monitoring
- Continued education and support to primary care
- Consolidation of oncology appointments (single queue)
- Ongoing work to improve waiting times for diagnostics and reporting for patients on suspected cancer pathways.
- Mutual aid offer for specialist surgery
- Embed faster diagnostic standard (FDS) principles in all site-specific pathways
- Roll out and compliance with personalised stratified follow-up (PSFU) to release clinical time to be re-invested pathway improvement

Measuring our Delivery

- Reduce the volume of patients on active PTLs over 62 days. NHSE target 1051 by end March 2024. GM target 761

- Meet the Faster Diagnosis Standard (FDS) Standard by March 2024 so that 75% of patients have cancer confirmed or excluded by day 28 of their pathway. Achieve the milestone targets of 67.5% end June 2023; 70.0% end September 2023; 72.5% end December 2023
- Improving 1 year and 5 year survival for all cancers, and the NHS Long Term Plan ambition that 55,000 more people diagnosed in 2028 will survive for 5 years or more
- Ensuring cancer patients can access high quality personalised care that meets their needs during their treatment and follow up, and continuing to track the quality of life of people who are living with the disease

Accountability

- Cancer Board
- Locality Boards
- Primary Care System Board

7.2.8 Action: Improving Diagnostics

GM trusts have each developed plans to achieve the ambition of 95% diagnostics tests within six weeks for all relevant modalities by March 2025. These have been brought together into a single plan for GM and approved by the regional team. The trajectories in these plans will achieve 87% within six weeks by the end of March 2024. This is being set as the target for the 2023/24 plan. Key risk areas within the plans have been highlighted and mitigating actions are being put in place.

The Endoscopy network have finalised a set of productivity KPIs as a starting point to extensive improvement and standardisation work in this area. The Theatre Rooms In Virtual Environments (THRIVE) tool is being rolled out at most GM sites to support this.

Endoscopy workforce scoping and review was undertaken in late 2022 with a workforce plan in development. This will which address workforce gaps and retention and drive up activity levels. It is planned to have at least one room at each site working a 6/7-day week giving the potential to increase activity significantly. Capital schemes are planned to build additional room capacity at specific sites.

At system level, the Community Diagnostic Centre (CDC) programme will create additional capacity across GM and short form business cases (SFBCs) have been submitted from all localities. GM will implement the CDC programme to create

essential new diagnostic capacity within localities as soon as practical once capital and revenue funding is agreed.

We have plans to improve the productivity of pathology and imaging networks through digital diagnostic investments and optimal rates for test throughput and the expansion of diagnostic capacity including through the CDCs programme. Specifically, the introduction of PACS (Picture Archiving Communications System) based reporting by March 2024 across all organisations will facilitate delivery of a minimum 10% efficiency in reporting by 2024/5.

In addition, the introduction of MRI (Magnetic Resonance Imaging) accelerator technology will increase productivity of MR scanner throughput for image acquisition. The implementation of digital pathology across all cellular pathologies in GM by end of 2023/4 will facilitate a minimum 10% efficiency gain in reporting by 2024/25.

Measuring our Delivery

- Deliver the ambition of 95% diagnostics tests within 6 weeks for all relevant modalities by March 2025
- Give priority to people with suspected cancer, so that at least 75% of people referred urgently receive a diagnosis within 28 days
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
- The implementation of digital pathology across all cellular pathologies in GM

Accountability

- Diagnostics Board
- PFB

7.3 Area of Focus: Improving service provision and access

7.3.1 Action: Improving Access to Primary Care

In organising primary care, we always seek to balance convenience and continuity of care between online or face to face appointments according to the patient's wishes and needs. Our Primary Care Blueprint (currently being finalised) will describe how we will approach this.

The pandemic brought change and in some cases transformation to demand, access and capacity. The Primary Care delivery model had to change overnight with a short term reduction in capacity and more access being delivered online. The opportunity to

move to digital solutions where appropriate was accelerated and now needs to settle into a more measured way of understanding how digital can support Primary Care services and citizens alike.

It is important to reflect that demand, access and capacity is different in the four disciplines of Primary Care and in some cases demand and access are merged due to the open-door nature of services. It is also important to acknowledge the role of preventative, screening, and wellness services which fundamentally change the shape of demand into services, keeping citizens well, supporting early diagnosis and promoting self-care.

Primary Care, and particularly general practice has had the advantage of the Additional Roles Reimbursement Scheme (ARRS) initiative. This has brought many more clinicians and support workers into Primary Care Networks, increasing workforce and the opportunity to offer proactive, flexible solutions to patients and more capacity into neighbourhoods. For this opportunity to work well we must integrate not only across Primary Care disciplines but also with the wider public sector, voluntary sector, and the business community to make the most of our workforce, local services, and buildings.

We will seek to secure additional capacity when periods of surge demand occur, which we assess through our framework for reporting pressures. Primary care providers will enable the spread of access to online advice on symptoms and self-care.

Our key aims on improving access across primary care are:

- Ensuring same day urgent access to Primary Care where clinically warranted and agreeing an appropriate response at first contact for all non-urgent requirements
- Removing the “8 am rush” in General Practice, via a support programme which will include investment in the telephony infrastructure, encouraging optimal use of the NHS App and a programme of development support for PCNs and practices
- Delivery of a Dental Quality scheme which will seek to improve access to NHS Dentistry across GM. NHS Greater Manchester and primary care providers are engaging on options to address the current issues surrounding access to NHS dental services and to develop a dental access plan
- Building on the core Community Pharmacy Contractual Framework to develop and deliver pharmacy services to improve access and reduce health inequalities – for example, in developing a harmonised GM Minor Ailments scheme
- Increase the number of patients accessing Red Eye services without going to their GP (walk in service)

Measuring our Delivery

- Number of general practice appointments per 10,000 weighted patients
- Percentage of patients describing their overall experience of making a GP appointment as 'good'
- Continue on the national trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- Proportion of regular general practice appointments delivered within 14 days of request
- Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted

Accountability

- Primary Care System Board

7.3.2 Action: Digital transformation of Primary Care

Practices and Primary Care Networks have been on an accelerated journey of the deployment of digital tools from the start of the COVID-19 pandemic. Digitisation in General Practice broadly meets foundational requirements. However, there remain outstanding challenges to optimise the use of the digital technology. This involves a focus on workforce and connecting existing systems to truly integrate care across care settings.

Practices and PCNs are facing more aggregate demand and an increase in non-patient-facing workload. Change is required to manage demand and capacity efficiently with digital tools, delivering effective digital access for patients, alongside traditional routes – all to support the best possible experience and outcomes for patients.

Our Digital First Primary Care Programme is supporting the Primary Care Recovery Plan with digital access for capacity and demand management – measured by dashboards that provide evidence on benefits of using digital solutions. This will include supporting practices with Virtual Contacts, Digital Care Navigation and Triage to enable easier digital access to help tackle the 8am rush and assessment of need or signposting to appropriate services on first contact

Measuring our Delivery

- Standardising practice websites across GM with consistent messages to meet national standards for accessibility and quality of information provided
- Promoting usage of NHS App across GM for particular use cases
- 75% of all adults in England to be registered on the NHS App by March 2024
- Every PCN to have a named person as a Digital Change Champion with support from Digital Facilitator or Digital Change Manager
- Deployment of GM Care Record to Community Pharmacy to improve medication safety, save time for pharmacists and practices and support decision making for enhanced services
- GM Care Record Realising Potential Programme to increase usage and utility including training and communications across care settings; clinical documents sharing; data feeds completion and data quality improvement
- Integrated Care Planning – adoption of the GM Care Record (GMCR) as the single platform for multi-agency integrated care planning - including EPaCCS (Electronic Palliative Care Communications System)
- Cloud-based telephony functionality for practices will help them offer a more reliable service and facilitating PCN hub delivery both in hours and out of hours
- Modern General Practice Access - all practices to have been offered procurement support and asked to sign up for digital telephony by July 2023, with 1,000 transitioned before the end of 2023, and all practices to have new digital tools made available to them by the end of 2023

Accountability

- GM Health and Care Digital Transformation Board
- Primary Care System Board

7.3.3 Action: Ensuring universal and equitable coverage of core mental health services

We will support people with mental health needs through improvements in crisis services working with GMP and NWAS. We will also work in partnership to support people with a serious mental illness to access housing and employment. We must tackle long waiting-times in mental health as a priority.

We will adopt a proactive approach to supporting children and young people to reduce the impact of mental health problems and specifically to improve the pathway for eating disorders.

The GM Mental Health and Wellbeing Strategy is a five-year strategy that sets out what we intend to do as a city region to improve the mental health of people in GM, support those will mental ill health, and reduce mental health inequalities across Greater Manchester. The stated vision in the strategy is that 'Greater Manchester will be a mentally healthy city-region where every child, adult and place matters'.

We will further integrate mental health offers into Early Help, family support, housing and education. We will work with leaders across Greater Manchester to drive forward the missions and address the historic under-investment in mental health.

A comprehensive two-year action plan, detailing specific commitments and timeframes for delivery, will be developed by autumn 2023. An outcomes dashboard with key success indicators to measure progress annually. This dashboard will be the framework utilised to report progress back to our governance

We will know we have achieved this vision when we are able to improvements in the five missions identified in the GM Mental Health and Wellbeing Strategy:

- People will be part of mentally healthy, safe and supportive families, workplaces and communities.
- People's quality of life will be improved by inclusive, timely access to appropriate high quality mental health information, support and services
- People with long term mental health conditions will live longer and lead fulfilling and healthy lives
- People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care they receive
- The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and can access and benefit from

We intend to increase our longer-term baseline investment in mental health services, recognising that demand now is substantially above pre-pandemic levels, and that Greater Manchester has historically under-invested in mental health, learning disability and autism compared to other areas. This has resulted in significant variation in the availability of services across Greater Manchester, which must be properly resourced going forward through an agreed investment plan.

This is consistent with seeking parity of esteem for mental health services with physical health services and will be challenging for our system in terms of allocating limited

resources. Recognising the starting position, our ambition would be to move Greater Manchester to the second quartile (50th percentile) of expenditure per capita with consequent improvements in access and outcomes across the life of this plan. We estimate that the increase in expenditure to move to the second quartile is £97 million.

Measuring our Delivery

- Work towards eliminating inappropriate adult acute out of area placements
- Reduce the length of stay for adult mental health inpatients
- Move Greater Manchester to the second (50th percentile) quartile of expenditure per capita on mental health – we estimate that this is an increase of £97 million
- Inpatients with a learning disability and/or autism per million head of population
- Ensuring urgent mental health support through 111 is universally accessible
- Continue to deliver the LTP ambitions through improving the quality of mental health care
- Continue to deliver the LTP ambitions through improving access to and quality of services for people with a learning disability and autistic people
- Levelling up provision to ensure we reduce current shortfall in benchmarked mental health spend in GM, moving spend to at least the middle quartile
- Progress improvements identified annually via GM Mental Health and Wellbeing Strategy outcomes dashboard which will include reducing unwarranted variation and inequality in health outcomes, timely access to services and experience

Accountability

- Mental Health Board

7.3.4 Action: Digital transformation of Mental Health Services

We have made progress in provision of digital tools to support mental health patients Fundamental risk factors for mental health patients are related to social challenges, and physical health.

In accordance with NHSE requirements, GM Provider Trusts are working towards implementing the Electronic Patient Record meeting the Minimum Digital Foundations by the end of 2025 across all their hospital sites

Measuring our Delivery

- Integrated Shared Care Record - increasing usage of the GM Care Record across all care settings; redefining and implementing a consistent data set for Mental Health feeding into the GMCR
- 90% of NHS trusts and foundation trusts should have electronic health records by December 2023, and 95% by March 2025

Accountability

- GM Health and Care Digital Transformation Board
- Mental Health Board

7.4 Area of Focus: Improving quality through reducing unwarranted variation in service provision

7.4.1 Action: Improving Quality

Our quality strategy describes the collective ambition of GM Integrated Care to improve people's experience through the delivery of good quality, safe and effective care. The national principles for quality are fundamental to our approach:

1. A shared commitment to quality
2. Population-focused
3. Coproduction with people using services, the public and staff
4. Clear and transparent decision-making
5. Timely and transparent information-sharing
6. Subsidiarity

The actions needed to embed these principles into our system, with clear responsibilities, are completed or on track (as of June 2023) and detailed in the GM quality strategy.

Improving the quality, safety, efficiency and effectiveness of prescribing in Greater Manchester is a key enabler of the Joint Forward Plan In 2023/24, we will develop a Medicines Strategic Plan aligned to our overarching strategy including: sustainability, prevention, and recovery of core services.

In year 1 (2023/4) the focus will be on developing the quality priority workstreams and finalising the emerging quality governance assurance processes – putting the foundations in place. Our priority actions are:

a) Ensuring good governance of Quality Assurance for NHS GM and a common understanding of quality data.

b) Establishing and embedding our integrated care system wide priorities for areas of quality improvement
c) Establishing and embedding locality quality arrangements for areas of quality improvement
d) Demonstrating where initial improvements have been made by measuring our progress as a system.
e) Confirming that the quality ambitions for years 2- 5 meet the triple aim of improving health and wellbeing, quality of care and are an efficient/sustainable use of resources

These actions are undertaken in the appropriate part of the system – NHS GM, localities, system subject leads. Engagement on the strategy made clear that its implementation will be achieved through a series of improvement actions that contribute to the overall shared purpose. The delivery and coordination of the individual components of the quality strategy will be managed by the Quality Strategy Delivery Group.

Our shared purpose for 2023/24 is:

- Setting system-wide quality priorities
- Setting outcomes that are measured to inform improvement
- Setting the expectation of all those involved in providing care access across the system

For years 2-5 (2024/5 and onwards), our shared purpose will be:

- Improved standards
- Improved quality
- Improved population health and wellbeing through the reduction of inequalities

Safeguarding

We have a statutory responsibility for safeguarding which is enacted via the NHS GM Chief Nurse and supported by the Deputy Chief Nurse and Associate Director of Safeguarding. Statutory safeguarding responsibilities are delegated to the Associate Director of Quality and Safety in each of the GM localities and delivery of the statutory functions are undertaken by the locality Designated Teams.

NHS GM can demonstrate that there are appropriate safeguarding governance systems in place for discharging statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014

- Children Act 1989 and 2004
- Children and Social Work Act 2017
- Working together to Safeguard Children 2018

We will undertake our statutory duties across the GM Safeguarding Children Partnerships as one of the equal and joint statutory partners (Local Authority, ICBs and Chief Officer of police) and as a statutory partner for the GM Adult Safeguarding Boards. The ICB will ensure that the delivery of safeguarding aligns with the NHS Safeguarding Accountability and Assurance Framework (2022)[16].

It is the responsibility of the ICB and each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect. NHS GM Safeguarding will encompass an all-age and a Think Family model supporting an integrated safeguarding partnership approach.

Measuring our Delivery

- Through metrics developed as part of the Quality Strategy. This will include those reported nationally (at Trust level unless otherwise indicated):

Accountability

- Quality and Performance Committee

7.4.2 Action: NHS at Home – Including Virtual Wards

We recognise the potential and importance of developing new models of care enabled by technology to provide care to people in their own homes and place of residence as an alternative to a hospital bed.

The virtual wards programme aims to deliver between 40-50 virtual wards beds for per 100,000 adult population. This equates to between 1,110 to 1,250 for Greater Manchester. GM is now projecting to deliver approximately 1,095 beds by March 2024. The current virtual ward average length of stay is approximately 7 days, equating to a

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[16] B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf (england.nhs.uk)

conservative estimate of 1,960 bed days saved each week. This will increase throughout 2023/24.

The GM virtual wards model comprises four networks working across the city-region to achieve adoption and spread at scale, equity of access for patients and reduce unwarranted variation. All sites have now mobilised standard clinical pathways for acute respiratory infection and frailty virtual wards (step-up and step-down) co-produced with senior clinical leaders, alongside a clear set of operating principles and standards.

The expansion of the programme through 2023/24 and beyond will focus on:

- New pathways – heart failure, end of life, post-op, general medicines
- Optimising admission avoidance and increasing referrals
- Enabling patient flow between virtual ward networks
- Optimising non-clinical activity at scale

Measuring our Delivery

- Deliver 1,095 virtual ward beds by March 2024, achieving 80% occupancy from September 2023 onwards
- Adoption and spread of all agreed pathways across all sites, supporting flow across the system

Accountability

- UEC Board
- NHS at Home Programme Board

7.5 Area of Focus: Using Digital and Innovation to Drive Transformation

7.5.1 Action: Implementation of Health and Social Care Digital Strategy

To deliver on our strategic vision and support the ambition for Greater Manchester to become a world-leading digital city region we need to embrace digital transformation opportunities across the health and care system. We want to be a truly digital health and care system, leveraging partnerships across academia and industry with one of the largest life sciences clusters in the country.

However, there are many areas of our health and care system which remain paper-based or operate on clunky, outdated systems that are not connected to each other. This impacts on the quality and standard of care and the experience of people using

our services. There is an urgent need to get the basics right alongside our ambition to develop leading-edge approaches.

Our five digital transformation ambitions are to:

- Deliver integrated, coordinated and safe care to citizens
- Enable staff and services to operate efficiently and productively
- Empower citizens to manage their health and care needs
- Understand population health needs and act upon insights
- Accelerate research and innovation into practice, as a globally leading centre

We have developed the GM Digital Maturity and Investment Framework in each care setting to understand our status and next priorities. This strategy presents three layers of activity required - to digitise, integrate and innovate.

Measuring our Delivery

- A joint delivery plan targeting the priority capabilities across all major delivery partners is being developed. Progress is measured through a) digital maturity scores per capability (assessed annually in each care setting), b) delivery of milestones and c) programme level benefits evaluation
- Social care - increasing uptake of Digital Social Care Records by independent social care providers (from ~50% to 80% by March 2025) and deployment of the GM Care Record to independent social care providers
- Secondary Care - In accordance with NHSE requirements, GM Provider Trusts are working towards implementing Electronic Patient Record meeting the Minimum Digital Foundations by the end of 2025, across all their hospital sites: 90% of NHS trusts and foundation trusts should have electronic health records by December 2023, and 95% by March 2025

Accountability

- GM Health and Care Digital Transformation Board

7.5.2 Action: Driving transformation through research and innovation

Greater Manchester is regarded as one of the most active, diverse and growing health innovation ecosystems due to our concentration of advanced health and care, academic, life sciences and digital sectors.

Health Innovation Manchester (HInM), now in its sixth year, continues to work on behalf of GM health, care and academic system partners to discover, develop and

deploy innovation aligned to the needs of GM citizens and supporting economic development across the city region.

Through the course of 2023/24, HInM will be working with GM system partners to develop a new three-year strategy, building on the research and innovation assets of the system.

We are committed to using research and evaluation to promote continuous system learning and to drive improvement. Academic partners in Greater Manchester play an important role in both:

- Summarising existing research evidence to inform policies, innovation and adoption
- Co-producing research and evaluation in areas of high priority, to inform future commissioning and policy making

The relationship between the Integrated Care Partnership, HInM and the Higher Education Institutes (HEI) in Greater Manchester is crucial to achieving these ambitions.

Our innovation priority projects for 23/24 are:

- Enhanced diagnostics accelerator - this £15.1m programme will deliver novel diagnostics in cardiovascular, respiratory and liver disease, specifically addressing communities most at need. The programme will drive better access to care and improve clinical outcomes for local people, as well as increasing impact from GM academic activities and creating new market opportunities for local industry partners
- GM Care Record optimisation and development of the Secure Data Environment (SDE) - the GM Care Record is a direct care and innovation asset which is already funded by GM system partners. We will accelerate our activities to maximise the benefits from the platform
- Deployment of proven innovation - we are in the final stages of agreeing the initial set of deployment at scale projects with system partners, based on proven solutions that meet key system challenges, population health needs and contribute to tackling inequalities.
- Continued expansion of virtual wards and NHS at Home –this will include the rollout of further virtual ward pathways, supporting providers to optimise admission avoidance and further developing this model of care
- Strategic industry partnerships - we will continue to deliver our industry strategy and our pipeline of proven innovations, secure additional resource for local

innovation deployment, and bring benefits to industry which will encourage further investment and collaboration
- Academic partnerships - we will continue to make develop our university and NHS research assets so that we can improve our innovation pipeline and achieve greater local impact from investment to the GM academic infrastructure.

GM Health Innovation Accelerator

GM is one of three UK city-regions to be awarded funding as part of the Government's levelling up white paper to launch 'innovation accelerators' to advance R&D in key areas.

The GM health innovation accelerator will focus on tackling some of the most challenging disease areas through early diagnosis using novel approaches and holistic treatment aligned to people's specific needs. It will focus on enhanced diagnostics and genomics, delivered through a partnership between Health Innovation Manchester, Manchester University NHS Foundation Trust, and the University of Manchester. Further significant investment has also been leveraged through partnerships with businesses in life sciences, digital and creative industries

Measuring our Delivery

Each innovation project is delivered through a structured innovation pipeline method and approach, including a PID, benefits realisation plan and logic model outlining the following deliverables:

a) Inputs – funding, costs and resources

b) Activities – the key tasks and milestones

c) Outputs – measurable/quantifiable results

d) Outcomes – what the innovation led to, short medium-term consequences

e) Impacts – longer term wider contextual changes

Accountability

- Health Innovation Manchester Board
- GM NIHR Infrastructure Oversight Board
- GM Health and Care Digital Transformation Board

7.6 Area of Focus: System Resilience and Preparedness

Action: Supporting System Resilience

Our Partnership has an important role to play in supporting the health and care system to be resilient and prepared for a range of threats. We will:

- Support the resilience and preparedness of regional and local UKHSA (UK Health Security Agency) health protection systems and local authority public health teams.
- Be ready for future health security hazards and reduce harm through an effective health protection response that enables effective collaborative working
- Contribute to ongoing preparedness and response to significant health protection incidents to ensure our health society, public services and the economy are less impacted.
- Collaborate and work closely with the local UKHSA Health Protection Team in supporting health protection incidents and outbreaks to ensure pathways are in place for the provision of clinical/medical assessment
- Work to ensure catch up vaccination in response to health protection incidents.
- Collaborate to reduce health care associated infections and tackle antimicrobial resistance and will support whole system approach to winter planning.

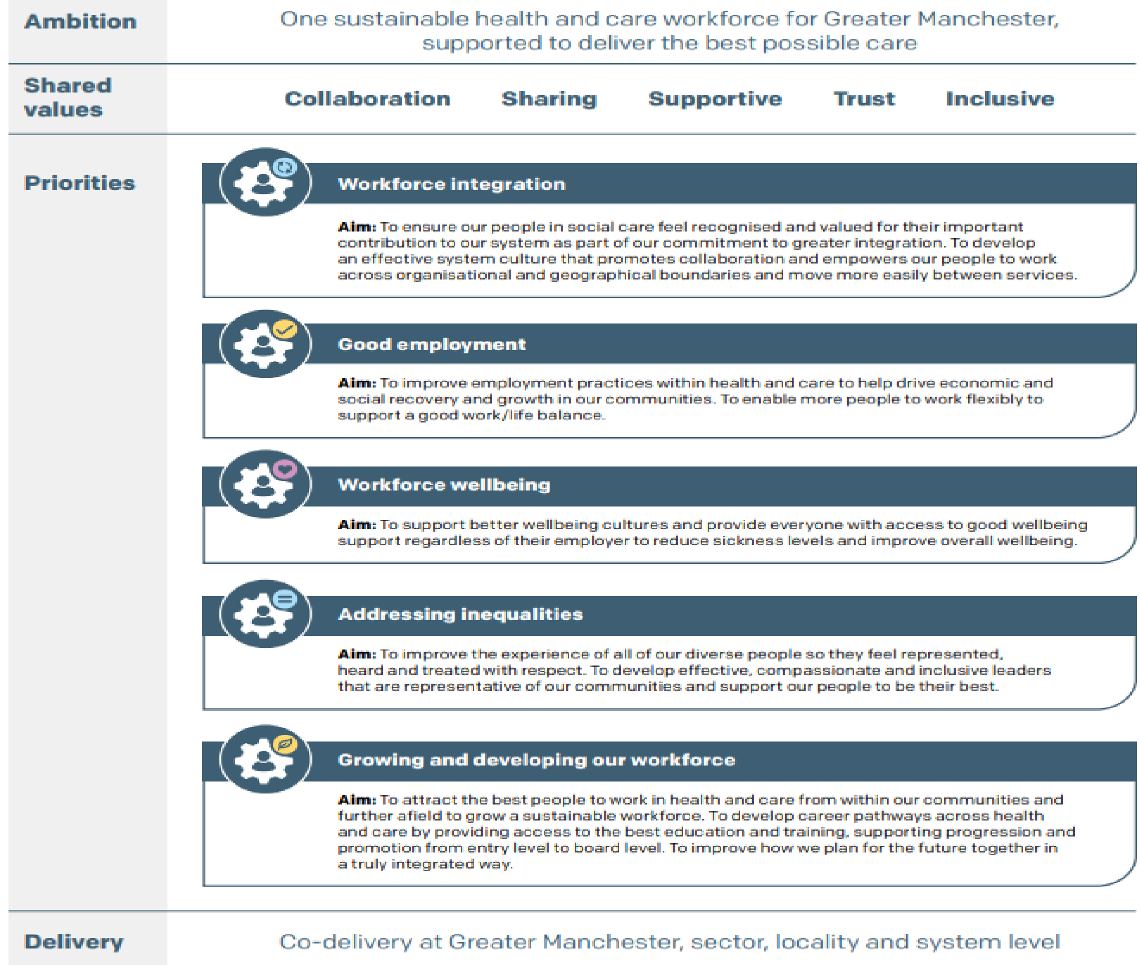
8 Supporting our workforce and our carers

We will promote integration, better partnership working and good employment practices, as well as supporting our workforce to be well and addressing inequalities faced in the workplace. We want more people to choose health and care as a career and to feel supported to develop and stay in the sector.

Supporting our workforce and our carers Delivery Leadership: NHS GM People & Culture Function, NHS GM, NHS Trusts, Primary Care providers, Local Authorities, Social Care Providers, VCSE Organisations System Leadership: GM People Board	
Areas of Focus	**Actions**
Workforce Integration	Enable leaders and staff to work across traditional boundaries to support service integration
	Share best practice and develop tools to support a dynamic system culture
Good Employment	Increase in Good Employment Charter Membership and payment of Real Living Wage
	Improve access to staff benefits and flexible working
	Share best practice and resources to support managers
Workforce Wellbeing	Take action on the cause of staff sickness and improve wellbeing support
Addressing Inequalities	Building a leadership culture committed to addressing health inequalities
	Adapt the recruitment process to provide alternative entry routes for diverse talent
Growing and Developing	Develop our Greater Manchester careers approach to attract and support career development
	Develop and deliver the Greater Manchester retention plan
	Embrace digital innovation to improve the way we work – starting with HR digitisation
Supporting Carers	Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

We have set out a shared ambition for the health and care workforce in our People and Culture Strategy 2022-2025. The People and Culture Strategy is summarised below. We await the publication of the national, long-term workforce plan (expected summer 2023) and will review our plans against this.

Figure 9



8.1 Area of Focus: Workforce integration

We will increase the opportunities for sharing best practice and partnership working across our system and organisational boundaries and increase the number of people working in integrated roles.

8.1.1 Action: Enable leaders and staff to work across traditional boundaries to support service integration

- Co-create a culture of collaboration, including development of ways of working which are adopted at all levels such as our system boards and wider leadership development
- Promote the development of neighbourhood based integrated health and social care roles, including the expansion of the blended roles programme

- Make it easier for our workforce to move across different settings, including the expansion of the GM passport across health and care settings
- Work with our regulators to develop standards around integration

Measuring our Delivery

- Increase in number of integrated learning environments within nursing, AHP (Allied Health Professional) and medical education programmes
- Total number of senior leaders participating in system integration development programme
- Increase in number of integrated health and social care roles, including blended roles programme. Increase in number attending our workforce summits and post event evaluation
- Increase in number using the digital training passport

Accountability

- People Board
- Locality Boards

8.1.2 Action: Share best practice and develop tools to support a dynamic system culture

- Continue to share best practice and ways of working to support integration and collaboration, through toolkits and events such as the Workforce Collaborative Summit
- Establish a system induction toolkit that can be incorporated into place and organisation inductions to provide useful context around how our system works and supports the development of a system culture
- Establish a system staff survey to improve our understanding of our workforce experience across the sector
- Develop a plan for cross system mentoring and coaching – with a focus on groups who are underrepresented at senior management level

Measuring our Delivery

- Total number of organisations incorporating system induction piece into their induction programmes
- Survey measuring perceived integration/survey of leaders feeling able to work across boundaries

Accountability

- People Board
- Locality Boards

8.2 Area of Focus: Good Employment

8.2.1 Action: Increasing membership of the GM Good Employment Charter and payment of the Real Living wage for health and care organisations

- Increase in Good Employment Charter membership and payment of the Real Living Wage. Supporting organisations to achieve Charter membership will also improve employment standards across all areas covered by the Charter, including security, flexible working, employee engagement, recruitment, people management wellbeing provision and inclusion
- Establish a Good Employment Charter definition for good leadership – piloting in NHS Greater Manchester and sharing best practice with the system
- Work with partners to help embed good employment practices in our commissioning and contracting of services
- Share best practice and resources to support managers to be the best they can be and explore a core development programme for managers – including line management and clinical supervision
- Deliver the Greater Manchester Champion Awards to celebrate collaboration and good practice
- Continue to work in close partnership with trade unions, supporting ongoing engagement between unions and employers in the event of industrial dispute

Measuring our Delivery

- Increase in Good Employment Charter membership
- Good Employment Charter Steering Group engagement on perceived change in the system
- Increase in the number of health and care employers paying the Real Living Wage

Accountability

- People Board
- Locality Boards

8.2.2 Action: Improve access to staff benefits and flexible working

- Improve access to staff benefits, starting with the Blue Light Card
- Support our net zero ambitions by promoting active travel and improving access to electric cars and cycle schemes

Measuring our Delivery

- Improvement of the wider employment standards included in the Good Employment Charter, such as increase in access to flexible working

Accountability

- People Board
- Locality Boards

8.2.3 Action: Share best practice and resources to support managers

- Coordinate action to tackle violence and bullying experienced by our workforce in their place of work
- Improve workforce engagement and access to flexible working by sharing good practice

Measuring our Delivery

- Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from managers
- Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from patients/service users
- Staff survey engagement theme score (Out of 10)
- Aggregate score for NHS staff survey questions that measure perception of leadership culture

Accountability

- People Board
- Locality Boards

8.3 Area of Focus: Workforce Wellbeing

8.3.1 Take action on the cause of staff sickness and improve wellbeing support

- Supporting workplaces to keep people well to reduce workforce sickness levels
- Improve access to existing resources so that all our people can get the support they need for maintaining good wellbeing
- Improve infrastructure and systems for absence management to support effective workforce planning
- Take a more standardised approach to occupational health in secondary care
- Establish occupational health and Employee Assistance provision for NHS Greater Manchester and look to extend this where possible in primary care, social care and the VCSE sector
- Support organisations and networks to embed good wellbeing cultures and practices
- Identify Wellbeing needs/gaps and working with partners address them together at a Greater Manchester level

Measuring our Delivery

- Sickness absence rates
- Leaver rate

Accountability

- People Board

8.4 Area of Focus: Addressing Inequalities

We will improve diversity at senior manager and executive level and improve the opportunity and experience for all our workforce with protected characteristics.

8.4.1 Action: Building a leadership culture committed to addressing health inequalities

- Develop and implement a Greater Manchester Workforce Disability Equality Scheme
- Delivery of the national Stepping Up programme at scale
- Develop a culture of services across Greater Manchester addressing wellbeing inequalities experienced by specific groups

- Develop and implement an Equality, Diversity and Inclusion Framework for inclusive leadership

The work of the Fairer Health for All Leadership Academy will also contribute to this action.

Measuring our Delivery

- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age
- Reduction in the disproportionality in disciplinary investigations by people with protected characteristics

Accountability

- People Board

8.4.2 Action: Adapt the recruitment process to provide alternative entry routes for diverse talent

- Implement the #InclusiveHR initiative to create more representative and inclusive People and Culture services
- Adapt the recruitment process to provide alternative entry routes for diverse talent

Measuring our Delivery

- Proportion of staff in senior leadership roles who are from a) a BME background or b) are women or c) are disabled
- Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants
- Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants
- Increase representation of people with protected characteristics at all levels, within the NHS that will be particularly at entry levels at Band 2, Band 5 and Junior Medical Grades
- Number of organisations that have adapted their recruitment processes to attract diverse talent and impact this has had on those recruited

Accountability

- People Board

8.5 Area of Focus: Growing and Developing

We will increase recruitment to the sector from within our own communities and beyond, including key areas such as nursing, midwifery, social care and mental health. We will support more people to develop and stay and improve our workforce planning system infrastructure.

8.5.1 Action: Develop our Greater Manchester careers approach to attract and support career development

- Develop our Greater Manchester careers approach to reach into our communities and engage with school leavers as well as those looking for a new career
- Develop our talent pool to ensure it is diverse and meets the needs of our system
- Develop the Social Care Careers Academy to support growth, retention and development of the social care workforce
- Building on the findings from research into the workforce development needs of the VCSE sector, support workforce development within the VCSE sector to create a more sustainable, resilient and integrated workforce
- Work closely with HEE (Health Education England) to create more development opportunities and enable people to have the protected time to participate
- Use the work within the People and Culture Strategy to build a strong narrative on why people should want to work in health and care in Greater Manchester

Measuring our Delivery

- Increase the number of people engaged through GM careers activity
- Increase in the size and diversity of the GM talent pool
- Increase in perceived access to development opportunities through staff surveys
- Increase in utilisation of CPD (Continuing Professional Development) funding to support development

Accountability

- People Board
- NHS Provider Trusts
- Locality Boards

8.5.2 Action: Develop and deliver the Greater Manchester retention plan

- Develop and deliver the Greater Manchester retention plan: focusing on the experience of our health and care people and integrated roles
- Provide a single point of contact for matching workforce and employers through a GM platform.
- Targeted action on nursing, midwifery and AHPs – including student recruitment, placement capacity and promotion of working in GM
- Recruit and retain key primary care roles including GPs, nurses, community pharmacists, NHS dentists and dental nurses working in partnership with HEE
- Support primary care employers to utilise Additional Roles Reimbursement Scheme (ARRS) funding and strengthen the multi-disciplinary approach in primary care
- Support providers with the delivery of the Sustainable Services programme – managing workforce shortages by developing new ways of working to support the system to continue to provide valuable services

Measuring our Delivery

- Increase in student numbers in nursing, midwifery and mental health
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- FTE doctors in General Practice per 10,000 weighted patients
- Direct patient care staff in GP practices and PCNs per 10,000 weighted patients

Accountability

- People Board
- NHS Provider Trusts
- Locality Boards

8.5.3 Action: Embrace digital innovation to improve the way we work – starting with HR digitisation

- Improving workforce data within primary care to support better workforce planning
- Provide a single point of contact for matching workforce and employers through a GM platform
- Embrace digital innovation to improve the way work in a more efficient way, with a focus on digital literacy and exploring different ways of working

- A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on community services, the social care workforce and unwaged carers

Measuring our Delivery

- Increase number of programmes supporting workforce digitisation

Accountability

- People Board

8.6 Area of Focus: Supporting Carers

We recognise the enormous pressures faced by carers, making life harder for the people they are trying to support. As an Integrated Care Partnership, we need to take action to create the conditions to allow our people to provide the best possible care – including our paid and unwaged workforce.

8.6.1 Action: Provide more consistent and reliable identification and support for Greater Manchester's unwaged carers

- Implementation of GM Carers' Charter and the Greater Manchester Working Carers' Toolkit
- A GM approach to supporting capacity and capability to deliver virtual wards – considering their impact on unwaged carers
- Support for unpaid carers funded through the Better Care Fund (BCF) enabling people to stay well, safe and independent at home for longer
- Embed Carers Exemplar Model consistently across GM
- Further develop and promote tools and opportunities for supporting working carers
- Launch best practice for carers in ethnic minority communities
- Develop products to support primary care to identify and signpost carers

Measuring our Delivery

- 10,000 uses of SNOMED CT (an electronic health record) contingency code for carers in 22/23 (10% of 24/25 target below per region)
- 2,000 young carers identified by uses of SNOMED CT in 22/23 (10% of 24/25 target below per region)

Accountability

- GM Directors of Adult Social Care

9 Achieving financial sustainability

Financial sustainability - 'living within our means' - requires an initial focus on financial recovery to achieve a balanced position. We will identify the main reasons for financial challenges in Greater Manchester, and implement a system wide programme of cost improvement, productivity, demand reduction and service transformation.

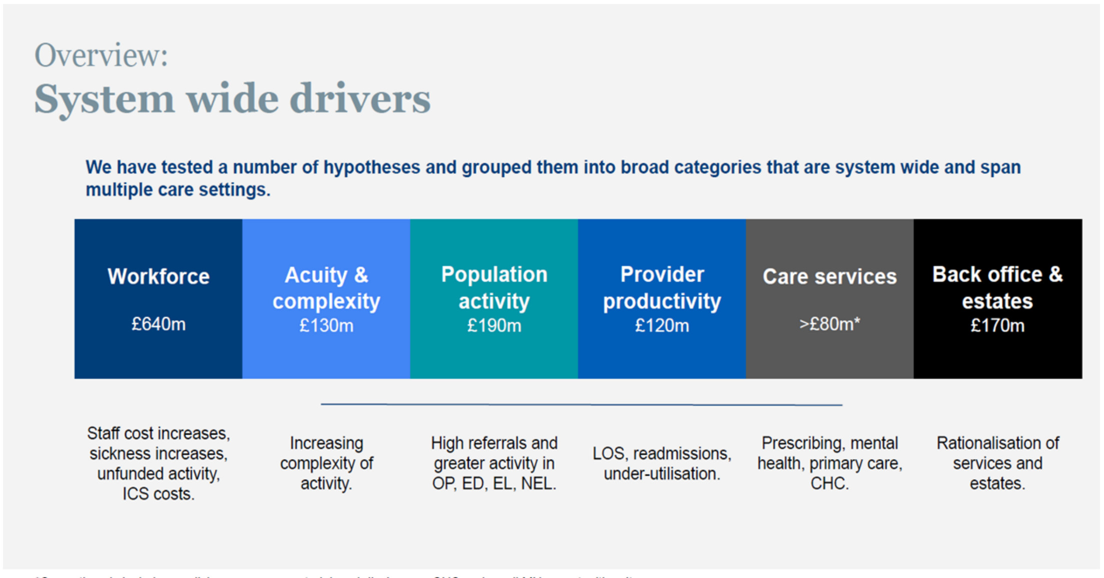
The Greater Manchester system has both an efficiency and a productivity challenge. NHS GM inherited a system structural budget deficit (commitments over revenue) of over £500 million (out of a total budget of £6.5 billion) on its establishment on 1st July 2022. This reflects the ongoing cost of additional resources (mainly workforce) put in place during the COVID-19 pandemic. One of the national requirements of an ICB is to bring the system into balance

Achieving financial sustainability Delivery Leadership: Locality Boards; PFB System Leadership: Finance and Performance Recovery Board	
Areas of focus	**Actions**
Finance and Performance Recovery Programme	System recovery programme based on drivers of operational and financial performance
Developing Medium Term Financial Sustainability Plan	Development of three-year financial plan

9.1 Area of Focus: Finance and Performance Recovery Programme

Our system is under significant financial and operational pressures with the position having worsened due to the impact of COVID-19. To build the foundations for long-term sustainability we will put in place a recovery programme covering both finance and performance. The first step we took in early 2023 was to deepen our understanding of what is driving our current challenges. Figure 10 shows one of the outputs of this exercise with the drivers set out in broad system categories.

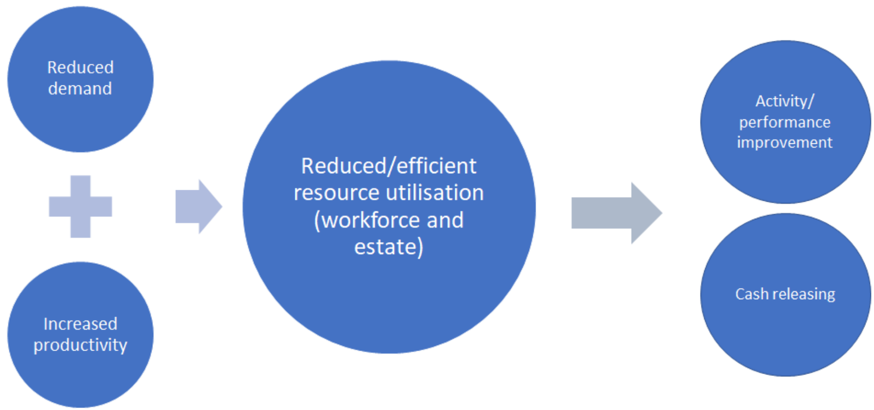
Figure 10



*Currently only includes medicines management, delayed discharges, CHC and small MH opportunities. It is likely that this number will grow when further analysis is undertaken.

As part of our approach, we need to better understand and act on our performance on productivity (which has declined since 2019/20) Improved productivity will create activity or cash benefits (Figure).

Figure 11



Measuring our Delivery

- Return of System to Recurrent Financial Balance

Accountability

- Finance and Performance Committee

9.2 Area of Focus: Securing Long-Term Financial Sustainability

It is recognised that GM needs to move into a more sustainable position in terms of finance, performance and service sustainability. Specifically, that the system can plan and deliver financial and performance objectives without a sense of crisis or non-recurrent interventions. This is more than a single year task.

The delivery of the missions in this plan all contribute to the medium - and long-term achievement of financial and operational sustainability. As well as reducing costs, we will also need to drive down demand on services by continuing to invest in early intervention, prevention and integrated neighbourhood care and support. We must also consider how resources are distributed across GM to maximise our efforts to reduce health inequalities.

9.2.1 Development of three-year financial plan

We have identified 13 improvement opportunities following the diagnostic into GM's drivers of operational and financial challenge. Reforming how the system operates in these areas will be key to our securing long-term transformation and financial sustainability.

Theme	Transformation Opportunities
Workforce	1. Identify opportunity to 'right size' the workforce across GM 2. Plan to identify shared services business model across corporate functions
Acuity and Complexity	3. GM System High Impact Care model 4. Digital Health Model
Population Activity	5. System review of volume of Outpatient referrals
Provider Productivity	6. Reduce DNAs through patient engagement 7. Reduce Non-Elective Length of Stay 8. Improve Outpatient Performance 9. Improve Theatre Throughput
Care Services	10. Mental Health Operational Processes and Demand and Capacity Review 11. Discharge to Adult Social Care Process Review
Corporate Functions and Estates	12. Optimised Estate 13. Maximise value of tech assets and licenses

This work will support the GM system moving to a multi-year planning cycle. We propose to start the planning process much earlier in the financial year – allowing us greater scope to align our approach across the system; confirm our priorities; and mitigate key risks. This will also support greater integration between NHS and local authority planning – including on budget setting. Our approach will be to set out our plans and then make any adjustments to these based on national guidance.

Measuring our Delivery

- Return of System to Recurrent Financial Balance

Accountability

Finance and Performance Committee

10 How We Will Deliver

10.1 Performance Framework

The ICP strategy contains four high-level outcomes (what we are aiming to achieve) and six missions (what we will do – our actions) which will together lead to the outcomes. This relationship is shown in the table below:

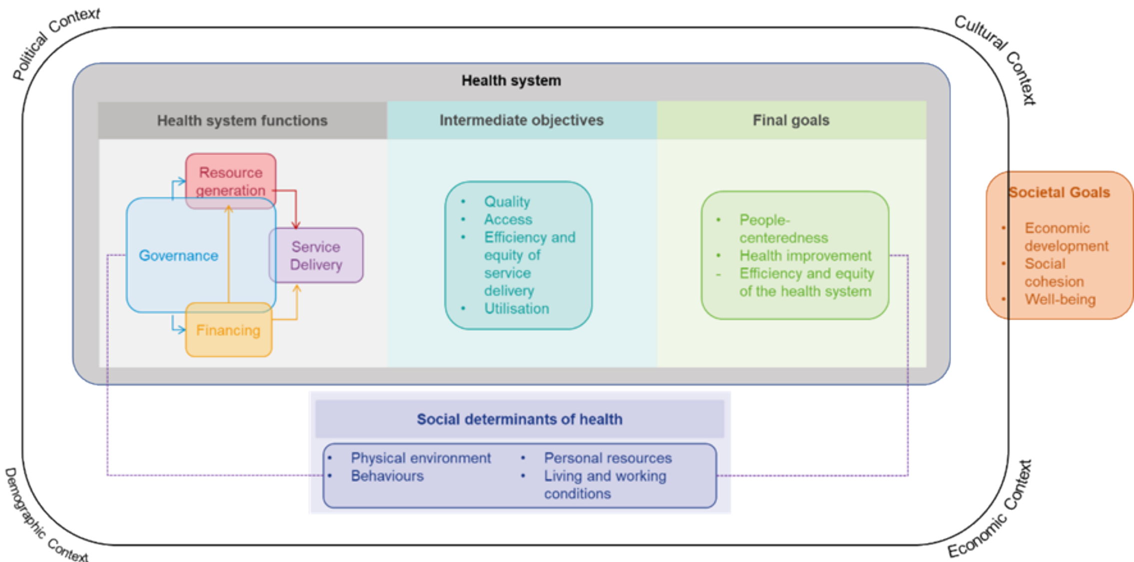
Health and care services are integrated and sustainable	Everyone experiences high quality care and support where and when they need it	Everyone has improved health and wellbeing	Everyone has an opportunity to live a good life
Achieving financial sustainability • Delivery of a balanced recurrent ICB and system financial position ***Supporting our workforce and our carers*** • Increase in Good Employment Charter membership from the health and care sector • Number of health and care organisations paying the RLW	***Recovering core NHS and care services*** • Year-on-year improvement in meeting national targets for core services • Equitable service provision across all areas in Greater Manchester	***Helping people stay well and detecting illness earlier*** • Life Expectancy and Healthy Life Expectancy • Avoidable mortality rates • Reductions in health inequality in the onset of multiple morbidities • Physical activity • Smoking prevalence • Obesity	***Helping people get into, and stay in, good work*** • Number of people starting work • Number of people staying in work ***Strengthening our communities*** • Reduced anxiety • Improved life satisfaction • Feelings of safety

Both the outcomes and the missions are interlinked and depend on each other. We have developed a framework for performance to be assured and assessed and accountability to be clear. This framework applies to both the activities under the direct influence and resourcing of NHS GM and the social determinants of health. Both are essential to improving the health of our population and delivering our strategy.

Our approach is based on a revised version of the framework selected by the University of Manchester research team for their analysis of the effects of health and social care devolution and the World Health Organisation (WHO) Health System Performance Assessment (HSPA) framework

This framework shows how the health system – its functions, intermediate objectives and final goals - and the social determinants of health act together to influence societal goals, within a political, socio-economic, demographic and cultural context. This is illustrated below.

Figure 12



NHS England requires reporting against the objectives it sets for the NHS in England (NHS Oversight Framework metrics). For 2023/4 there are 56 measures across the domains defined by NHSE as:

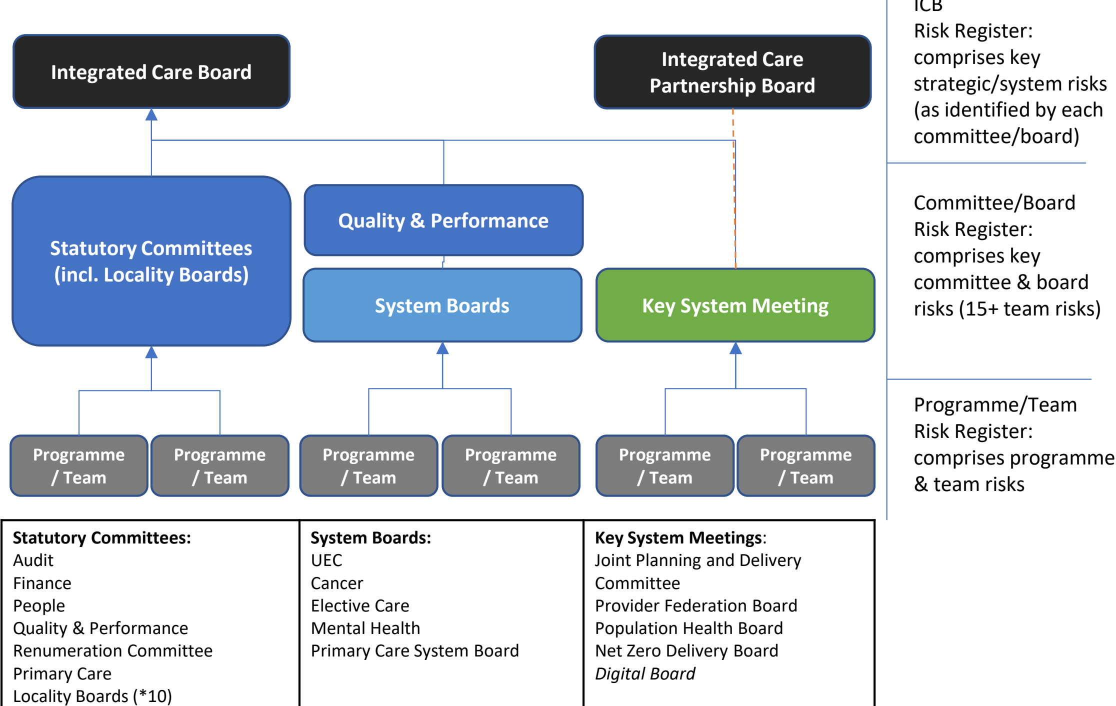
- Quality of care, access and outcomes (34 measures)
- Preventing ill health and reducing inequalities (8 measures)
- Leadership and capability (3 measures)
- Finance and Use of Resources (4 measures)
- People (7 measures)

We will use all these measures to assess progress against this plan but will also add others to enable a balanced view of performance across the whole health system and its wider context. These will be mapped to the sections of the performance framework.

10.2 Assurance and Governance Arrangements

We will manage delivery and risk through our governance and assurance arrangements – these are shown in Figure 13.

Figure 13



The delivery of our operational plans will be overseen by a Finance and Performance Recovery Board, which will be responsible for assuring delivery of the GM operational plan, providing overall system oversight and direction.

Through its membership reporting will flow into the various statutory organisations within the system.

It will be supported by

(a) A Finance and Workforce Group: responsible for

- Having oversight of the overall GM financial plan / position
- Tracking delivery of system/organisation Cost Improvement Plans (CIPs) and Quality, Innovation, Productivity and Prevention (QIPP) plans
- Alignment of workforce planning with financial recovery
- Overseeing implementation of specific projects relating to financial recovery

(b) A Performance and Delivery Group: responsible for

- Resolving planning risks
- Gaining greater assurance of delivery of high-risk plans
- Tracking achievement of GM planning assumptions
- Overseeing implementation of specific projects to achieve either performance or financial objectives.

10.3 Commissioning

The 2022 Health and Care Act entailed significant structural change for NHS commissioning with NHS Greater Manchester Integrated Care becoming responsible for the commissioning responsibilities of CCGs, as well as taking on several commissioning functions from NHSE (with a plan for further delegation over time).

We are working with partners across GM to optimise the way we commission services and realise the efficiencies from bringing twelve organisations into one. We will confirm our plans in 2023/24.

10.4 Our Equality Objectives

The Health and Care Act 2022 introduced a range of obligations in relation to health inequalities, which underpin the discharge of NHS Greater Manchester's functions as a statutory organisation.

We have prioritised three overall Equality Objectives to cover the period to March 2026. This is set out below:

Equality Objective	*In doing so, NHS Greater Manchester Integrated Care will*
Our People	
• Strengthen inclusive and accountable decision making and leadership with a clear organisational commitment to advance Equality and Inclusion	• Develop and monitor equality performance objectives for all senior leaders and staff in NHS GM Integrated Care. Measure and share progress and achievements. • Develop and implement a diverse leadership, talent, and career progression action plan to work towards reaching representational parity over time with a focus on race and disability initially • Strengthen governance for equality and inclusion with a particular focus on ensuring equality impact assessments are integral to decision making
• Improve representation and provide an accessible and	• Have designed and begun delivering an equality education programme for all ICB staff and board to meet the

inclusive working environment and culture enabling NHS GM Integrated Care to become an employer of choice where all people can flourish	challenges set out for ICSs to improve outcomes in population health and healthcare and tackle inequalities in outcomes, experience, and access. • Strengthened staff and leadership capability to recognise and act on existing workforce disparities by setting and moving towards aspirational targets to improve recruitment, experience, and development opportunities for minoritised ethnic staff and disabled staff in the first instance
Our Communities and Insight	
• Engage and involve communities who experience discrimination and disadvantage in planning, design, and delivery of health interventions	• Improve the collection, analysis, and application of quantitative and qualitative equalities related information, insight and learning to enable targeted action where required. • An agreement with VSCE and user led/community organisations where NHS Greater Manchester Integrated Care decisions will be co-designed with communities /VCSE • Strengthened and harmonised an approach to integrating community intelligence into commissioning decision making
Improving our Outcomes	
• Working with others to drive the reduction of inequalities in access, experience and outcomes of health and care services	• Build capabilities and confidence across the NHS Greater Manchester Integrated Care workforce to recognise and mitigate disparities experienced by protected groups and their intersectionality across all commissioned services through performance requirements of providers • Be able to evidence consideration in commissioning expenditure decisions to address inequalities and advance equalities • Quality and performance reviews of providers able to identify and measure provider progress towards addressing inequalities and advancing equality • Evidenced meeting agreed targets to reduce inequalities in our Core 20 plus 5 priority areas
• Set equality performance goals and develop a measurement framework to evidence how we are addressing inequalities and advancing equalities	• Co –produce a single bank of online community and NHS equality intelligence and insight • Develop a broad approach to inclusive data particularly for gender, ethnicity, disability, and sexual orientation to better understand patterns and gaps and to respond accordingly • Agree equality related performance objectives for all its staff. • Developed an equalities measurement framework by which we can evidence impact and change towards addressing inequalities

• Pro-actively address existing systemic and structural racism through the implementation of an anti-discrimination approach for NHS GM Integrated Care. Intersectional by default	• Develop an effective and evidence-based race equality action plan aligned to the Race Equality Strategy being developed through the GMCA and the GM Race Equality panel • Intersectionality will be considered within this work to understand how systems of oppression overlap to create distinct experiences for people with multiple identity categories • Become an early adopter of the NW BAME Assembly's anti-racist framework and set structures to deliver fair and equitable outcomes for people and communities that experience racial inequality which will include our workforce. • Set out an approach with providers and localities that will evidence improved outcomes for those most likely to have difficulty accessing health and care, have a poorer experience or outcomes related to institutional discriminations

10.5 Locality plans

Our ten localities in Greater Manchester - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan - all have local authority plans (or strategies), locality plans for health and care and Health and Wellbeing plans. The Joint Strategic Needs Assessments (JSNAs) in each locality have specifically informed the Health and Wellbeing plans, as well as the other plans.

These plans have informed our ICP Strategy and this Joint Forward Plan. As set out in this document, a significant proportion of this plan will be delivered by our 10 localities.

Links to each of these plans for each of the localities, where information is available at time of writing, are given in the table below, along with a link to the Health and Wellbeing Board in each locality. This information will be updated as plans in localities are updated. A summary of the plans can be found in Appendix 2.

A draft of this plan was sent to each Health and Well Being Board (HWB) in GM for comments. When the plan is updated, it will be shared with HWBs for comment and feedback will be incorporated.

Locality	Local Authority Plans/ Corporate Plans	Health & Care (Locality) Plans	Health & Wellbeing Plans Health and Wellbeing Board
Bolton	Bolton Vision 2030 (currently being updated)	Currently being updated	Same as LA plan **H&WB Board**: Active, Connected and Prosperous Board 2014 Onwards > The Active, Connected and Prosperous Board (bolton.gov.uk)
Bury	Let's Do It! Strategy (bury.gov.uk)	221222 locality plan refresh v3.1.docx	Same as LA plan **H&WB Board:** Browse meetings - Health and Wellbeing Board - Bury Council
Manchester	Our Manchester Strategy- Forward to 2025 | Manchester City Council	Refreshed 2021 - 5 yr. strategy Manchester Locality Plan Refresh v2.0 MPE Priorities for adults and children (2023-2026) MPB priorities - 2 slides.pptx	Making Manchester Fairer https://www.manchester.gov.uk/makingmanchesterfairer **H&WB Board** Browse meetings - Health and Wellbeing Board (manchester.gov.uk)
Oldham	Corporate Plan | Corporate Plan | Oldham Council - 2022-27	currently being updated	Currently being updated **H&WB Board:** Committee details - Health and Well Being Board (oldham.gov.uk)
Rochdale	https://www.rochdale.gov.uk/downloads/download/393/corporate-plan	Rochdale Borough Locality Plan 2020-2024	Same as locality plan **H&WB Board** https://democracy.rochdale.gov.uk/mgCommitteeDetails.aspx?ID=558
Salford	Our priorities, the Great Eight • Salford City Council	Salford Locality Plan 2020-25 (partnersinsalford.org)	Same as locality plan **H&WB Board** Browse meetings - Health and Wellbeing Board • Salford City Council
Stockport	borough-plan.pdf (onestockport.co.uk)	Enc 1 - One Health and Care Plan.pdf (stockport.gov.uk)	Same as locality plan **H&WB Board** https://www.stockport.gov.uk/health-and-wellbeing-board
Tameside	'Our People Our Place Our Plan'	Currently being updated - will be a joint locality and H&WB Plan	Currently being updated **H&WB Board** https://tameside.moderngov.co.uk/mgCommitteeDetails.aspx?ID=221
Trafford	Corporate-Plan-2021-2024.pdf (trafford.gov.uk)	2021 refresh Trafford Together Locality Plan (traffordpartnership.org)	2019-2029 Trafford Health and Wellbeing Strategy 2019.pdf **H&WB Board:** Health and Wellbeing Board (traffordpartlonership.org)
Wigan	The Deal 2030 (wigan.gov.uk)	Currently being updated - Due Sept 23	Currently being updated - Due Sept 23 **H&WB Board:** Committee details - Health and Wellbeing Board (wigan.gov.uk)

10.6 Implementing this Plan – Next Steps

This is the first delivery plan for the Integrated Care System in Greater Manchester. In developing this plan, we are clear that we must maintain our focus on making best use of our resources and achieving the best outcomes for our residents.

This means that we will continue to develop this plan after this first version is finalised at the end of June 2023. There will be particular focus on delivering the recommendations from the Leadership and Governance Review carried out in the first quarter of 2023/24 including revisiting the accountability proposals set out in this document and confirming our operating model.

The steps we will take following the publication of this plan will focus on confirming our approach to long-term financial sustainability. The steps we will take are:

- Setting out in detail the phasing of all the programmes set out in this plan – across years 1,2 and 3 of the plan and prioritising those initiatives that will have the greatest impact
- Ensure that all elements of the plan are costed and the impact quantified in line with our medium-term financial plans
- Continue to strengthen the delivery metrics
- Quantify the population health potential of a fundamental shift in demand and a greater emphasis on early intervention and prevention.
- Informed by this, position the key choices the GM system will need to make to deliver on long-term financial sustainability and continuing to improve health outcomes

We expect to complete these steps by October 2023.

Appendix 1

How this plan addresses the statutory requirements for a JFP

The legislative requirements for the JFP[17] – which relate to the statutory responsibilities of the ICB – are summarised below, along with how they are covered in this plan.

Legislative requirement	GM response
Describing the health services for which the ICB proposes to make arrangements.	Covered particularly in our missions for: • Helping people stay well and detecting illness earlier • Recovering core NHS and care services • Supporting our workforce and carers
Duty to promote integration	As part of a mature partnership model in GM, working across sectors, this plan ensures that the ICB develops activities and works in ways which promote and enable integration. Going beyond the legislative requirements, the integrated approaches adopted in GM ensure that health services, social care and health-related services and designed and delivered in ways which align to support attainment of the whole systems shared outcomes and commitments.
Duty to have regard to wider effect of decisions	The outcomes we have defined through the strategy and that will be delivered through this plan, have been developed in ways which ensure we are clear on the impacts of our decisions, and responsive to the 'triple aims' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.
Financial duties	Described in our mission for: • Achieving financial sustainability

[17] https://www.england.nhs.uk/long-read/guidance-on-developing-the-joint-forward-plan/#appendix-1-legislative-framework-further-detail

Legislative requirement	GM response
Implementing any JLHWS	Our locality (health and care) and Health and Wellbeing Plans are all linked from this plan (section 10.5) and summarised in Appendix 2. They are aligned with this plan.
Duty to improve quality of services	Covered in our missions for: • Helping people stay well and detecting illness earlier • Recovering core NHS and care services. Our quality strategy is a specific action in this mission.
Duty to reduce inequalities	The activities we deliver through this plan seek to reduce unwarranted inequalities in outcomes, service experience and access for all people and parts of Greater Manchester, as described throughout. One of our ways of working (section 3.2) specifically emphasises this duty
Duty to promote involvement of each patient	In addition to this being one of our ways of working (section 3.2), it is also a fundamental element of our Model for Health and Wellbeing. It is also a focus of our missions for: • Strengthening our communities and • Helping people stay well and detecting illness earlier.
Duty to involve the public	The strategy was developed through extensive consultation and engagement with communities, partner agencies, practitioners and staff, across all ten localities (section 1.4). The process of development was iterative, developing and adapting to the feedback received and ensuring the strategy and this plan are reflective of the needs and expectations of our communities.
Duty to patient choice	This is implicit in our mission for recovering core NHS and care services
Duty to obtain appropriate advice	As part of the network of governance which oversees and supports the delivery of this plan the ICB has access to and routinely draws upon appropriate advice and guidance from partners, stakeholders and experts.
Duty to promote innovation	Innovation is a specific action in the mission for Recovering core NHS and care services (section 7.5.2), and draws on our assets in Health Innovation Manchester

Legislative requirement	GM response
Duty in respect of research	Utilising the research expertise in our city region, and building on working relationships we already have, we will ensure our responses to these challenges are data driven, drawing on the best possible evidence to support the design and delivery of our actions, as described in section 7.5.2.
Duty to promote education and training	Covered in our mission for: • Supporting our workforce and our carers
Duty as to climate change, etc.	As partners in Greater Manchester, we share the GMS vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region. The NHS contribution to this (section 4.3.1) is an area of focus in our mission for: • Strengthening our communities
Addressing the particular needs of children and young persons	This is a specific action in our mission for strengthening our communities (section 4.2.4) and is also covered in a number of other sections including sections 5.1.3 and 5.2.5.
Addressing the particular needs of victims of abuse	A specific action in our mission for strengthening our communities (section □), and part of a GM approach to violence reduction.
Engagement with Health and Well-Being Boards	All our Health & Wellbeing Boards (HWBs) have been consulted on the development of the JFP – a draft version of which was circulated to the 10 HWBs for review at the end of May with a set of key questions This was followed up with an invitation to attend the respective H&WB meetings to present on the JFP and discuss the process by which local Health and Wellbeing strategies were utilised to support in the development of the JFP Comments, amendments and additions were received from the ten HWBs – these were fully considered and where appropriate the JFP was revised accordingly.

Appendix 2

Our locality plans[18]

Bolton

The health and care (Locality) plan is currently being updated. The Health & Wellbeing Plan is the Local Authority Plan.

Bolton Vision 2030 is a local partnership that brings together senior leaders from the voluntary, community and faith sector, the private sector, the university, college and schools, health, emergency services and the council. Bolton 2030 is the long term vision for the borough. The vision partnership wants to see a Bolton which is ACTIVE, CONNECTED AND PROSPEROUS

Principles

The vision is supported by a set of principles:

- Generating inclusive growth and prosperity which reaches all corners of communities and benefits all citizens
- Protecting the most vulnerable whilst recognising that they are members of their communities and can have much to offer
- Reforming services in partnership in order to maximise the impact of activities and create sustainable change in communities.

Outcomes

Bolton 2030 is built around 6 outcomes for their people and places. These are:

- **Start Well:** Our children get the best possible start in life, so that they have every chance to succeed and be happy
- **Live Well:** The health and wellbeing of our residents is improved, so that they can live healthy, fulfilling lives for longer
- **Age Well:** Older people in Bolton stay healthier for longer, and feel more connected with their communities
- **Prosperous:** Businesses and investment are attracted to the borough, matching our workforce's skills with modern opportunities and employment
- **Clean and Green:** Our environment is protected and improved, so that more people enjoy it, care for it and are active in it
- **Strong and Distinctive:** Stronger, cohesive, more confident communities in which people feel safe, welcome and connected

[18] Correct as of 31 May 2023

Bury

The Health & Wellbeing Plan is the Local Authority Plan

Bury's refreshed Locality Plan (2023) is a refresh of their strategy for health and care and wellbeing in the borough. It sits in the context of the overall strategy for the borough – "Let's Do It". This plan – like its predecessors - has at its core the ambition to fundamentally improve population health and wellbeing, and to reduce health inequalities. This is important to ensure Bury residents can lead the lives they want, but also to create a financially sustainable health and care system that is characterised by prevention of poor health, and early intervention, rather than reactive and costly service provision.

Bury has four overarching outcomes for the Locality Plan:

1. A local population that is **living healthier for longer** and where healthy expectancy matches or exceeds the national average by 2025.
2. A **reduction in inequalities** (including health inequality) in Bury, that is greater than the national rate of reduction.
3. A local health and social care system that provides high quality services which are **financially sustainable and clinically safe.**
4. A greater proportion of local **people playing an active role in managing their own health** and supporting those around them.

The objectives of the refreshed locality plan are:

1) We will seek to **influence the factors that improve population health** and well-being and reduce health inequalities and foster inclusion
2) We will **support residents to be well, independent, and connected** to their communities and to be in control of the circumstances of their lives
3) We will support **residents to be in control of their health and well being**
4) We will **support children to 'start well'** and to arrive at school ready to learn and achieve
5) We will **support people to take charge of their health and care and the way it is organised around them, and to live well at home**, as independently as possible
6) We will ensure all residents **have access to integrated out of hospital services** that promote independence, prevention of poor health, and early intervention and where front-line staff are working together in 5 neighbourhood teams
7) We will work to ensure **high quality responsive services** where people describe a good experience of their treatment
8) We will work to **control the overall costs of the health and care system** by earlier intervention, prevention, and working with the strengths within people, families, communities

A range of Transformation Programmes are described including Urgent and Emergency Care; Learning Disabilities; Elective care; Cancer Services; End of Life Care Pathway; Primary Care; Mental Health; Community Services; Adult Social Care; Children's Health and Care and Public Health.

Manchester

The 2021 refresh of Manchester's Locality Plan, Our Healthier Manchester, seeks to reaffirm their ambition to create a population health approach that puts health at the heart of every policy, improving health and care outcomes for the people of Manchester, whilst recognising that plans for the future will need to continue to evolve and respond to those changing needs, within a new governance structure.

Manchester's Locality Plan has five strategic aims and key intended outcomes:

- Improve the health and wellbeing of people in Manchester
  - Narrow the life expectancy gap between the city's residents
  - Improved health & wellbeing, quality of life
  - Reduction in preventable deaths (all causes).
- Strengthen the social determinants of health and promote healthy lifestyles
  - Reduction in smoking prevalence to 15% or lower by 2021
  - Increase in the number of children who are school ready
  - Reduction in residents who are out of work due to an underlying health condition/disability.
- Ensure services are safe, equitable and of a high standard with less variation
  - All providers have a CQC rating of good or above
  - All national and local quality standards are met.
- Enable people and communities to be active partners in their health and wellbeing
  - Increase the level of knowledge and confidence that people have in managing their own health.
- Achieve a sustainable system
  - Achievement of financial balance across the system
  - Achievement of constitutional and statutory targets
  - Developing a sustainable workforce.

Manchester's Health and Wellbeing Plan is the 'Making Manchester Fairer' Plan 2022-2027 which has 8 themes focused on tackling health inequalities:

1) Focus on giving children the best start in life
2) Addressing poverty. This affects everything, especially set against the cost-of-living crisis
3) Good work is good for your health
4) Focus on preventing ill health and preventable deaths, so this will also include the four big killer diseases/conditions in Manchester
5) Homes and housing
6) Places, environment and climate change
7) Tackling systemic and structural racism and discrimination
8) Focus on communities and power, so that we concentrate on what really matters to our local communities and residents, and so that they are heard and influence what we do. This includes acting on the voices of those who are often less heard.

Oldham

Locality Plan currently being updated – due July 2023

The Oldham Health & Wellbeing Strategy (2022-30) does not represent the extent of their commitment to health and wellbeing or all the work on health and wellbeing taking place in the borough but focuses on some of the issues which make the greatest contribution, and where they can have the biggest impact in the shortest amount of time, working together. The overall aim for the Health and Wellbeing Strategy is to close the gap in life expectancy between Oldham and England as a whole.

Vision
Oldham residents are happier and healthier; they feel safe, supported and they thrive in this vibrant and diverse borough.

Ambition
People lead longer, healthier, and happier lives, and the gap in health outcomes between different groups and communities in Oldham, and between Oldham and England, is reduced. A demonstrable difference will be made to the average life expectancy and average healthy life expectancy of residents, and inequalities will be reduced.

Principles

Oldham are resident-focussed, this means they are:

- Having a two-way conversation with residents about their health and wellbeing, making sure residents feel heard and that needs are responded to in ways that can be understood by all
- Building trust and strengthening relationships with residents through kindness and compassion
- Engaging with communities to co-produce solutions and co-design services
- Providing support and care which is as close to, and as connected with, home and community as possible

We have a well-managed health and care system:

- Which provides good quality, safe services, and we use resident feedback to continually improve
- With services which are easy to access, and transition between different services is seamless; digital solutions are embraced where appropriate
- Which uses data, intelligence, and insight to plan services and improve the coordination of care
- Ensuring best value for the Oldham pound and maximising the wider social, economic, and environmental benefits of public spending

We are champions of equality; we are:

- Striving to reduce inequalities, offering more to those who face the greatest disadvantage or experience the worse outcomes
- Recognising diversity and delivering culturally competent services

- Developing a workforce which represents the community
- Focussing equally on mental health and emotional wellbeing, and physical health

We prioritise prevention by:

- Promoting wellbeing and prevention of ill-health for residents in all life-stages
- Providing residents with easy access to the information and support that need to stay well, healthy and be independent
- Taking a whole-system view for each of our residents, taking account of wider determinants and past experiences to provide the most appropriate and effective care
- Recognising the importance of voluntary, community and faith organisations in improving health and wellbeing, and making the most of existing community assets and insight

Oldham's Priorities

- Supporting our residents to gain the knowledge and skills to confidently make choices and participate in decisions about their own health
- Giving children the best start in life
- Improving mental wellbeing and mental health
- Reducing smoking
- Increasing physical activity

Rochdale

The Health & Wellbeing Plan is the Local Authority Plan

The Rochdale Locality Plan 2020-24 – 'Co-operating for better health and wellbeing' - sets out how they will do all they can so that residents in the borough live long and happy lives that are as healthy as possible, for as long as possible. If achieved, it will mean that they will have '**improved the health, care and wellbeing outcomes for the borough of Rochdale'.** They will work together in partnership so that '**everyone in the borough will make things better for themselves and others'.**

To do this, Rochdale have established six core principles, or ways of working across their partnership of stakeholders (including residents). These six principles run through every aspect of the plan and are core to how they operate. These principles are set out below.

- Co-operation
  - Public services, partners, citizens, businesses and the voluntary sector will share decision making and jointly design and deliver services.
- Prevention and intervention
  - Prevention will be part of everything they do, and they will support their residents and workforce to take care of themselves and others.

- Integrated and local

  - Public services, partners and the voluntary and community sector will share skills, expertise and resources to deliver person and community centred services at the right time and in the right places for residents.
- Strengthening community assets
  - Individuals and families will be supported to use their skills, experience and collective kindness to improve communities.
- Collective change
  - They will work together to change things so that Rochdale will have sustainable services and have reduced inequalities.
- Addressing the climate emergency
  - Rochdale will increase efforts to ensure that they consider and reduce the negative impacts that services and activities have on the environment

Strategic workstreams

- Further developing **Integrated Strategic Commissioning**
- Further establishing the **Local Care Organisation**
- Delivery of a programme of **transformation** in order to reduce demand, improve outcomes and reduce inequalities
- Strengthening a range of **enablers** to support this work; Workforce, Health and social care intelligence, Estates, Digital and Finance.

Salford

Locality plan is also the Health and Wellbeing Plan

The 2020-2025 refreshed Salford Locality Plan is the link between understanding of needs and opportunities in health and wellbeing, and the coordinated response to them. Right across Salford, all partners are committed to improving health and wellbeing and to reducing health inequalities and maximising the social value return to Salford. Pooling of the great majority of the health and social care budget, and greater transparency on the rest, is helping Salford to invest in prevention, to prioritise spend on areas most needed, and to mitigate the impact of reducing resources on the most vulnerable and on health inequalities.

Vision: Salford is a place where everyone can enjoy the best opportunities that Salford has to offer. People in Salford will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health well into their older age and die in a dignified manner in a setting of their choosing. People across Salford will experience health on a parallel with the current 'best' in Greater Manchester (GM), and the gaps between communities will be narrower than they have ever been before.

Core outcomes

1) People will live longer, and those years will be lived in good health
2) The gap in life expectancy between the most and least deprived communities in the city will be reduced

Starting well outcomes
- I am a child who is physically and emotionally healthy, feel safe and able to live life in a positive way
- I am a young person who will achieve their potential in life, with great learning, and employment opportunities
- I am as good a parent as I can be.

Living well outcomes
- I lead a happy, fulfilling and purposeful life, and I am able to manage the challenges that life gives me.
- I am able to take care of my own health and wellbeing and I am supported to care for others when needed.
- My lifestyle helps me to stop any long term condition or disability getting worse and keeps the impact of this condition or disability from affecting my life.

Ageing well outcomes
- I am an older person who is looking after my health and delaying the need for care.
- If I need it, I will be able to access high quality care and support.
- I know that when I die, this will happen in the best possible circumstances.

Strong and resilient communities
- I feel safe and connected, and able to influence the decisions that affect me.
- I feel supported to make healthy choices in the places where I live, work, volunteer or visit.
- I have opportunities to contribute, and benefit from, a strong economy with quality local jobs.

There are a number of cross-cutting enablers that will facilitate delivery of the plan through workforce, estate, supportive technology, and a focus on quality and social value.

Stockport

Locality plan is also the Health and Wellbeing Plan

ONE Stockport - the Borough Plan - is based on the priorities which have come from extensive engagement with the people who live and work in Stockport. Health and Wellbeing are at the forefront of Stockport's vision for 2030 and a key priority for local people. Stockport believe that the best way to deliver their vision is through collaboration across the wide range of partners who support health and wellbeing for local people.

The locality plan – ONE Stockport Health & Care Plan - sets how they will work together as a system to deliver ONE Stockport's vision for **a Healthy and Happy Stockport.** Stockport's vision for 2030 sees everyone working together to develop a

borough which is inclusive, caring, enterprising and full of ambition. They want people to live the best lives they can and feel happy, healthy, included, and independent.

Their principles are:

- Person-centred
- Place-based
- Outcomes-focused
- Strengths and asset-based
- Fair
- Sustainable

Stockport intend to deliver each of the health and care commitments in the borough plan through eight delivery programmes:

- Quality & Leadership
- Early Help & Prevention
- Independence & Reablement
- Mental Health & Wellbeing
- Tackling Inequalities
- Stockport's Neighbourhoods
- Age-Friendly Borough
- Valued Workforce

The impact of these changes will be seen in the following outcomes:

- Stockport residents will be healthier and happier
- Health inequalities will be significantly reduced
- Safe, high quality services will work together for you
- Stockport residents will be independent and empowered to live their best lives

Tameside

Currently being updated (Joint Locality and Health and Wellbeing Plan) – Timescales TBC

Trafford

The Trafford Together Locality Plan 2019-24 was first agreed in November 2019, and the plan has been refreshed in 2021 in light of the changing context and the formation of the Integrated Care System. The refresh, like the 2019 Plan, is based on 4 main priorities; Our Population, The People We Serve, The Place Where We Live and Work, and The Partnerships We Create. There are three main aspirations for this plan: better lives for Trafford's most vulnerable people, better wellbeing for their population and better connections across their communities.

The principles in the 2019-24 Plan remain a key focus; Together as Partners – co-ordinating across the health and social care system, thinking bigger and doing better using combined resources to improve outcomes for residents.

- In a Place – being positive about places and spaces, bringing people who live and work in an area together to build stronger communities.
- With People – putting residents at the heart of what they do, listening and working with people.
- Focusing on Prevention – commitment to taking action early and making every contact count.
- Continually improving – making the most of technology and using data and information to make shared decisions. Continuing to learn and develop workforce and make the best use of combined assets

Trafford has 4 Strategic Design Groups:

- Living Well in My Community
- Living Well at Home
- Short Stay in Hospital
- Our Ambition for Children in Trafford

The Health and Wellbeing Board is focussed on its residents' journeys through life, taking a life course approach that reflects the public health needs of that age group. Through the Health & Wellbeing Strategy they aim to improve outcomes at each stage while ensuring that seven overarching priorities (below) are considered, and ensuring interventions are evidence based, measurable and add value.

1. To reduce the impact of poor mental health
2. To reduce physical inactivity
3. To reduce the number of people who smoke or use tobacco
4. To reduce harms from alcohol
5. To reduce poverty
6. Reduce the impact of climate change
7. Healthy Weight

Wigan

Wigan's Locality Plan sets out our ambition to deliver integrated care and support tailored to local needs that is available closer to home in the neighbourhoods where people live. It brings together the borough's NHS care for physical and mental health along with GPs, social care, and the voluntary sector.

Our single system plan is overseen by the strategic partners in the Healthier Wigan Partnership (HWP) including secondary care, mental health, social care, primary care, and the voluntary, community, faith, and social enterprise sectors. The plan restates the collective long-term ambition of the partners, building upon the 'Wigan Deal', and provides a 'golden thread' to connect the programmes of work that will drive the improvements, service transformation, and outcomes which we will collectively deliver. The Locality Plan is the foundation for driving the work of the HWP System Board's strategic decisions about the use of our collective assets and resources.

Our ways of working

We recognise that there needs to be a fundamental shift in the way that we plan and deliver services. We have agreed a set of principles which underpin the way we work in Wigan in order to achieve our collective objectives. These are:

- Community health and wealth building
- Asset-based and personalised approaches
- A focus on early intervention and prevention
- A Marmot approach taking action on the wider determinants of health
- Integrated approaches in planning, delivery, and decision making; working as 'Team Wigan'
- A neighbourhood approach building relationships and connections; empowering and working with our communities to improve health and wellbeing
- Intelligence-led (including insights from those with lived experience)

Our programmes

Our Integrated Delivery Board oversees the following programme steering groups and reports on progress to the HWP System Board:

- Children and Young People
- Population Health
- Mental Health
- Community Health Building and Asset-based Approaches
- Urgent and Emergency Care
- Elective and Cancer Care
- All Age Integrated Neighbourhoods

Our priorities

The locality has jointly agreed the following three priorities for 2023 / 24:

- Diabetes
- Patient flow and discharge
- Children and young people

Appendix 2

Manchester's plan on a page for 2023 to 2026

Strategic aims:

- Improve the health and wellbeing of people in Manchester
- Strengthen the social determinants of health and promote healthy lifestyles
- Ensure services are safe, equitable and of a high standard with less variation
- Enable people and communities to be active partners in their health and wellbeing
- Achieve a sustainable system

Our two priorities for 2023-26 are:	As a result, people will:	We will deliver through action on:
1. Improve physical and mental health and wellbeing, prevent ill-health and address health inequalities	• Live longer in good health, wherever they are in the city	• Effective prevention and management of long term conditions to keep people healthier • Targeted work with communities, regeneration and improving the social determinants of health • Joined up health and care services in neighbourhoods, which meet people's physical, mental and social needs
2. Improve access to health and care services	• Be able to access the right care, at the right time, in the right place, in the right way	• Improving speed and methods of access to primary care and mental health services • Optimising capacity in the community to reduce demand for hospital care and expedite hospital discharge • Enabling self care and promoting independent living • Improving workforce sustainability via local recruitment

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Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board - 20 September 2023

Subject: Armed Forces Community JSNA

Report of: Strategic Director of Children and Education Services

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Summary

This Joint Strategic Needs Assessment (JSNA) provides a summary of the evidence and data regarding the health of the armed forces community. It describes some of the health issues that may affect members of the armed forces community and what the data from the 2021 Census tells us about UK armed forces veterans living in Manchester.

It also describes what Manchester City Council and other organisations working in the city are doing to support members of the armed forces community and their families as well as some of the opportunities for action that exist.

Recommendations

The Board is asked to:

1. Note the content of the JSNA
2. Support the opportunities for further action described in the JSNA

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Members of the ex-Service community and their families are also at greater risk of financial and debt-related problems linked to poorer access to suitable employment opportunities.
A highly skilled city: world class and home-grown talent sustaining the city's economic success	Members of the ex-Service community are more than twice as likely than the general population to receive sickness or disability benefits, contributing to the high levels of ill-heath related economic inactivity in the city.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Members of the ex-Service community are more likely than the general population to report health conditions that limit their daily activity. Work to addressing these disparities will

	contribute to strategies to tackle health inequalities in the city.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection):

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

Manchester City Council. Armed Forces Annual Report 2021/22

1.0 Background

1.1 The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) states that every local authority must produce a Joint Strategic Needs Assessment (JSNA) describing the health needs of the population(s) within its area. Local Health and Wellbeing Boards are statutorily responsible for ensuring that a JSNA is published and that local partners have regard to the JSNA when planning health and care services for the populations they are responsible for.

1.2 This Armed Forces Community JSNA is designed to:

- provide a summary of the evidence and data regarding the health issues that may affect members of the armed forces community
- summarise what the data from the 2021 Census tells us about UK armed forces veterans living in Manchester
- describe what Manchester City Council and other organisations working in the city are doing to support members of the armed forces community and their families
- outline some of the opportunities for action that exist to address the health and care issues that affect the armed forces community in Manchester.

1.3 The initial content of the JSNA was put together to support preparations for Armed Forces Day on 20 May 2023. It adopts a newer, more succinct format that is designed to highlight the key messages and actions. However, it is underpinned by a more detailed and comprehensive set of evidence and data, which can be made available on request.

2.0 Armed Forces Community JSNA

2.1 For the purpose of the JSNA, the armed forces community includes serving members of the armed forces or reservists, armed forces veterans and the partners and children of serving members or veterans of the armed forces.

2.2 The 2021 Census in England and Wales was the first to ask people if they had previously served in the UK armed forces. Overall, 7,728 people in Manchester reported that they had previously served in the UK armed forces, which is equivalent to 1.8% of usual residents of the city aged 16 years and over. In total, there were just over 7,300 households in Manchester with one or more persons who had served in the UK armed forces (3.4% of all households in the city).

2.3 Appendix 1 contains a copy of the current version of the Armed Forces Community JSNA. Key points highlighted in the JSNA are as follows:

- National data indicates that working age ex-Service community are more likely than the general population to report health conditions that limit their daily activity, such as hearing difficulties, musculoskeletal problems and depression, and are also more than twice as likely than the UK population as a whole to be in receipt of sickness or disability benefits.

- The physical and mental health difficulties experienced by ex-service personnel may also have a wider impact on parents, siblings, partners, spouses and children.
- According to the 2021 Census, UK armed forces veterans in Manchester were over twice as likely as non-veterans to report being in poor health. Overall, 15.6% of UK armed forces veterans in Manchester reported that their health was “Bad” or “Very Bad” compared with 7.2% of people who had not previously served in the armed forces.
- Members of the ex-Service community and their families, particularly younger single people, those with dependent children or a long-term illness or disability, are also at greater risk of financial problems and are more likely to take on debt. The working age ex-forces community is almost twice as likely than their civilian peers to have unpaid caring responsibilities for family members, friends or neighbours.

2.4 The JSNA goes on to describe what Manchester City Council and other organisations working in the city. including the Royal British Legion and Walking with the Wounded, are doing to support members of the armed forces community and their families, and how this work links with other Council strategies. It also summarises the national NHS mental health and wellbeing support offer for armed forces veterans, including the Ministry of Defence Veterans and Reserves Mental Health Programme (VRMHP) and the Pennine Care Military Veterans Service (MVS).

2.5 The final part of the JSNA outlines some of thew opportunities for action, including Local Armed Forces Covenant Networks, the Defence Employer Recognition Scheme (DERS) and the role that local partners can play in continuing to provide support, general guidance, and specialised advice on issues within the context of their service/function.

3.0 Recommendations

3.1 The Board is asked to:

- Note the content of the JSNA
- Support the opportunities for further action described in the JSNA

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The Armed Forces Community in Manchester

Joint Strategic Needs Assessment (JSNA)

June 2023

Contents

1. Introduction: What is the JSNA?
2. What is the armed forces community?
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5. What is Manchester City Council currently doing to support the armed forces community?
6. Other organisations working to support the Armed Forces Community in Manchester
7. Potential links with other Council strategies
8. Opportunities for action

Introduction

This 'mini' Joint Strategic Needs Assessment (JSNA) provides a summary of the evidence and data regarding the health of the armed forces community. It is designed as a precursor to a more extensive JSNA that will be published later in 2023.

The JSNA describes some of the health issues that may affect members of the armed forces community and what the data from the 2021 Census tells us about UK armed forces veterans living in Manchester.

It also describes what Manchester City Council and other organisations working in the city are doing to support members of the armed forces community and their families as well as some of the opportunities for action that exist.

Introduction: What is the Joint Strategic Needs Assessment (JSNA)?

The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) states that every local authority must produce a **Joint Strategic Needs Assessment (JSNA)** covering the population(s) within its area

Local Health and Wellbeing Boards are statutorily responsible for assessing the health and wellbeing needs of their population and for publishing a JSNA.

Local partners are responsible for agreeing the content, format and frequency of update of the JSNA. There are no national standards for this.

Local authorities, Integrated Care Boards (ICBs) and NHS England must have regard to the JSNA when planning health and care services for the populations they are responsible for.

What is the armed forces community?

The Armed Forces Community includes:

- a serving member of the armed forces or a reservist
- an armed forces veteran (defined as someone who has served in the armed forces for at least one day)
- partners and children of a serving member or veteran of the armed forces

In the 2021 Census, 1,853,112 people in England and Wales reported that they had previously served in the UK armed forces (3.8% of usual residents aged 16 years and over).

The Armed Forces Covenant

The Armed Forces Covenant, published in May 2011, recognises that the whole nation has a moral obligation to members of the armed forces and their families and establishes how they should expect to be treated.

The core principles of the Covenant were enshrined in law in the Armed Forces Act 2011.

The Armed Forces Act 2021 introduced a new policy directive for some public bodies, including the NHS and local authorities, to pay due regard to the principles of the Covenant when carrying out work in the areas of housing, healthcare and education.

Under the Covenant all ex-service personnel are entitled to priority access to NHS non-emergency care for any condition as long as it is related to their service. However, some ex-service personnel have found that NHS staff are not always aware of their obligations under the covenant.

Health issues experienced by the armed forces community and their families

Research shows that:

- 35% of previously deployed veteran reservists report general health problems (10)
- 9% of veteran regulars and reservists report PTSD (10)
- 14% of veteran regulars with a deployment history report alcohol problems (10)
- 23% of ex-service personnel report common mental health disorders (8)
- 52% of veterans report long-term illness, disability, or infirmity (11)
- Females reported higher rates of mental disorders while males reported higher rates of PTSD

Physical and mental health difficulties experienced by ex-service personnel, such as sleepless nights, irritability, anger, isolation, depression, increased alcohol use, drug misuse and self-harm, may also impact on parents, siblings, partners, spouses and children

Health issues experienced faced by the armed forces community and their families (continued)

In addition to any health problems or disabilities that might arise during military service, ex-service personnel may also experience problems in adjusting to civilian life on leaving the Armed Forces, particularly, if they leave the services early.

Problems may include alcohol misuse and mental health issues such as anxiety, depression and post-traumatic stress disorder (PTSD). Finding employment and housing may also be difficult. (12)

Working age ex-Service community are more likely than the general population to report health conditions that limit their daily activity, such as hearing difficulties and musculoskeletal problems. They are also more likely to report being depressed. (12)

Working age veteran households are more than twice as likely as the UK population to be receiving sickness or disability benefits. (12) More than half of veterans (52%) report long-term illness, disability or infirmity compared with 35% of the general population. (11)

Many of the problems faced by the increasingly elderly ex-Service population are similar to those faced by the UK's elderly as a whole: isolation, physical health problems and difficulties with mobility and care. Widowed members of this community and those aged 75 or over face particular problems. (12)

Disparity in prevalence of general health conditions between veterans and civilians

This data was collected as part of a household survey conducted by the Royal British Legion in 2014. Though now outdated, it serves to illustrate how veterans are disproportionately affected compared to their civilian peers. (12)

Condition	Veterans (%)	General population (%)
Depression	10	6
Back problems	14	7
Leg and feet problems	15	7
Problems with arms	9	5
Heart problems	12	7
Diabetes	6	3
Hearing difficulty	6	2
Sight difficulty	5	1

Source: A UK household survey of the ex-Service community, Royal British Legion, 2014

Mental health issues faced by the Armed Forces Community

The majority of ex-service personnel are not affected by mental health issues. However, for those who are, there can often be a delay in identifying problems.

It is estimated that around 23% of ex-service personnel suffer from depression, anxiety or other common mental health disorders compared with 16% of the general population. (8)

Overall rates for PTSD are estimated at around 9% for previously deployed regular and reserve personnel. (10)

The Royal British Legion reports one of the most significant problems amongst service personnel and recent service leavers, and linked to deployment in Iraq and Afghanistan, is heavy drinking.

The Commons Select Defence Committee found that the mental health of recent service leavers was "intrinsically linked to hazardous levels of alcohol consumption" within the armed forces. (12)

Other areas of disadvantage experienced by the Armed Forces Community

Finance and housing are also areas of disadvantage for the ex-Service community. Working age households with dependent children, particularly divorced parents, people with a long-term illness or disability, and young singles are at greater risk of financial problems and are more likely to take on debt. (12)

The working age ex-forces community is almost twice as likely than their civilian peers to have unpaid caring responsibilities for a family member, friend or neighbour (23% v 12%).

16-34-year-olds, particularly veterans and those who live alone, report a number of issues around debt, employment and transition and a significant proportion have caring responsibilities. (12)

Working-age households report a number of distinct difficulties, particularly related to illness and disability, isolation, employment and material deprivation. Some of these issues seem to have a particular impact on ex-Service families. (12)

Population who had previously served in the UK armed forces in England and Wales: 2021 Census

For the first time, the 2021 Census in England and Wales asked people if they had previously served in the UK armed forces. The question was added to better meet the needs for service providers and others who support veterans, in line with the Armed Forces Covenant.

People aged 16 years and over were asked whether they had previously served in the regular or reserve UK armed forces, or both. People currently serving in the UK armed forces and those who had never served were both advised to tick "no".

32 Have you **previously** served in the UK Armed Forces?

Current serving members should only tick "no"

- ☐ Yes, previously served in **Regular** Armed Forces
- ☐ Yes, previously served in **Reserve** Armed Forces
- ☐ **OR** no

People who have *previously* served in the regular or reserve UK armed forces are often known as the veteran population and form part of the armed forces community (along with those who *currently* serve in the armed forces or Merchant Navy and their families).

What do we know about UK armed forces veterans living in Manchester?

At the time of the 2021 Census, there were reported to be 7,728 armed forces veterans living in Manchester - 1.8% of people aged 16 years and over. This compares with a figure of 3.8% of usual residents aged 16 years and over in England and Wales as a whole.

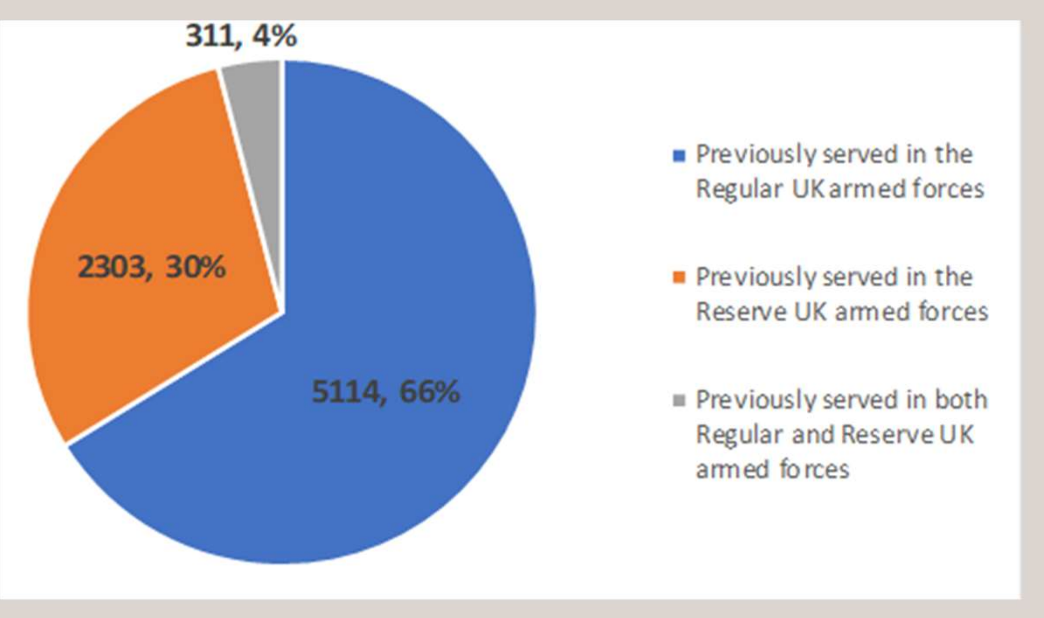
Over 1 in 10 of Manchester residents aged between 80 and 89 years reported that they were an armed forces veteran.

Just over two-thirds (66.2%) of UK armed forces veterans in Manchester, reported that they had previously served in the regular forces and 29.8% reported that they had served in the reserve forces. Around 4.0% had served in both the regular and reserve forces.

Overall, there were 7,301 households with one or more persons who had served in the UK armed forces. This is equivalent to 3.4% of all households.

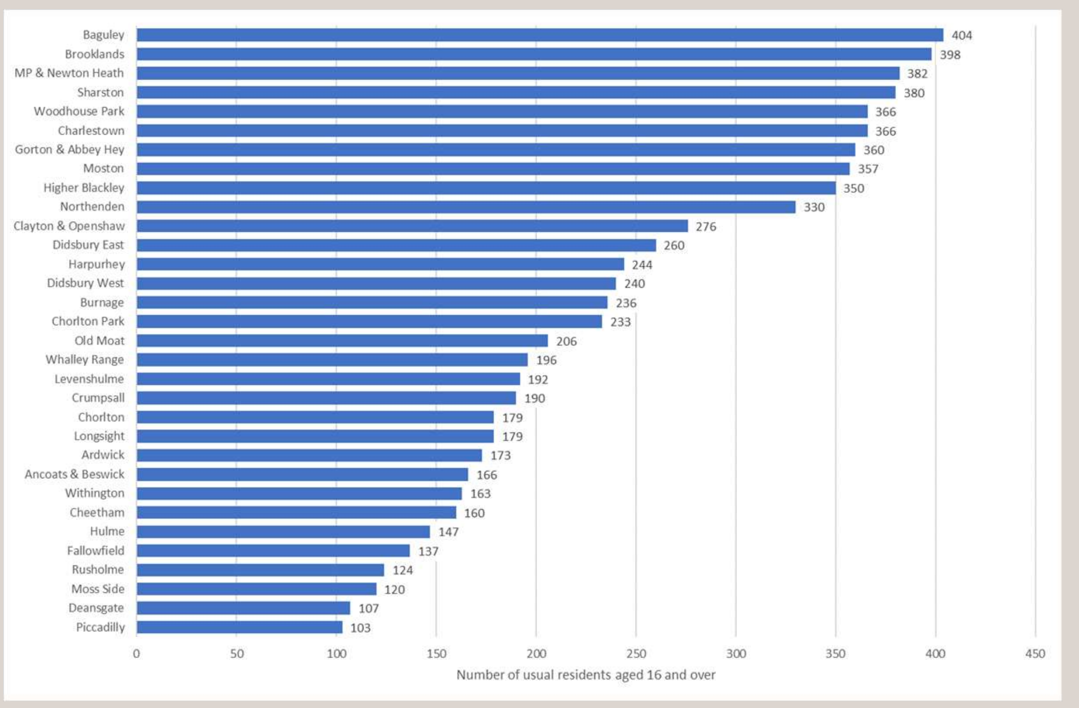
In total, 97.2% of armed forces veterans in Manchester were living in private households and 2.8% were living in a communal establishment of some types. These figures are similar to those found in England and Wales overall.

UK armed forces veterans living in Manchester



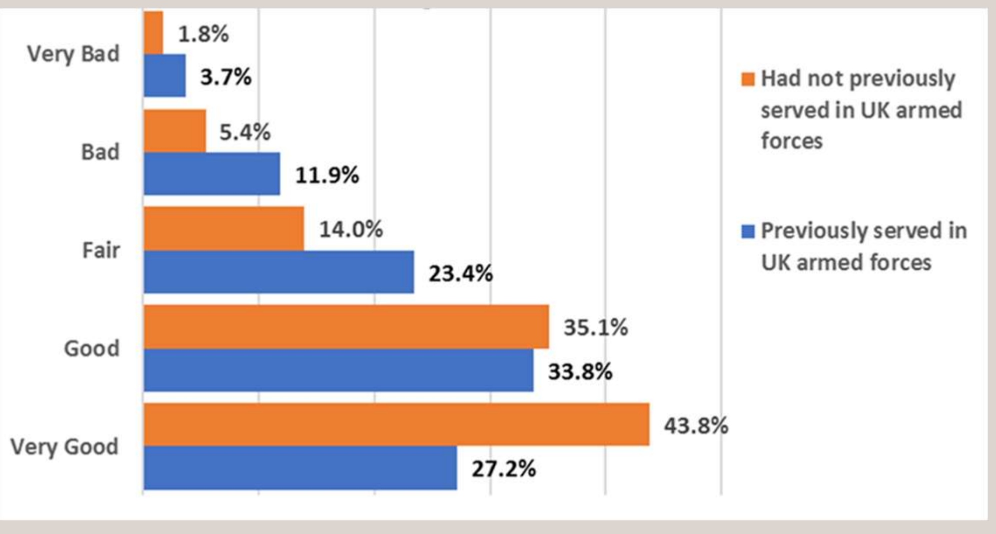
Where in Manchester do UK armed forces veterans live?

At the time of the 2021 Census, the wards with the highest number of armed forces veterans were Baguley, Brooklands, Miles Platting and Newton Heath, and Sharston.



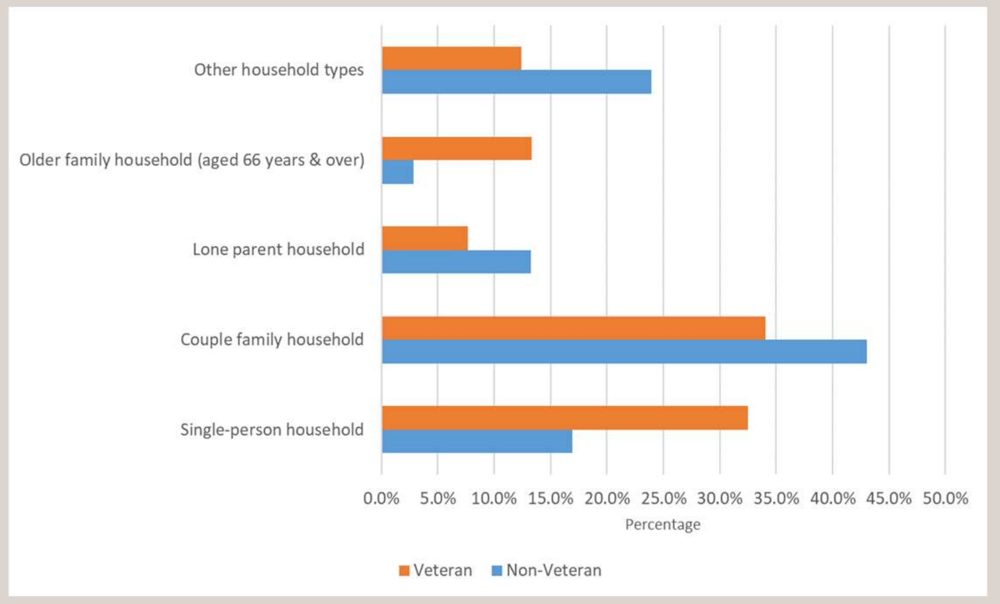
Self-reported health status of UK armed forces veterans living in Manchester

UK armed forces veterans in Manchester were **over twice as likely to report being in poor health** compared with non-veterans. In 2021, 15.6% of UK armed forces veterans in Manchester recorded their health as being "Bad" or "Very Bad" compared with 7.2% of people who had not previously served in the armed forces.



Living arrangements, and family status of veterans in Manchester

Veterans were more likely to live in a **single-person household** than non-veterans. Veterans were also much less likely than non-veterans to have **children living with them**. Combined with higher rates of self-reported poor health, this may indicate a greater need for social care and support.



Local Action: The Armed Forces Community Covenant

The Armed Forces Community Covenant is a local voluntary statement of mutual support between a civilian community and its local armed forces community. It is intended to complement the Armed Forces Covenant which outlines the moral obligation between the nation, the government and the armed forces.

The purpose of the community covenant is to encourage support for the armed forces community living and working in Manchester and to recognise and remember the sacrifices made by members of this community, including in-service and ex-service personnel, their widow(er)s and families.

The community covenant presents an opportunity for the City Council and its partner organisations to bring their knowledge, experience and expertise to bear on the provision of help and advice to members of the armed forces community. It also presents an opportunity to build upon existing good work on other initiatives such as the welfare pathway.

For the armed forces community, the community covenant encourages the integration of service life into civilian life and encourages members of the armed forces community to help their local community.

The Armed Forces Community Covenant: Key Aims

- To ensure that the health and social care needs of armed forces and veterans (and their families) are fully reflected in the local implementation plans arising from the powers and resources relating to the Greater Manchester devolution agenda, including those powers and budgets devolved to GM.
- To work towards ensuring that members of the armed forces and their families are considered in all commissioning arrangements.
- To work towards ensuring that the needs of armed forces, veterans and their families are addressed in all customer service delivery and policy decisions.
- To ensure that in all funding applications we consider armed forces, veterans and their families as well as the aims of the covenant itself.
- To work with our armed forces charities and partners to better share information and ensure that armed forces, veterans and their families receive the best and most appropriate support available.
- To continue the work within all areas to remember the sacrifices made by armed forces, veterans and their families and to reflect on those sacrifices.
- To co-ordinate and direct the implementation of support to the armed forces across Greater Manchester.

Work So Far

What Manchester City Council is doing to support the Armed Forces Community

- Employers' recognition scheme
- Guaranteed interview
- Armed Forces Champions
- Armed Forces toolkit
- Armed Forces Staff Focus Group
- Funding to Armed Forces Community HQ
- Armed Forces Friendly Employers

What Manchester City Council is doing to support the Armed Forces Community (continued)

Armed Forces Covenant Steering Group

The Armed Forces Covenant Steering Group facilitates cross-organisational collaboration, enables network expansion, and co-ordinates objectives. The Steering Group provides a strong network of organisations and service providers that work together on both strategic and front-line tasks and is the nucleus of the armed forces' work in the city.

Guaranteed Interview Scheme

The City Council guarantees an interview to veterans and reservists if they meet the minimum requirements for a role. This is made clear on each job posting, as a statement about our guaranteed interview scheme is included to encourage veterans and reservists to apply. This ensures the armed forces community will not face disadvantage when applying for roles within the Council.

Reservist policy

The Council's Reservist Policy ensures that reservists are aware of the support they receive from the Council while serving. The Policy outlines all entitlements due to reservists working within the Council and also asserts the Council's full support for the mandatory annual training expected of reservists and the adjustments needed should they be mobilised by their unit.

What Manchester City Council is doing to support the Armed Forces Community (continued)

Armed Forces Toolkit

The Council has refreshed the online Armed Forces Toolkit to make it more relevant, dynamic, and informative. The toolkit provides advice and signposting for critical support areas to ensure that the armed forces community can access appropriate support with ease. The Council's intent is to ensure the toolkit does in fact have the tools to effectively help individuals and professionals alike, while remaining accessible and relevant to those in need of support.

Naval affiliation

The Council has re-established its affiliation with the Royal Navy and it has been confirmed that the vessel representing Manchester will be a next-generation naval frigate. The new ship will act as a symbol of mutual support between both organisations and allow the development of a stronger relationship.

Armed forces-friendly employers

The Council has developed a network of armed forces-friendly employers to engage, encourage and recognise their contribution to helping those leaving the armed forces to find employment. The network will help to cultivate a supportive environment for those leaving the forces and entering civilian employment and also encourage other employers to do the same.

What Manchester City Council is doing to support the Armed Forces Community (continued)

Armed Forces Focus Group

The Council hosts an Armed Forces Focus Group which consists of current and former members of the armed forces who are currently employed by the Council. The role of the Focus Group is to inform the armed forces work of the Council and ensure that efforts are directed to the right areas. The group meets tri-monthly, utilising a thematic structure to cover current areas of interest as dictated by the Steering Group.

Departmental Armed Forces Champions

To ensure the consistent presence and awareness of the Armed Forces Covenant Principles, the Council have embedded Armed Forces Champions into a number of departments. This creates a web throughout the Council by which information can be shared, updates given, and objectives tackled as one. This will synchronise all involved departments and make certain that all progress and effort is symmetrical throughout the organisation.

Manchester City Council Armed Forces Annual Report 2021/22

https://democracy.manchester.gov.uk/documents/s35848/Appendix%20-%20Armed%20Forces%20Annual%20Report.pdf

Armed Forces Annual Report

Review of work undertaken over the past year and our priorities for the next year

National NHS Support for Veterans Mental Health and Wellbeing: Op COURAGE

Op COURAGE is an NHS mental health specialist service designed to help serving personnel, reservists, armed forces veterans and their families who are due to leave the military. It helps people transition from military to civilian life by providing mental health care with Defence Medical Services (DMS).

The service provides support to help people recognise and treat early signs of mental health problems, as well as more advanced mental health conditions and psychological trauma. It also provides support and treatment for substance misuse and addictions, facilitates access to other NHS mental health services (e.g. talking therapies and eating disorder services) and liaises with charities and local organisations to address wider health and wellbeing needs, such as housing, relationships, finances and employment.

The service is supported by trained professionals who are from, or have experience of working with, the Armed Forces community. It is available to anyone who has served in the UK armed forces for a full day and is registered with a GP surgery in England (or is willing and eligible to register with a GP).

National NHS Support for Veterans Mental Health and Wellbeing: Veterans and Reserves Mental Health Programme

The Veterans and Reserves Mental Health Programme (VRMHP) is a Ministry of Defence (MoD) specialist service that provides mental health assessments and treatment advice for veterans and reservists who feel that their time serving in the armed forces has affected their mental health

The VRMHP works closely with the NHS and Defence Medical Services (DMS) to provide appropriate treatment.

All veterans referred to the VRMHP receive a full psychiatric assessment completed by a consultant psychiatrist. Reserves whose condition is found to be operationally related and of a nature that can be treated within the resources of the DMS can access treatment in a MoD UK Department of Community Mental Health (DCMH) and will be offered out-patient treatment at a DCMH closest to where they live.

Other organisations working to support the Armed Forces Community in Manchester: Pennine Care Military Veterans Service

The Pennine Care Military Veterans Service (MVS) is a specialist psychological therapies service, for British armed forces veterans across Greater Manchester and Lancashire which provides mental health support to ex-service personnel for conditions including depression, alcohol and substance misuse, anger problems and post-traumatic stress disorder. Care is delivered against National Institute for Health and Clinical Excellence (NICE) guidelines and Care Quality Commission (CQC) standards.

The team is overseen by a consultant clinical psychologist and includes clinical psychologists, cognitive behavioural therapists, eye movement desensitization and reprocessing (EMDR) practitioners, cognitive analytic therapy therapists (CAT), psychological wellbeing practitioners, a substance misuse worker and employment placement support workers.

The team understands armed forces culture and works alongside a number of veterans who have been through the service to support continuous improvement.

Greater Manchester Mental Health NHS Foundation Trust delivers the service across Cheshire and Merseyside.

Other organisations working to support the Armed Forces Community in Manchester: Royal British Legion

The role of the Royal British Legion is to ensure that every member of the ex-Service community is able to live happily and independently, with a sustainable future. The Legion's Royal Charter defines the beneficiaries as all those currently serving in Her Majesty's Armed Forces, including Reservists, all those who have served, and all their dependents.

The Legion's role can range greatly but its work includes:

- Helping veterans back into work
- Giving smaller charities a helping hand
- Reviewing and improving specialist services
- Providing assistance for veterans living with dementia
- Improve access to services for people who need advice by rolling out pop-in centres and a freephone contact centre
- Securing funding for injured veterans
- Provision of specialist advice and support for beneficiaries facing financial challenges, including money, benefits and debt advice.

The Legion puts the beneficiary is at the heart of everything it does and is committed to spending the money it raises as efficiently and effectively as possible.

Other organisations working to support the Armed Forces Community in Manchester: Walking with the Wounded

The aim of Walking with the Wounded is to support the most vulnerable veterans regain their independence through employment. The organisation works from a hub on Canada Street in Manchester and provides a support service to wounded and vulnerable veterans across the Region.

The charity takes a holistic approach and works with a broad number of partners, both charities and statutory organisations. It runs a number of programmes of work which focus on:

- People who have been homeless (Home Straight)
- People in police custody (Project Nova)
- People with a mental injury (Head Start)
- Providing access to skills and training (First Steps).

The organisation also runs a work experience programme within the NHS (Step Into Health).

These programmes work in harmony to support vulnerable, wounded, injured and sick veterans in their pathway to sustainable independence and employment.

Links with other Council strategies: Work and Skills

- Include veterans in area specific data collection and subsequent targeted interventions, taking advantage of the new harmonised data standards.
- Understand veteran barriers to work from an employer's perspective
- Removal and mitigation of barriers to learning and employment
- Work with employers to be veteran friendly
- Improve access to funding for employers and veterans for training and qualifications

Links with other Council strategies: Anti-Poverty

- Improve data, intelligence, and targeting precision re themes, drivers, and contributors
- Inclusion of veterans in targeted campaigns to improve inclusion and engagement
- Educate front-line staff on the unique drivers of poverty within the armed forces community
- Improve veteran access to tailored financial advice and support
- Allow veterans a voice in anti-poverty service development/delivery
- Include veterans in list of most vulnerable groups

Links with other Council strategies: Digital Strategy

- Get more veterans benefiting from access to the internet
- Remedy veteran digital exclusion
- Create new links between libraires, learning providers, and local veteran organisations
- Target veterans in communications
- Include veterans in the wider offers
- Enable digital champions to identify, educate, and signpost veterans to online services

Links with other Council strategies: Homelessness

- Give veterans a voice in service design and delivery
- Implement preventative measures to combat veteran exclusive drivers
- Educate and promote the Covenant to private and social landlords
- Train front line staff to understand and effectively support veterans
- Create new links with local armed forces support network

Links with other Council strategies: Age Friendly Manchester

- Tap into existing networks to ensure and improve engagement with older veterans
- Include Armed Forces Community in targeted campaigns
- Include Veterans in offer of meaningful retirement and later-life planning

Opportunities for action

Local Armed Forces Covenant Networks

There are numerous Armed Forces Covenant groups throughout the public and third sector that exist to help deliver the covenant, educate interested and obligated entities and share best practices. Each group has a wealth of experience and information that is valuable to all parties regardless of their status and progress.

Defence Employer Recognition Scheme

The Defence Employer Recognition Scheme (ERS) encourages employers to support the armed forces community and inspire others to do the same. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community and align their values with the Armed Forces Covenant.

The scheme is designed primarily to recognise private sector support, although public sector bodies such as the emergency services, local authorities, NHS trusts and executive agencies are also eligible. A set of criteria is defined and required for each award, so that organisations know where to start, what is effective and how they can make themselves an armed forces friendly employer.

Opportunities for Action (continued)

Steps for local partners

Local partners can assist by continuing to provide support, general guidance, and specialised advice on issues within the context of their service/function. This can be achieved by actively staying involved with the local network, sharing the identification of current themes and issues and continuing to play a key part in the City Council's Armed Forces Covenant Steering Group.

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Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 20 September 2023

Subject: Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027

Report of: Deputy Director of Public Health

Summary

This report provides an overview of progress made during June to August on the Making Manchester Fairer Action Plan and a case study on Manchester Housing Provider Partnership's approach to Making Manchester Fairer and tackling health inequalities.

Recommendations

The Board is asked to note progress made in implementing the Making Manchester Fairer Action Plan. As well as noting the work that is taking place across partner organisations to integrate the Making Manchester approach and principles system wide.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	This Action Plan impacts positively on all strategy priority areas
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

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Background documents (available for public inspection):

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

Building Back Fairer – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 6 July 2022

Making Manchester Fairer, Tackling Health Inequalities in Manchester 2022-2027 – Health Scrutiny Committee, 12 October 2022

Making Manchester Fairer - The Anti-Poverty Strategy 2023-2028 – Economy Scrutiny Committee, 18 January 2023

Making Manchester Fairer - – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 25 January 2023

Making Manchester Fairer - – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 7 June 2023

1.0 Introduction

1.1 Making Manchester Fairer (MMF) is Manchester City Council's five-year action plan to address health inequalities in the city focussing on the social determinants of health.

1.2 In the wake of the COVID-19 Pandemic and the current cost-of-living crisis, the need to tackle inequalities in the city continues to be a corporate and political priority.

1.3 The delivery of Making Manchester Fairer can be summarised under its 8 themes, 4 ways of involving communities and 6 principles that underpin the way the programme will be delivered. Implementation of the plan has focused on the foundational workstreams required to ensure robust delivery of the plan (see section 2).

Figure 1: MMF Delivery Plan Themes, Principles and Ways of Involving communities

Themes	Principles for delivery	Ways of involving communities *
❖ Early years, children and young people. ❖ Poverty, income and debt. ❖ Work and employment. ❖ Prevention of ill health and preventable deaths. ❖ Homes and Housing. ❖ Places, transport and climate change. ❖ Systemic and structural racism and discrimination. ❖ Communities and power.	❖ Proportionate universalism and focus on equity. ❖ Respond to and learn from impact of COVID-19.- ❖ Tailor to reflect the needs of Manchester ❖ Collaboration, creativity, and whole system approach. ❖ Monitor and evaluate to ensure we are Making Manchester fairer – narrowing gaps within Manchester as well as regional and national averages. ❖ Take a life course approach with action on health inequalities starting before birth and right through to focus on ageing and specific needs of older people.	❖ Listen to us ❖ Trust us ❖ Employ us ❖ Create and support the conditions for social connections to develop and flourish

*Based on insight from community group engagement

2.0 Making Manchester Fairer Programme Workstream Update

2.1 The MMF Programme Management Team have established a number of workstreams that are forming the foundation for delivery of the programme. These workstreams are:

- The MMF Programme Board
- General Communications and Engagement
- Workforce Engagement and Development
- Resident and Community Engagement and Involvement
- Kickstarters
- Anchor Institutions
- Monitoring
- Evaluation

2.2 The MMF Programme Board

2.2.1 The Making Manchester Fairer Programme Board was established in May 2023. The Board meets quarterly and is co-chaired by Cllr Robinson and Cllr Midgely.

The Board will:

- Contribute to the strategic direction of Making Manchester Fairer and ensure implementation of the Action Plan and the Anti-Poverty Strategy
- Hold partners responsible for delivering the Plan to account
- Review and scrutinise activities across the partners delivering the Plan to ensure that they are delivered in line with the Making Manchester Fairer principles and that our aims and objectives are achieved.
- Ensure the maintenance of sound financial management of resources, and that expenditure is in line with our objectives.

2.2.2 Board members were recruited through a combination of direct invitations and an expression of interest process. These roles will supplement existing partnerships that will be engaged in the delivery of the plan. All board positions were in place for the July board meeting. A list of board members is included in Appendix 1.

2.2.3 Through the expression of interest process the aim was to recruit a multi faceted board that can draw upon not only the insight gained from professional and organisational experience, but lived experiences as well. This will enable the board to have a stronger sense of what is needed to direct, focus and challenge the programme to deliver positive change in terms of the social barriers that impact on health.

2.2.4 The Making Manchester Fairer Programme Board have endorsed:

- Phase One Kickstarter schemes
- Year One Anti-Poverty Strategy Priorities
- Community Engagement and Involvement Framework and Community Forum

2.3 General Communications and Engagement

2.3.1 Sitting alongside the MMF programme and aligned to key milestones there is a proactive, system-wide strategic communication and media plan in place.

2.3.2 The current focus of the communications plan is a renewed citywide focus for the cost-of-living campaign and promotion of the advice line as part of the Anti- poverty strategy. Support was outlined for summer, including free events and preparation for the return to school. All the community networks established during the Covid pandemic, were used to help with both fronting and helping to share these messages.

2.3.3 This approach also incorporates our support around food poverty, where there are two main areas of focus: letting people know where and how they can get help; and the recruitment of more food bank volunteers. There is also a concentration focus on culturally appropriate food support – which was featured in our Making Manchester Fairer podcast series.

2.3.4 The MMF podcast series was launched. This conversational series highlights the issues that can cause inequality in an accessible way– involving people who are helping to address that imbalance, or who are facing its effects. The podcast series has a profile on RSS, a digital comms site so that it can be distributed to key platforms including Spotify, Apple and Amazon Music.

2.3.5 The first podcast concentrated on Haveley Hey Community School in Wythenshawe, where the work of an Intensive Support Teaching Assistant is helping pupils with their writing. This is part of the children and young people's Kickstarter scheme – helping children who may have fallen behind on key developmental milestones, as a result of the pandemic.

2.3.6 The development of family hubs in the city is also a key part of the Making Manchester Fairer action plan and it was vital that communities felt an affinity with the new centres. This is why we carried out co-production and design with community groups so that their opinions were reflected within the branding and look and feel of the centres. The results from this co-production will also be factored into subsequent projects and have formed a blueprint for how we can engage with communities for meaningful and inclusive communications.

2.3.7 Community voice has also been reflected in the communications support for Manchester's Health Determinants Research bid. If successful, this initiative will marry local feedback and local experience with academic research and policy delivery. Our Manchester bid needed both films and endorsements that could explain why it would make a difference for the city and add speed to the change we are looking for.

2.3.8 This narrative is also reflected in a broader film being produced that not only explains all the different elements of the Making Manchester Fairer programme, but also highlights the statistics behind its ambitions and how they equate to improving chances for local people.

2.4 Workforce Engagement and Development

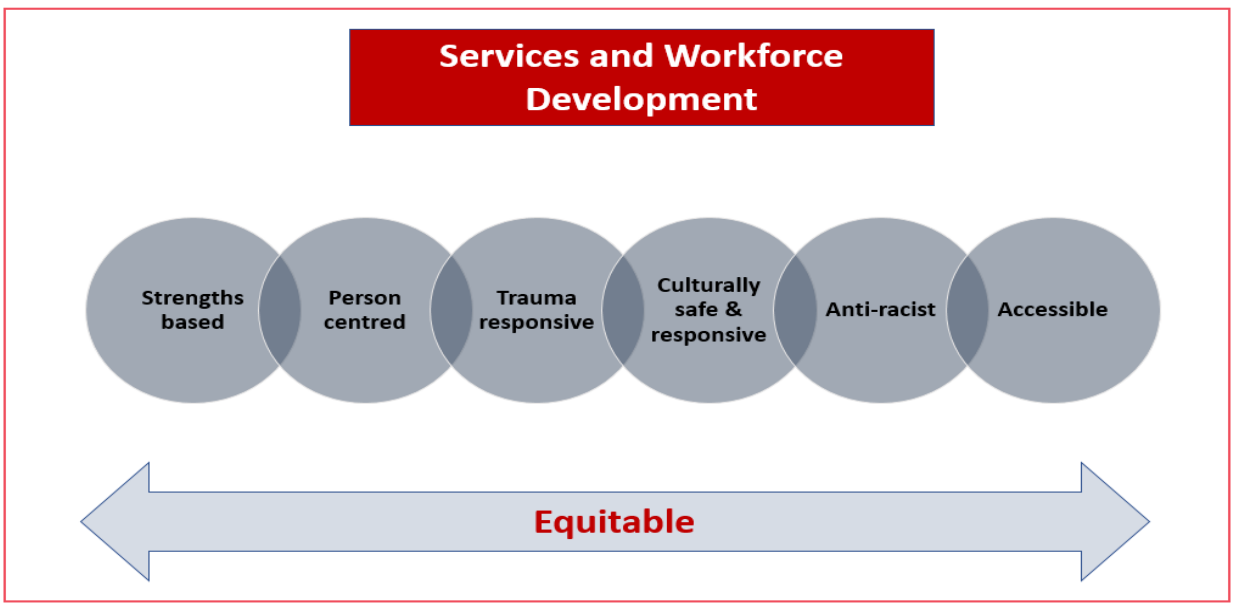
2.4.1 Work has commenced on developing a plan for the wider programme of work around workforce engagement with discussions taking place to utilise opportunities to align this work with the wider Organisational Development plan refresh, and different pieces of work across Human Resources and Organisational Development.

2.4.2 By engaging with our wider workforce our aim is to promote the lens of inequality. We will be working with them to inform, motivate and develop skills that will lead to the residents of Manchester benefiting from equitable services, and that will positively impact on health and wellbeing outcomes.

2.4.3 On the pathway to improvement, we aim to see:

- MCC and staff in the wider public health system aware of the reasons for MMF and what the plan looks to achieve.
- A suite of evidence-based tools / interventions / approaches being delivered in collaboration with our wider workforce
- Behaviour change of staff including the adoption and scaling up of existing good practice, improvement of existing practice that fails to recognise and address inequalities and the cessation of practice exacerbating inequalities.

Figure 2: Service and Workforce Development



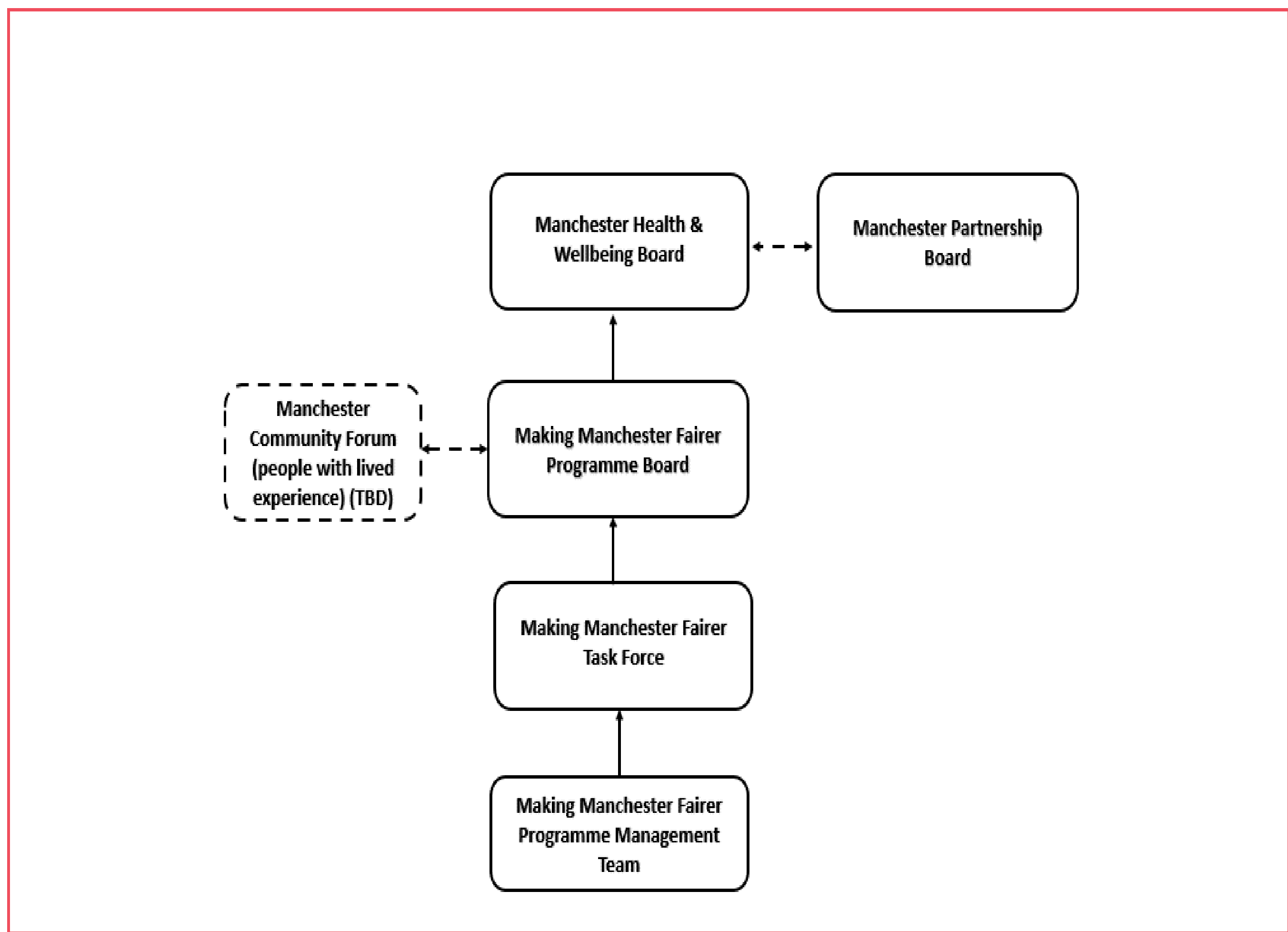
2.5 Resident and Community Engagement and Involvement

2.5.1 In July a MMF Community Engagement and Involvement Framework was developed which highlights how community engagement activity, to deliver the MMF ambitions, will focus on involving, collaborating and empowering residents whilst adding value to engagement activity already taking place across the city. Engagement activity will specifically focus on residents and

communities that are most adversely impacted by health inequalities through socio-economic disadvantage, who have first-hand experience of discrimination and whose voices are traditionally less heard or have less influence in policy and decision making. This Framework was endorsed by the MMF Programme Board in July 2023.

2.5.2 A key element of the framework is to ensure that the voice of lived experience and community perspective is embedded in the MMF governance structure. The 'MMF Community Forum' will work with and support the Programme Board by reviewing, questioning, and helping to develop MMF delivery plans and will have a key role in supporting the Programme board to hold partners to account from a community perspective.

Figure 3: MMF Programme Governance



2.6 Kickstarters and Investment Fund

2.6.1 MMF is a broad and ambitious plan that will take time to get underway and deliver well. In recognition of that, four Kickstarter schemes were identified to "kickstart" delivery of the plan with a focus on improving health equity, exemplifying the MMF principles and building momentum for the plans delivery whilst the detail of the broader approach takes shape.

2.6.2 Two Kickstarter schemes were prioritised for investment in the first phase and will be expected to deliver financial benefits as well as improving health equity for the target population groups. An update on the two Kickstarter schemes prioritised for investment and endorsed by the MMF Programme Board is provided below.

(i) Improving Health Equity for Children and Young People

Children's element: In April work began to implement the 3-tier support offer delivered by a collaborative task force of services to provide intensive, targeted and universal support and interventions for children and families in early years.

9 out of the 10 schools identified for intensive support have recruited a Support Worker and are working with Speech and Language Therapists and Education Psychologists to plan support.

39 out of 40 targeted schools, are engaged and are working in groups to plan how they are using the resources available through the Kickstarter scheme.

The universal offer has started with an Early Years transition read that went out to all children in Manchester starting Reception in September 2023. Books and the parent activity/enrichment pack went out to all settings before the end of term.

Young People's element: This was endorsed by the MMF Programme Board in July. The Kickstarter seeks to reduce the inequality or gap between the general young people population and certain groups who are at an increased risk of experiencing poor mental wellbeing or developing mental ill health, such as those most impacted by the cost-of-living crisis, LGBTQ+ young people, racially minoritised young people, and those who have needed social care service support.

The main target groups will be young people (aged 13-25) living in the 11 wards in the city where poverty, marginalised communities, and young people's needs are the greatest. This will include young people living with their family, and young people living independently (e.g., young people in or leaving the care system or young people who are homeless).

There will be 2 delivery elements for the Kickstarter: a) mental health and wellbeing support (online and 1-1) for young people, and b) a multi-component skills-based training and support programme for frontline workers and managers in community settings, to increase skills and capacity for supporting young people's mental health and wellbeing and preventing mental ill-health.

Specialist VCSE organisation(s) with knowledge and experience of the needs of young people in Manchester, skills in supporting young people with mental health issues, and understanding of the needs and assets of Manchester's communities and young people, will be commissioned to deliver these. This work will begin in August.

(ii) Early Help for Adults Experiencing Multiple and Complex Disadvantage

This Kickstarter will allow Multi-Agency Prevention and Support (MAPS) meetings to be delivered across 13 Integrated Neighbourhood Team footprints, bringing together locality- based professionals with intelligence and experience working with adults who require supportive interventions. A commissioned local support provider with experience of working across sectors will draw on the intelligence of all MAPS and VCSE partners and to provide a bespoke holistic support intervention and a single point of contact for the individual receiving support. The target group are adults experiencing multiple disadvantage (e.g. homelessness, mental ill health, alcohol or drug misuse, and unemployment)
It is envisaged that a local provider will be commissioned in early 2024 to provide bespoke holistic support interventions and be a single point of contact for individuals receiving support through the additional MAPS

2.7 Anchor Institutions

2.7.1 Mapping work to understand how different groups of anchor organisations in Manchester are structured and their main focus of activity is complete. The main groups of anchors, which are run by GMCA, MCC and NHS colleagues as well as the universities have some significant areas of overlap, particularly connected to employment and especially with regard to the living wage and good employment terms and conditions.

2.7.2 Next steps for this work are to agree a way to bring together the common work on employment outcomes between networks into a joint programme of activity that builds on and enhances existing good practice. It is likely that a particular focus will be around promoting the real living wage (RLW) and undertaking joint work to increase the number of businesses paying a real living wage and the number of Manchester residents being paid a RLW.

2.8 Monitoring

2.8.1 The Making Manchester Fairer Inequalities Data Development Group, focused on the strategic aim of embedding the routine monitoring of inequalities within partner organisations, continues to meet monthly. The group have helped facilitate connections with analysts and policy makers to co-produce the Manchester Measuring Inequalities Toolkit with the University of Manchester. The toolkit is intended to be a resource for analysts and policy makers to strengthen their understanding of, and inform the selection of methodologies for measuring inequality between groups. An initial course outline has been produced, content is in development, and the first iteration of the training course is planned for mid-September 2023.

2.8.2 Key indicators that will form the basis of an annual 'temperature check' of progress on Making Manchester Fairer have been identified. These are being collated as a more focused, locally informed, set of measures than the Marmot Beacon Indicators which will more accurately reflect where progress is expected to be made. Data that supports these indicators is being gathered to identify current performance and trends and identify where further

development might be needed to meet our ambition to report gaps in outcomes between groups alongside overall performance.

2.8.3 Kickstarter leads have been supported to understand the MMF approach to monitoring, within a framework for measuring short, medium and longer term progress that combines qualitative and quantitative data and is linked in with the evaluation workstream. Further discussions with individual Kickstarter leads are planned to support them in telling the story of how their projects are working to deliver against their ambitions.

2.9 Evaluation

2.9.1 The main programme evaluation for MMF is focused on the research question, "What is the best way to mainstream health equity approaches across Manchester?". This is separate, but aligned to, the individual evaluations taking place within individual work streams, themes or interventions. Where workstreams, themes or interventions have arranged to have their own" in-house" evaluations carried out by an external provider (e.g. the Young People's Kickstarter) the Evaluation Lead is working closely with the Kickstarter leads and external evaluators to ensure that findings are shared, and that work is not duplicated.

2.9.2 An exercise that focuses on the key evaluation elements and analysis is underway for the Kickstarters, which is the focus for year 1. Early findings show that data from business plans and interview transcripts can be categorised into the following themes:

- Needs Driven
- Multi-agency Working
- Placed-based Approach
- Recognition of Individual and Group Characteristics
- Healthcare Focus; Sustainability
- Longevity.

2.9.3 For the main programme evaluation, interviews are planned to take place across the year at relevant time points (e.g. after the finalisation of an action plan) and observations of meetings and events are taking place to establish the current status of health equity mainstreaming approaches for year 1. Data collection for two case studies (Inclusive Recruitment to the Programme Board and Promoting Making Manchester Fairer at the Neighbourhoods Awayday) is underway and other case studies will be identified across the year. The Evaluation Lead is working closely with the Monitoring Lead to take a mixed methods approach to exploring any effects and impact of MMF and exploring additional ways to build capacity within the evaluation team. This has involved liaising with contacts at the University of Manchester and exploring external research funding from the National Institute for Health Research

3. Making Manchester Fairer Thematic Progress

3.1 Further to the development of MMF workstreams, progress is being made deliver on the thematic actions set out in the MMF Action Plan. Captured in Appendix 2 is a key achievement for each of the themes from July 2022 to June 2023. The rest of this report details progress on four of the themes, and provides a case study on the Manchester Housing Provider Partnership Strategy Day. The updates focus on the following themes:

(i) Communities & Power
(ii) Systemic and structural racism and discrimination
(iii) Poverty, income and debt
(iv) Homes and Housing -Manchester Housing Provider Partnership Strategy Away Day Case Study

3.2 Communities & Power

3.2.1 A Communities and Power Steering Group, chaired by Manchester City Council's Deputy Leader Cllr Rahman, has been established to drive forward the actions outlined within the two Manchester-specific themes of (i) Tackling systemic racism and discrimination, and (ii) Communities and power. The Communities and Power Steering Group work has:

- Began to develop a community engagement maturity model and assessment. This will help us to understand how mature we are as a system in terms of our engagement approaches with communities across the city, particularly with those whose voices that tend to be less heard. The assessment is the beginning of the process and will ensure we have an evidence base that allows us to develop and strengthen our approach as well as develop and informing a set of quality standards for engagement activity in the future. The assessment will also contribute to ensuring that equality and inclusion runs throughout this engagement work and is key to developing trust and strong relationships with Manchester's diverse communities. This piece of work will start in September and conclude at the end of 2023. The output will be a clear action plan, enabling us to further strengthen our approach and relationship with communities across the city.

- Supported the development of the Building Stronger Together Communities Strategy, linking strongly with work on encouraging relationships, participation and belonging which is key to creating strength in community in the city. The strategy will go to Communities and Equalities Scrutiny Committee in October.

- Undertaken an in-depth analysis of census data to help support actions to be driven by this forum - this includes looking at challenges experienced by particular ethnic groups. Understanding data and evidence available and gaps in relation to this work is important.

3.3 Systemic and structural racism and discrimination

3.3.1 The seventh theme in the MMF plan is tackling systemic and structural racism and discrimination. A comprehensive and immersive education programme on Race and Health Equity has been developed and commissioned. This programme which has 75 participants as part of the first cohort from partners across the council, health, and housing will enable our workforce to be better informed, equipped and confident to implement the right solutions that will improve outcomes for communities experiencing racial inequality and discrimination.

3.3.2 The key learning outcomes from the education programme are as follows;

- Understanding how racial inequity operates at different levels within a system and the impact that has on health outcomes
- A better understanding of Manchester's population and its demographics with the ability to use data and insight effectively to make informed decisions
- An understanding and the importance of involving communities in co-designing and co-creating solutions to inform actions to reduce inequalities
- The development of knowledge, skills, resources, tools and confidence to create more inclusive work practices and approaches to services
- Giving participants the time, space, encouragement and permission to collaborate on planning and improving delivery

3.3.3 Further support will be provided through masterclasses where expert speakers will provide insight into a range of topics with a focus on the most persistent and pervasive issues marginalised communities face, and action learning sets to promote peer to peer support and collaborative problem solving during the programme and beyond.

3.3.4 An evaluation of the programme will be conducted during and after the completion of the programme. The evaluation will enable us to ascertain whether the aims of the programme and learning outcomes as set out have been achieved and the evidence gathered will help inform next steps for the programme.

3.3.5 Through the evaluation we want to be able to articulate what change has happened as a result of this intervention, and ideally which of these changes would not have happened had the programme not taken place.

3.4 Poverty, income and debt

3.4.1 The Anti-Poverty Strategy was formally adopted at Executive in January and is the main route to delivering the MMF theme of reducing poverty and debt. The strategy contains 53 actions across 12 priorities and 4 themes and sets out our vision that the whole of Manchester will work together to reduce poverty and lessen the impact of poverty on our residents.

3.4.2 The delivery and oversight has been integrated into the MMF programme, recognising that you cannot tackle health inequalities without addressing the effects and causes of poverty.

3.4.3 At the July MMF Programme Board meeting, the year one work APS programme was agreed. Actions have been prioritised to include those things which are important, achievable, or which need to happen first. This includes a mix of actions that will be MCC lead, and those which can be substantially led by our partners. In summary, priorities for year one includes:

- Completing and updating data products that allow us to better understand who experiences poverty in Manchester (particularly in relation to some protected characteristics, e.g., race, age) which will allow us to design and target future interventions more effectively.
- Reviewing approaches to charges and debt recovery action taken against residents experiencing poverty.
- Looking at how we can expand access to advice and make sure that advice provision is of consistently high quality.
- Working with anchor institutions to explore how we can make better use of social value in supporting people who experience poverty.
- Setting up an “insight group” of people with personal or professional experience of poverty to support and challenge officers and our partners in delivering the strategy.
- Creating opportunities for people in Manchester working on tackling poverty to come together and share best practice.
- Ensuring that access to food is secured for the least well off.

3.4.4 Most of this work is now in progress. Notable updates include:

- The Council’s Executive has recently adopted a new Revenues and Benefits Cost of Living Mitigation Policy that establishes arrangements to enable the repayment of Council Tax arrears over a longer period; enables a more proactive approach to writing off summons costs, introduces an informal breathing space arrangement and moves towards a more intelligence-based approach to referrals to Enforcement Agents.
- An external organisation will be commissioned to manage the Anti-Poverty Insight Group, helping build trust between participants and bringing in expertise in making marginalised voices heard. A scope of service is currently being finalised to commission this.
- A refresh of ward level data that has previously been used to inform cost-of-living response work is underway.
- We are working with representatives from other anchors networks in Manchester to design and progress joint areas of work, likely initially centred on employment.
- We are working with colleagues in commissioning to re-tender the Citywide Advice Service contract to ensure it reflects our learning from developing the anti-poverty strategy.

3.5 Homes and Housing - Manchester Housing Provider Partnership Strategy Away Day Case Study

3.5.1 Manchester Housing Provider Partnership (MHPP) are a key delivery partner for MMF Homes and Housing theme. Guy Cresswell the Executive Director of Great Places Housing Group is a Theme Lead on the MMF Task Force and has been working with MHPP on ways the partnership contributes towards delivering MMF. Below is a case study on this work and the MHPP strategy day that focused on how housing partners can collaborate towards tackling health inequalities and the delivery of MMF.

3.5.2 The contribution that MHPP can make towards MMF was a key focus of the MHPP strategy day held in April. Following keynote presentations from Cllr Gavin White Executive Member for Housing and Dr Cordelle Ofori, participants engaged in an interactive workshop focussed on the work of individual housing providers and how collaborative partnerships could contribute to towards each of the 8 MMF themes.

3.5.3 There was huge buy in from all providers, with many ideas being captured for each of the themes. Fundamentally there was a view that good quality, secure, affordable housing is a foundation to tackling health inequalities and Making Manchester Fairer.

3.5.4 The findings from this event were then summarised and presented back to the subsequent MHPP forum meeting in June, at which there was a discussion on how MHPP can maximise its contribution towards MMF through a more focussed approach. It was felt that MHPP is already making a significant contribution across all 8 themes, both through the work of the housing sector as a major employer and service provider to over 70000 households in Manchester, and in the quality of homes it provides. The following issues were considered:

- Overarching strategic message to be adopted whatever forums/ meetings we are in – affordable housing is the foundation to MMF.
- Positioning opportunity - Is there scope to adopt MMF signage on all new affordable housing developments across the city – a visible statement of the agenda and commitment?
- Is there scope for MHPP to be more focussed? Housing providers and/ or MHPP already contribute both directly and indirectly towards each of the 8 MMF themes. By having focus we can make the greatest progress and impact, and better measure the impact

Summary position of the partnership to the MMF themes were:

- Early years: – can we do more to promote right sizing, and free up more family housing to ensure children are not living in temporary or transient, overcrowded housing conditions?
- Poverty Income and debt - & - work & employment: - we invest significantly in debt advice and tenancy support services, and in developing

employment and skills opportunities. How can we share better our insight and be more influential at a strategic level?

- Ill health & early death: – a coalition of MHPP partners has been working with health and care organisations in both Manchester and Greater Manchester for a number of years and we will continue to do so on this long-term agenda. The City's new Enabling Independence Accommodation Strategy provides strategic direction for much of this work.
- Private Rented Sector: – there was a feeling we can do more to support the city council in this hugely important area.
- Growth and new supply: – We are already working closely with the city to maximise the supply of new affordable homes. However, there is always scope to build more, which we should focus on.
- Carbon and investment: - We are already working closely with the city as we prepare to deliver our plans to achieving carbon zero. Opportunity accelerates our work in this area.
- Transport & climate change: – We can contribute through work with community groups and in provision in new homes/ schemes.

3.5.5 It was agreed that Communities and Power and Tackling systemic and structural racism and discrimination would be the two themes the partnership would focus on, with progress monitored and reported at the quarterly MHPP Forum meeting.

3.5.6 In terms of the Communities and Power theme and social connections, MHPP is made up of a wide range of organisations – from place-based partners such as Wythenshawe Community Housing Group, Southway and One Manchester and long-standing organisations such as Mosscare Saint Vincent's, Great Places and Arawak, through to regional and national partners with relatively small footprints in the city. Whilst there may be different drivers, a huge amount of community engagement and activity is undertaken, and there are lots of positive examples of community investment and neighbourhood working. There was a discussion on how we can we better share what we are doing, to showcase good work in communities. We also saw opportunities to work more effectively with other stakeholders including the city council within the proposed Community Engagement and Involvement Framework.

3.5.7 The partnership strongly agreed that the Tackling Systemic and Structural Racism and Discrimination theme should be a key area of focus. Recognising that, whilst there are examples of good practice, fundamentally as a sector we have work to do here. Since the forum meeting this has been followed up and several MHPP colleagues will be participating in the forthcoming Race and Health Equity Education programme. We will also be using the quarterly forum meeting to "raise the bar" through sharing examples of good practice in this area.

3.5.8 Moving forward the partnership will introduce routine progress reporting on its contribution to MMF at each quarterly forum meeting.

4. Next Steps for MMF Action Plan

4.1 The next steps for the programme will be:

- Development of the MMF Network and launch event
- Further alignment of the workforce engagement workstream with the Organisational Development refresh to develop a coherent workforce development plan for MCC and partners
- Develop Phase 2 Kickstarter Models.

5. Recommendation

5.1 The Board is asked to note progress made in implementing the Making Manchester Fairer Action Plan and the work that is taking place across partner organisations to integrate the Making Manchester approach and principles system wide.

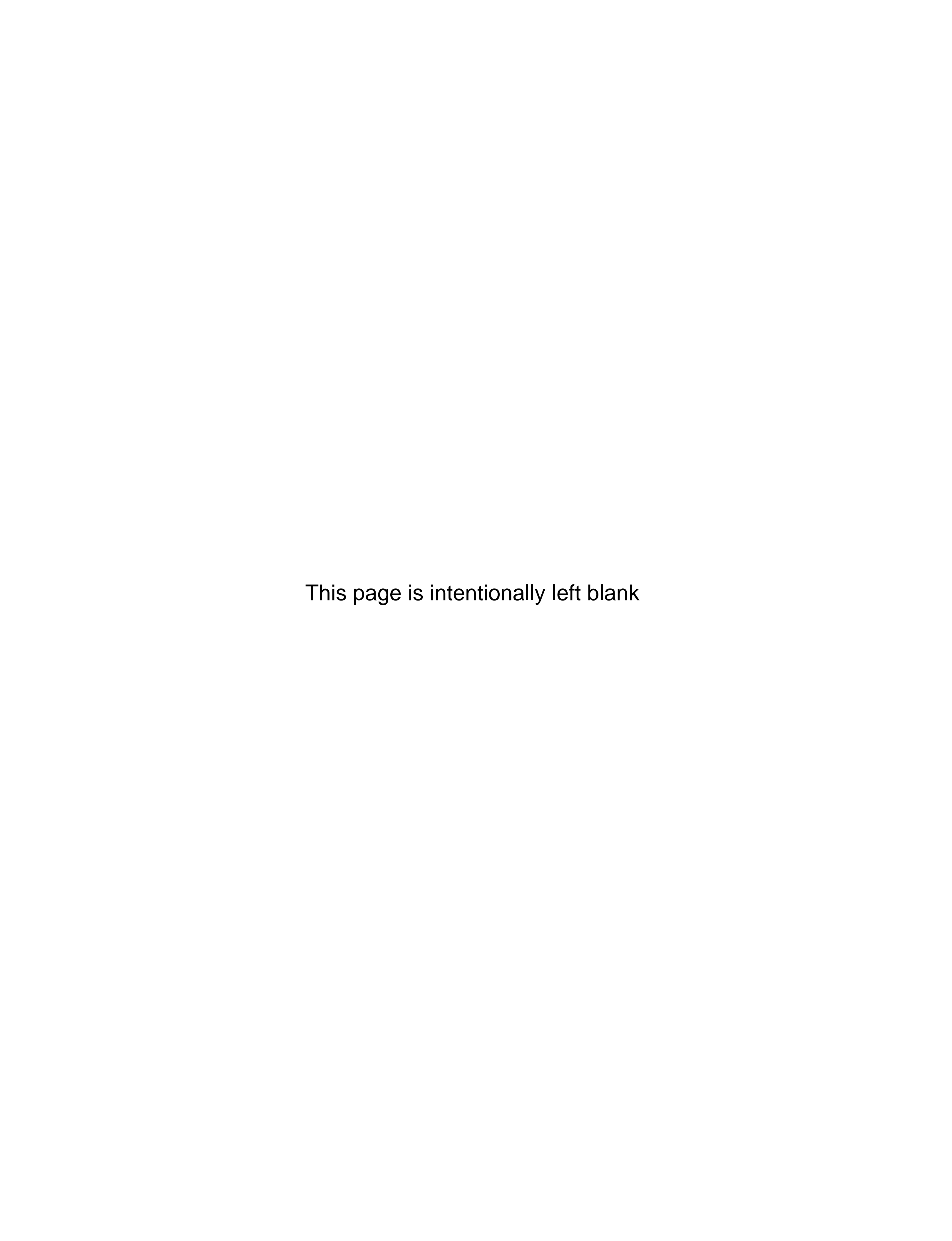
Appendix 1 – Membership of the Making Manchester Fairer Programme Board

The Programme Board is co-chaired by Cllr Thomas Robinson (Executive Member for Healthy Manchester and Social Care, Manchester City Council) and Cllr Joanna Midgley (Deputy Leader, Manchester City Council).

Joanne Roney OBE sits on the Board in her role as the Chief Executive of Manchester City Council and the Senior Responsible Officer for Making Manchester Fairer

The other board members are:

- David Regan is the Director of Public Health for Manchester
- Elaine Unegbu has brought her experience as a nurse to roles looking at quality outcomes for health and care services and has previously held the position of a non-executive director of the Manchester Heath Authority. She plays an active role on a number of boards and groups focusing on older people.
- Abigail Brown wants to bring her experiences as a young Black woman living in Manchester to the Board to help advocate for those 'not in the room' and continue to make sure those voices are heard and drive what we do.
- Katy Calvin-Thomas is the Chief Executive of Manchester and Trafford Local Care Organisation
- Leah Chikamba lives and works in Manchester and wants to influence policies that look at inequalities for Black, Asian and Minority Ethnic people in the city
- Jennifer Dootson was born and bred in Manchester and is a local business owner who wants everyone to have the support they need, when they need it and the opportunity to be the best version of themselves.
- Tom Hinchcliffe is the Deputy Place-Based Lead for Manchester for NHS Greater Manchester Integrated Care
- Adil Mohammed Javed is a Manchester-born actor turned social-entrepreneur, inspired by his experiences to drive change through creativity. He sees Making Manchester Fairer as an opportunity to actively dismantle barriers, give grassroots voices a seat at tables of power, and ensure Manchester thrives equitably.
- Mitesh Mistry has experience in policy making to improve outcomes for children, young people and families at a national level and wants to see changes in how communities access and interact with local services so that everyone has equal opportunities to lead happy and healthy lives.
- Sinead O'Connor is the Chief Executive of Cheetham Hill Advice Centre and believes that focusing on health inequalities allows us to see the lifelong impact of structural inequality. Sinead wants to contribute and to use her knowledge and experience to contribute to making Manchester a more equitable city to live in.
- Safina Islam has a background in biomedical science and now works in Health Inequalities focused research and policy development. She has a particular interest in improving access to mental health and wellbeing services for diverse communities (photo currently unavailable)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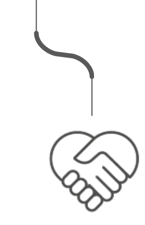
Making Manchester Fairer Theme Key Achievements

Making Manchester Fairer Action Plan endorsed by Manchester Health and Wellbeing Board

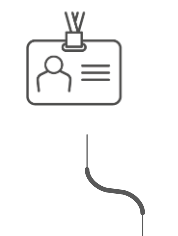
July

July 22 – Sept 22

Event held with 32 women of colour in senior positions within the VCSE sector to discuss the proposal and design of a VCSE Women Of Colour Leadership Programme in Manchester

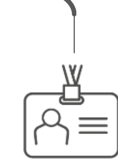


Manchester Work and Skills Strategy launched supporting development of inclusive economy aligned to Making Manchester Fairer

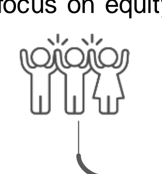


Oct 22 – Dec 22

Manchester achieves Living Wage Place Recognition; targets exceeded with 254 Manchester accredited businesses with 73,590 employees paid the Real Living Wage (an uplift of 8,808 employees, who would not otherwise have been paid it)

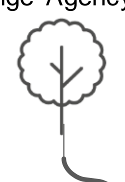


Community development service transferred from Greater Manchester Mental Health Trust (GMMH) into MCC's Neighbourhoods Directorate: the future working model for community development will have a focus on equity



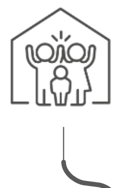
Jan 23 – Mar 23

Manchester Heat Pack & storyboard completed by the Met Office working with the Council and Manchester Climate Change Agency



Making Manchester Fairer Anti-Poverty Strategy endorsed by MCC Executive

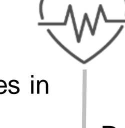
415 new affordable homes delivered in 2022/23



Provider commissioned to deliver Phase One of the Race and Health Equity Education Programme

Apr 23 – Jun 23

£200k funding granted to support the Winning Hearts and Minds 'Healthy Hearts' workstream, providing community-based interventions in North Manchester; £136k granted for work with Black communities in the South and East of the city

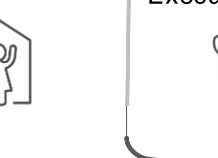


Number of families in Bed & Breakfast accommodation for more than six weeks reduced from a peak of 131 to zero

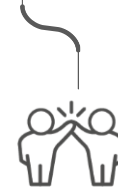
Work begins to scope out a 'Community Engagement Maturity Model' to help understand how mature we are as a system in terms of our engagement approaches with communities across the city, particularly with those whose voices tend to be less heard

Breast screening – shortlist of potential new screening locations in underserved areas agreed

Revenues and Benefits Cost of Living Mitigation Policy endorsed by MCC Executive

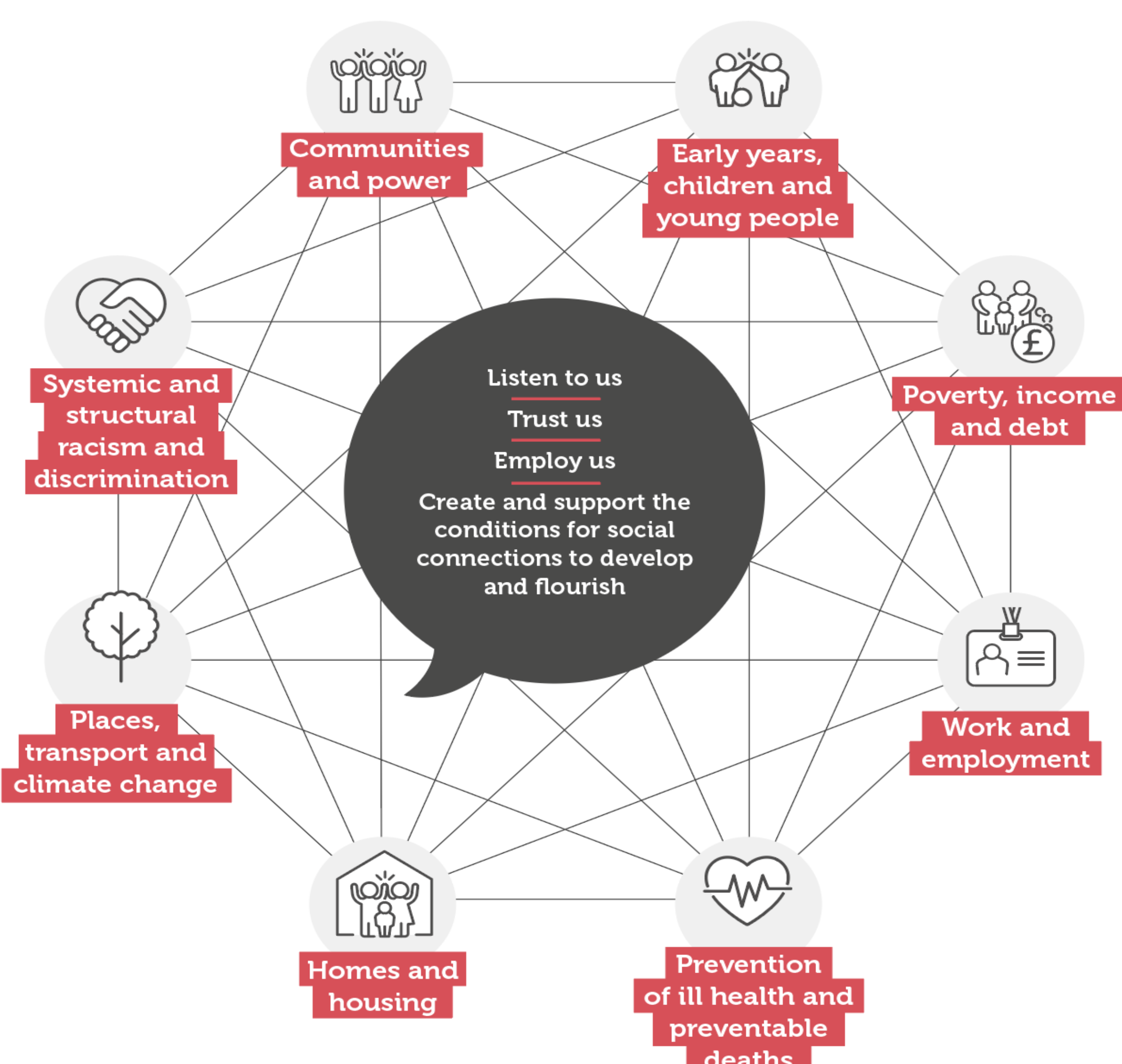


First of 3 planned Family Hubs opened in Longsight, offering a range of advice and services targeted at parents, children, and young adults. Second to open in Cheetham Hill in July



Appendix 2, Item 8

Making Manchester Fairer Framework



Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 20 September 2023

Subject: Children and Young People's Health Summit

Report of: Deputy Director of Public Health

Summary

The Children and Young People's Health Summit brought system leaders together to develop, drive and own the future direction and delivery of Manchester Locality's priorities for the health of our children and young people. This paper summarises the event and next steps.

Recommendations

The Board is asked to note the key outputs from the event and proposed next steps.

Our Manchester Outcomes Framework

<table>
<tr><th>Manchester Strategy outcomes</th><th>Summary of how this report aligns to the OMS/Contribution to the Strategy</th></tr>
<tr><td>A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities</td><td rowspan="5">Giving children the best start in life, and ensuring that children and young people have good physical health as well as social and emotional wellbeing will reduce health inequalities in the future adult population and enable them to make the most of the opportunities the city has to offer as well as contribute to the economic growth of the city.</td></tr>
<tr><td>A highly skilled city: world class and home grown talent sustaining the city's economic success</td></tr>
<tr><td>A progressive and equitable city: making a positive contribution by unlocking the potential of our communities</td></tr>
<tr><td>A liveable and low carbon city: a destination of choice to live, visit, work</td></tr>
<tr><td>A connected city: world class infrastructure and connectivity to drive growth</td></tr>
</table>

Contact Officers:

Name: Dr Cordelle Ofori
Position: Deputy Director of Public Health
E-mail: cordelle.ofori@manchester.gov.uk

Background documents (available for public inspection): None

1. Background

1.1 The Children and Young People's Health Summit brought system leaders together to **develop, drive and own the future direction and delivery** of Manchester Locality's priorities for the health of our children and young people.

1.2 The event aimed to begin the process of reviewing, developing, and agreeing a vision for the health of the children and young people of Manchester. This will contribute to and inform the refresh of Manchester Children and Young People's Plan 2020-2024 – building a safe, happy, healthy, and successful future for the City's children; in addition to informing the work of the Manchester Provider Collaborative and the Manchester Partnership Board.

2. Approach

2.1 The event was facilitated by Challenge to Care, and participants came from a wide variety of roles across health, social care and the third sector. Participants took part in structured conversations and exercises to address the following objectives;

- Establishing their personal and collective "why" for children and young people of Manchester
- Reflecting on where we are now, what has helped and what has got in the way of progress
- Reviewing the changing needs of the children and young people of Manchester and critically assessing how we may need to change our approach to meet these needs more effectively
- Agreeing priority areas for collective focus

2.2 Priority themes for discussion had been identified, through an analysis of public health data and informed by local insight into current challenges and areas where evidence shows collaborative action is likely to have impact. Participants also received a data information pack to inform their thinking in advance of the session. The themes were;

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

2.3 It was acknowledged that mental health was a priority, and that social and emotional wellbeing is crucial for children and young people to flourish. A separate discussion is taking place on mental health and work on emotional wellbeing will form part of the development of the city's strategic plan for mental wellbeing, commencing in September 2023.

3. Outputs

3.1 A number of over-arching themes were identified as important to drive strategic decision making for children and young people.

Well-Being and Support:
Child well-being, mental health support, and family support highlighting the importance of fostering a positive and supportive environment for individuals.

Education and Opportunity:
Education, equal opportunity, and access to resources, emphasising the significance of providing individuals with the tools and opportunities needed for success.

Mental and Physical Health:
Mental health and physical health, reflecting the understanding that overall well-being encompasses both psychological and physical aspects.

Collaboration and Connectivity:
Collaboration, communication, and support networks stressing the significance of working together to address challenges and create a supportive community.

Empowerment and Potential:
Empowerment, individual potential, and goal achievement, highlighting the importance of individuals realising their abilities and pursuing their aspirations.

Prevention and Early Intervention:
Prevention, early intervention, and data-informed decision-making underscoring the proactive approach to addressing challenges before they escalate.

Advocacy and Impact:
Advocacy, empowerment, and impact on various aspects of life emphasising the need for meaningful change and positive outcomes.

Safe Environments:
Ensuring safe and secure environments appears, recognising the foundational importance of a secure foundation for well-being.
Community Involvement:
Engaging with the community, creating connections, and involving children and young people highlighting the importance of collective efforts and inclusion.

Challenges and Resilience:
Overcoming challenges, breaking cycles, and dealing with adversity acknowledging the difficulties individuals may face while emphasising the importance of resilience.

3.2 Participants then started to identify areas for action and collaborative development for each of the priority health themes, following a discussion about what was already happening and working well across the system.

3.3 Finally participants reviewed the session and discussed what needed to happen next to make a difference to children and young people's outcomes in Manchester. Thoughts included;

- A focus on the needs of the future generation based on demographic change projections – understand what service and support provision will have the most impact
- Greater focus on qualitative measurement alongside quantitative measurement
- Involvement of children, young people and carers and families, including sharing data with them to help them inform the developments
- Agree shared performance indicators across organisations and with families
- Involve a broader range of partners in the ongoing development of vision and underlying actions
- A focussed session on mental health
- Keep the momentum going for this work

4. Next steps

4.1 In addition to being informed by the 'issues that matter' for children and young people as part of Manchester's Child Friendly City development and delivery plan, the discussions, data and themes identified during the summit will be developed further and ultimately contribute to the refresh of Manchester's children and young people's plan. This is expected to be finalised in May 2024.

5. Recommendations

5.1 The Board is asked to note the key outputs from the event and proposed next steps.

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