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MANCHESTER CITY COUNCIL

Manchester Integrated Care Partnership

Manchester Partnership Board

Date: Thursday, 29 February 2024
Time: 2.00 pm
Venue: Council Antechamber, Level 2, Town Hall Extension

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Membership of the Manchester Partnership Board

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

Agenda

1.	**Welcome, Introductions and Apologies**	
2.	**Declarations of Interest**	
3.	**Minutes of the previous meeting** To agree as a correct record the minutes held on 10 November 2023	7 - 16
4.	**Matters arising (if any)**	
5.	**ICB Executive update**	
6.	**North Manchester Strategy** Report of the Director of Public Health (MCC), Associate Director of Operations, Greater Manchester Mental Health NHS Foundation Trust and Group Chief Finance Officer, Manchester University NHS Foundation Trust attached	17 - 26
7.	**Strengthening strategic partnerships across Health and Care with the VCSE sector in Manchester** Report of the MPB VCSE representative and the Joint Director of Equality, Inclusion and Engagement attached	27 - 38
8.	**System Finance Update** Report attached	39 - 44
9.	**Any Other Business (if any)**	
10.	**Date of next public meeting** To note that the date of the next public meeting of the MPB will be 23 April 2024 at 2:00pm.	

Reports for Noting (comments by exception)

11.	**Manchester provider Collaborative update** Report of the Chair of Manchester Provider Collaborative Board and Executive Member for Healthy Manchester and Social Care attached	45 - 48
12.	**GP Board Update** Report of the Chair of Manchester GP Board attached	49 - 52
13.	**Clinical Professional Advisory Group update** Report of the Chief Medical Officer, Manchester Local Care Organisation attached	53 - 56
14.	**Delegated Assurance Board update** Report of the Deputy Place Based Lead attached	57 - 64

15. Palliative and End of Life Care in Manchester 65 - 88
Report of the Deputy Place Base Lead attached

Information about the Board

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

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

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

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

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

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

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

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

Further Information

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

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Manchester Partnership Board

Minutes of the meeting held on Friday, 10 November 2023

Present:
Councillor Craig, Leader MCC (Chair)
Councillor Robinson, Executive Member for Healthy Manchester and Adult Social Care, MCC
Joanne Roney, Place-Based Lead and Chief Executive MCC
Katy Calvin-Thomas, Chief Executive Manchester Local Care Organisation
Tom Hinchcliffe, Deputy Place-Based Lead NHS GM (Manchester)
Dr Vish Mehra, Chair Manchester GP Board
Dr Sohail Munshi, Chair of Clinical Professional Group
Simone Spray, VCSE Representative
Prof Manisha Kumar, Chief Medical Officer, NHS GM
David Regan, Strategic Director - Public Health, MCC

Also present:
Mark Cubbon, Group Chief Executive, MFT
John Foley – Greater Manchester Mental Health Foundation Trust
Julie Taylor, Director of Strategy and Provider Collaboration, NHS GM (Manchester)
Leigh Latham, Associate Director of Planning, NHS GM (Manchester)
Damien Heakin, Associate Director of Finance, NHS GM (Manchester)
Warren Heppolette, Chief Officer for Strategy and Innovation Strategy and Planning
Sharmila Kar, Joint Director – Equality & Engagement (Manchester)

Apologies:
Julia Bridgewater, Group Deputy Chief Executive, MFT
Jan Ditheridge, Interim Chief Executive, GMMH

MPB/23/22 Welcome, Introductions and Apologies

The Chair opened the meeting by welcoming everyone.

MPB/23/23 Minutes of the previous meeting

Decision

The Board approved the minutes of the previous meeting held on 15 September 2023 as a correct record.

MPB/23/24 ICB/ICP Updates

The Deputy Place Based lead provided an update from the Integrated Care Partnership Board which had met on 29 September 2023. He reported that there had been discissions around priority actions sitting under Mission 2 (Integrated Care Partnership Strategy) which was around the strategic shift towards prevention with positive examples being provided at the meeting of what was happening across Greater Manchester, including mental health and smoking cessation. In addition the

ICB agreed the Primary Care Blueprint for Greater Manchester and the overall Greater Manchester Mental Health Strategy.

The Chief Medical Officer (NHS GM) reported that the Finance Committee had met to consider the significant challenges that were being faced as an integrated care system and Board, the amount of work that was taking place in terms of financial recovery and the how things could be done differently and make savings to support winter and the coming months.

The Place Based Lead reported on the Executive Committee meeting, which was made up of all Place Based Leads from across Greater Manchester and the ICB Executive Board. It was reported that a new provider selector regime had been agreed which would enable work through commissioning in localities in a streamlined provider network that was created at the ICB. The role of the voluntary sector and its ability to commission quickly and efficiently was also discussed. Feedback from the Executive Group insofar as the financial strategy was a need to move to longer term thinking not just in relation to the funding envelope but also the organisational form. The Committee also discussed the winter vaccination and preparedness programmes as well as the announcement of some additional funding for local authority (winter pressures), hospices and assisted conception discussion.

Decision

The Board note the update.

MPB/23/25 Strategic Financial Framework

The Board considered a report of the Chief Officer – Strategy & Innovation, NHS Greater Manchester, which considered the Financial Framework. The Greater Manchester (GM) Integrated Care Partnership (ICP) had approved its 5-year strategy in March 2023. At the end of June 2023, the Partnership agreed and submitted the Joint Forward Plan (JFP) as the delivery plan for the ICP Strategy. It set out the key actions to deliver their ambition against each of the six missions and drew on a range of existing plans developed across the system and each GM locality. When submitting the JFP to NHS England, it was recognised that further work was needed to strengthen delivery plans to provide much greater detail on the approach to delivering the mission on financial sustainability.

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

Greater Manchester ended 2022/23 with a reported underlying financial deficit of £570m after removing nonrecurrent items. This would grow to £1.9b in 2027/28 based on expected funding growth compared to activity growth and inflation. To understand the health needs of the population the Advanced Data Science Platform (ADSP) had been used to access linked patient-level data on the GM population and developed a segmentation of the population. This showed that 29% of people in GM

were not in good health and account for 79% of total costs. Three opportunities had been explored to address the growing needs for healthcare:

- reducing prevalence growth,
- optimising models of care, and
- addressing inequalities in access.

The feasibility of these opportunities is tested in two ways: by validating the scale of the opportunity externally and by testing the achievability of the opportunities with analysis of quality indicators and to translate opportunities into potential spend/cost avoidance, each opportunity area had examined the evidence base for return on investment and timing.

Additional work would need to be done to determine the level of provider efficiencies achievable and ensure alignment with the outputs of the current financial recovery work. On completing the final outputs for the Financial Framework, the findings would be used initially to support the engagement and understanding across GM. This discussion and engagement would confirm the priority and phasing of initiatives. This in turn, would drive the development of Operational Plan for 2024/25.

The Leader noted that prevention had long been the fundamental tenet of what Manchester was trying to achieve, which was illustrated in how money had been invested in programmes developed through Making Manchester Fairer. There would be an offer from Manchester as a locality to help populate aspects of the Operational Plan with more localised data.

The Chief Medical Officer, NHS GM commented that unless drivers of demand were addressed health services would always be behind the curve in how they can be delivered. She commented that the data now presenting across GM was the same that had been present in Manchester for the last five years were a large amount of work had already taken place in reducing variation across primary care.

The Director of Population Health commented that one of the challenges would be where investment was coming form. He reported that as a Local Authority funding of £929,000 would be made available by Government to a tackle smoking cessation which was welcomed. There had also been similar investment in drug and alcohol treatment services, however as this was grant funded there would be a need for greater joined up working across GM to accelerate change.

The Chair of Clinical and Professional Advisory Group commented that historically Manchester had a strong business intelligence team presence both from the former CCG and the Council and consequentially, for the last few years there had been a deep level of involvement of population health management across the 14 PCNs. He reflected that it would be important to build on practical lessons learnt and mistakes made to drive improvements.

The Group Chief Executive, MFT commented that it was reassuring to hear that there would be a further iteration of this work to ensure that there was a whole system view rather than just costs to providers, and where savings could be made to support movement of resources.

The VCSE Representative commented on what assumptions and data was being used in relation to Children's Mental Health and how much VCSE data was included. She also commented that the VCSE sector was also really keen to be involved with some of the solutions to cost effective approaches.

The Place Based Lead commented that the framework currently omitted how local authority funding had been utilised, such as in relation to early years for children, investments made through public health and adult social care, which all fed into the Making Manchester Fairer approach.

In concluding the Leader commented that there needed to be some consideration to the framing of future conversations insofar as the document being framed as a Strategic Financial Framework, which potentially set a focus on money as opposed to what needed to be done and how things could be changed. In addition she commented that there was a need for mature conversations around how space was created for invest to save and the programme management structure that sat behind this. Finally she commented that there was as an opportunity to use the examples of good practice to demonstrate progress and promote the right kind of working.

Decision

(1) The Board note the contents of the report.
(2) The Board commits to engaging on the transition of the analysis into local and system wide activity.

MPB/23/26 Admissions Avoidance

The Board considered the report of the Chief Executive, Manchester Local Care Organisation (MLCO), Chief Medical Officer (MLCO) and Deputy Place Based Lead that stated that over the past five years, the development of integrated health and social care working in neighbourhoods had been a key strategic goal to support prevention and care closer to home.

It was reported that there had been significant progress in rolling out the admission avoidance model since the paper presented to the Partnership Board in July. Evidence from the pilot had been reviewed and incorporated into a high-level outline business case to secure funding so that a City-wide Hospital at Home offer could be in place for Christmas 2023.

The Hospital at Home roll out would bring together existing virtual wards with the community based pilot in central Manchester, creating a consistent city-wide offer. These existing services typically aimed at preventing readmissions following a spell in hospital by using remote monitoring technology to enable a proactive response when a patient is at risk of an acute emergency.

The community-based pilot in central Manchester tested an enhanced Hospital at Home model. This model was based on creating a workforce and infrastructure in the community, which enabled the safe care of frail patients who had not been medically optimised. The pilot had run for twelve months and there had been significant

learning from this period. The evidence suggested that the Hospital at Home model was capable of supporting frail and elderly people who could currently only be supported by admission to hospital and inpatient stay.

Patient safety would guide the roll out and expansion of Hospital at Home. The process would be cautious so that system partners can learn from and understand the full implications of the model before taking further steps. There would also be specific communications to GPs in each locality as Hospital at Home rolled out to their localities.

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

Decision

The Board:-

(1) Note the elements of the work being undertaken across the Manchester system on prevention and admission avoidance.
(2) Considered the initial feedback from Newton Europe's diagnostic work and considered the further steps that followed from this.
(3) Endorsed the continued work on the admissions avoidance component of the Keeping Well at Home Programme, and the further rollout of Hospital at Home.

MPB/23/27 Strengthening our approach to Patient & Public Engagement in Manchester

The Board considered the report of the Chief Executive and Place Based Lead which set out the opportunities for optimising the potential of Manchester's Patient and Public Advisory Group (PPAG) for the wider locality, drawing on the lived experience and knowledge of patients. Manchester has some of the most challenging health inequalities in the country yet has the greatest assets in its diversity of communities. The aim is to optimise those assets by addressing the unwarranted systemic and structural discrimination that impacts those communities access, experiences, and outcomes for better health.

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

- Manchester Area Prescribing Group
- Healthy Lungs Steering Group
- Healthy Hearts Steering Group
- Manchester Primary Care Commissioning Committee
- Community Health Equity Manchester (CHEM)
- Carers Learning and Development Board

- Community Diagnostic Centre (CDC) Equalities Group
- Manchester System Quality Advisory Group

PPAG members had also provided feedback and lived experiences by participating in the Manchester system on a range of subjects over the past year.

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

There was discussion about how patient and public engagement will be used to support the work underway on the Strategic Financial Framework, and how the impact of this engagement will be evidenced.

Decision

The Board:-

(1) Note the report.
(2) Support the work of the locality Equality and Engagement team with MPB partner organisations and GM Integrated Care to ensure they continue to build patient voice and experience into our approach to engagement, involvement, and quality improvement – to inform decision making to improve services.

MPB/23/28 System Finance Update

The Board considered a presentation from the Associate Director of Finance NHS GM (Manchester) which provided an update on the financial position of all localities across GM.

It was reported that all localities were predicting a deficit position, totalling circa £16m by the end of the financial year, with £10m relating to Manchester. Manchester had been asked to formulate a financial recovery plan along with three other Local Authorities (Bury, Stockport and Wigan). It was reported that recovery actions were now taking place.

In terms of providers, there was a £84m deficit being reported at month 6. Consequently a £122m deficit plan had been set which the ICS planned to balance this with £122m surplus, but there was risk of slippage in these rates.

In terms of MFT, the most recent figure reported was £50m deficit and there was significant pressures in adult social care.

In relation to the locality, the main financial pressures were being felt in prescribing, migrant health, mental health, and individualised packages of care.

The Deputy Place Based Lead assured the Boad that work was being done across all parts of the system to address recovery measures. He noted that a lot of the financial pressure being felt were arising from demand led services such as increasing costs for prescribing and increasing numbers of complex placements (Mental Health).

The Chief Medical Officer signalled that continued support from the locality would be needed for the work to that is underway around Mental Health discharge, and to address the numbers of Mental Health Out of Area placements.

The Group Chief Executive, MFT commented that it was important that of the £800m government had allocate nationally, Greater Manchester received its fair share and that it went towards the financial recovery plans it was intended for and not to offset other deficits being incurred elsewhere.

Decision

The Board:-

(1) Noted the financial position at Month 6 across the system.
(2) Noted the allocation for UEC capacity funds.

MPB/23/29 Date of next public meeting

The Board agree the date of its next public meeting.

MPB/23/30 Manchester Provider Collaborative Board

The Board considered the report of the Chair of Manchester Provider Collaborative Board and Executive Member for Healthy Manchester and Social Care that updated the Board on the work of the Provider Collaborative Board as part of the agreed reporting cycle to MPB. The report covered the outputs of the meetings held 21st September and 19th October 2023.

The key discussion points from the meetings were:-

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

- Update on the Manchester system's Winter Resilience Plan and discussion/agreement on the allocation of Manchester's Urgent & Emergency Care funding between Primary Care, GMMH and MFT.

Decision

The Board note the report.

MPB/23/31 GP Board Update

The Board considered the update report of the Chair of Manchester GP Board. Manchester GP Board meets monthly to discuss a range of current and future priorities relevant to Primary Care.

At the meetings in September / October 2023 the Board focused on the following areas:

- Primary / Secondary Interface
- Urgent & Emergency Care (UEC) / Winter Update
- NHS GM Quality Scheme Review
- Primary Care Health Infrastructure
- Workforce and Additional Roles Reimbursement Scheme (ARRS)
- Hospital at Home
- Winter Vaccination Programme
- Spirometry

Decision

The Board noted the report.

MPB/23/32 Clinical and Professional Advisory Group

The Board considered the report of the Chief Medical Officer (MLCO) that provided an update on the work of the Clinical and Professional Advisory Group.

Decision

The Board note the report.

MPB/23/33 Delegated Assurance Board

The Board considered the report of the Deputy Place Based Lead which stated that the Delegated Assurance Board (DAB) formed a key element of the governance structure for the Manchester Locality, as part of NHS Greater Manchester Integrated Care (NHS GM). The DAB is a sub-group of the Manchester Partnership Board (MPB) and is a means for the Place Based Lead (PBL) to gain support and assurance in discharging their responsibilities. The report provided an update from the DAB meeting held on 6 September 2023 and 4 October 2023. No issues or risks were identified that required escalation to the Manchester Partnership Board.

Decision

The Board note the report.

MPB/23/34 System Urgent Emergency Care

The Board considered the report of the Deputy Place Based Lead which gave an update on winter planning for 2023/24. In line with previous years, the Manchester and Trafford System Resilience Team were to lead and co-ordinate on all aspects of winter planning and the lessons learnt from winter 2022/23 had been incorporated into the organisational delivery plans.

Decision

The Board note the report.

MPB/23/35 Manchester Local Care Organisation Accountability Board

The Board considered the report of the Chief Executive (MLCO) which provided Manchester Partnership Board with an MLCO progress update for October 2023. The MLCO Accountability Board met on Thursday 19th October 2023 to consider papers that provided updates against core operational delivery and performance. As a reminder the MLCO Accountability Board was re-established in June 2023 and is co-chaired by Julia Bridgewater, Deputy Chief Executive, MFT and Councillor Tom Robinson, Executive Member for Healthy Manchester and Adult Social Care.

Decision

The Board note the report.

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Manchester
Integrated Care Partnership

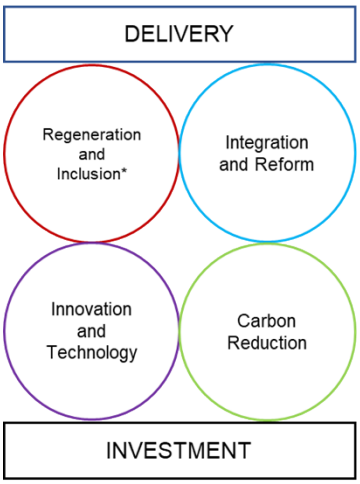
Manchester Partnership Board

Report of:	David Regan, Director of Public Health, Manchester City Council; Strategic Director (Population Health), NHS Greater Manchester Integrated Care (Manchester); and North Manchester Strategy Programme Senior Responsible Officer Deborah Goodman, Associate Director of Operations, Greater Manchester Mental Health NHS Foundation Trust Jenny Ehrhardt, Group Chief Finance Officer, Manchester University NHS Foundation Trust
Paper prepared by:	Sarah Griffiths North Manchester Strategy Lead and Head of Programme Management Office, Manchester Local Care Organisation
Date of paper:	29 February 2024
Subject:	North Manchester Strategy Programme Update
Recommendations:	Manchester Partnership Board is recommended to note the update; note the links to wider system work; and continue to support the partnership work taking place through the North Manchester Strategy

Manchester
Integrated Care Partnership

1. Introduction

The North Manchester Strategy programme brings together the partnership work that spans and seeks to maximise the impact of the major capital developments in North Manchester – the healthcare-led North View build and North Manchester General Hospital (NMGH) site redevelopment; and the residential-led Victoria North development. These developments have a combined value of around £4.5bn over a twenty year timeframe and present a significant opportunity to improve services and outcomes in a manner that stimulates civic regeneration, addresses inequalities and grows prosperity in and around North Manchester. It is an opportunity to take a place-making approach that leverages partners' collective influence as Anchor institutions to shape services and places that support good health and wellbeing into the future and, as such, this work is a place-based exemplar of the city's Making Manchester Fairer approach. The North Manchester Strategy is framed around a series of thematic priorities as shown below and it features in Manchester Partnership Board's priorities given the significance of the healthcare-led regeneration taking place. This paper updates Manchester Partnership Board on the progress made during 2023/24.



Formerly Levelling Up and Recovery

Regeneration and inclusion: using the health, care and housing investment to create positive social value, improve life chances and support inclusive pandemic recovery in North Manchester / North GM.

Integration and reform: building on organisational and system changes to transform service delivery and workforce models to meet diverse needs, prevent ill-health, and aid productivity and sustainability.

Innovation and technology: deployment of digital technologies in a wide variety of settings, and innovation opportunities in the Healthy Neighbourhood.

Carbon reduction: sustainable placemaking, including net zero carbon, sustainable resources, green space and biodiversity, sustainable travel and climate change adaptation.

Investment: core developments of North View, North Manchester General Hospital, Victoria North. Connectivity with wider developments in North Manchester e.g. Central Park, Strangeways.

2. Programme arrangements

Delivery of the North Manchester Strategy is a system enterprise that draws on leadership and delivery capacity from multi-agency partners. The North Manchester Strategy Board (NMSB) is responsible for the strategic direction and oversight of the North Manchester Strategy and its associated programme of work. The NMSB is comprised of political and officer leadership from Manchester City Council, NHS Greater Manchester Integrated Care (Manchester), Manchester University NHS Foundation Trust, Manchester Local Care Organisation, and Greater Manchester Mental Health NHS Foundation Trust. The NMSB is complementary to the governance arrangements for each of the major capital developments that come under the umbrella of the strategy. It has a reporting line to Manchester Partnership Board in keeping with the North Manchester Strategy being a feature of

Manchester Partnership Board's priorities.

Partners agreed to establish a North Manchester Strategy Team (Programme Management Office) to bring additional capacity to aid delivery of the partnership work under this programme. The role of this team is to:

- Work with system leaders to set the policy direction for the North Manchester Strategy
- Convene and coordinate multi-agency activity to deliver the North Manchester Strategy
- Lead and contribute to the definition, development and delivery of priority products / work and funding strategies
- Identify and manage interdependencies with city, Greater Manchester and national policies and strategies
- Programme manage the North Manchester Strategy Programme, including governance, assurance, and evaluation

The North Manchester Strategy Team (Programme Management Office) has been recruited, with all appointees due to be in post by 1 April 2024. The Team is employed by Manchester University NHS Foundation Trust and hosted in Manchester Local Care Organisation under the Drector of Strategic Planning and Reform. As the Team works on behalf of the system, it reports to the Director of Public Health / Strategic Director of Population Health as the Senior Responsible Officer for the programme and is accountable to the Place Based Lead for Manchester.

The Team is funded by system resource which in the long-term has been earmarked to support the running costs associated with the proposed NMGH redevelopment's Health and Wellbeing facility. NMSB has agreed that the resource will be in place for the North Manchester Strategy programme and associated team until the funding is required to be used for its original purpose, currently anticipated to be 2030.

3. Capital investments

3.1 North View

Greater Manchester Mental Health NHS Foundation Trust's North View development provides £105.9m of investment to replace the existing Park House mental health inpatient unit, in line with the government's strategy to eradicate the use of dormitories in mental health services. North View will provide significantly improved facilities in a purpose-built therapeutic environment that will enhance the experience of service users and staff. Its redeveloped model of care will also support a reduction in the average length of stay and contribute to the elimination of out of area placements.

North View forms an integral part of the wider NMGH redevelopment plans. Construction of North View commenced in August 2022. It is expected to be completed in August 2024, with

the building anticipated to be operational by the end of 2024. Service users and carers continue to be engaged in the delivery of North View, including in relation to interior design, arts and the model of care.

In November 2023, the development welcomed the then Secretary of State for Health and Social Care, The Rt Hon. Steve Barclay MP, for an unscheduled site visit.

3.2 North Manchester General Hospital redevelopment

Manchester University NHS Foundation Trust's redevelopment of the NMGH site is part of the government's New Hospital Programme, which aims to complete 40 new hospitals by 2030. The NMGH site redevelopment master plan takes a campus approach that seeks to improve health and wellbeing through the provision of hospital and wider health, care and wellbeing facilities; high quality residential and commercial provision; and green spaces. A key part of the master plan is the Healthy Neighbourhood, and an update on work to develop this concept is included at section six of this paper.

The Trust has been successful in drawing down over £70m from the New Hospital Programme to date to fund critical enabling works on site and to prepare the site for the new hospital. With the support of the North Manchester Strategy partnership, the Trust has progressed the redevelopment scheme through the achievement of key milestones including the development of the masterplan, the completion of Enabling Works Phase 1 and the handover of the former Trust Headquarters site to Greater Manchester Mental Health NHS Foundation Trust. The following table sets out the key milestones achieved.

	NMGH Redevelopment Milestones	Date Achieved
1	NMGH announced as part of the Health Infrastructure Plan	October 2019
2	Strategic Outline Case approved by Department of Health and Social Care	August 2020
3	Initial Enabling Funds approved for NMGH	August 2020
4	NMGH Outline Business Cases submitted	January 2021
5	Strategic Regeneration Framework endorsed by Manchester City Council's Executive Committee	March 2021
6	NMGH Multistorey Car Park and Cycle Hub planning approval secured	March 2021
7	NMGH becomes part of the Manchester University NHS Foundation Trust Group	April 2021
8	North Manchester House (decant of Trust Headquarters) operational	November 2021
9	Handover of former Trust Headquarters site to Greater Manchester Mental Health NHS Foundation Trust	August 2022
10	NMGH Multistorey Car Park and Cycle Hub operational	September 2023

In August 2023 the Trust welcomed Lord Nick Markham, Parliamentary Under Secretary of State (Minister for the Lords), and members of the New Hospital Programme team to a visit at NMGH.

The Trust is working with the New Hospital Programme and local system partners to confirm the funding envelope and timetable linked to the NMGH redevelopment in order to meet the national timeline for a 2030 completion date for the major works. In preparation, the Trust has submitted an application to the New Hospital Programme for programme fees that would fund the required internal and external team to progress the design and complete the Outline Business Case process.

3.3 Victoria North

Victoria North is a joint venture between Manchester City Council and Far East Consortium which will deliver around 15,000 homes during the 2020s and 2030s. At 155 hectares, it is one of the largest regeneration projects in the country, reaching from Victoria Station to Collyhurst. The programme presently has three main areas of focus:

- Collyhurst (Collyhurst Village and South Collyhurst): up to 3,000 homes could be delivered over 15 years. Phase one is on site, comprising 274 new homes (including 130 for social rent) and a park. Collaborative work with health and education partners is informing planning for social infrastructure
- Red Bank: around 5,500 homes and accompanying social infrastructure could be delivered in this area in to the 2030s and £51.6m Housing Infrastructure Funding has been secured to enable the repurposing of this brownfield land. 634 homes are on site at Victoria Riverside
- Sandhills: up to 2,500 homes could be provided here, along with the potential for a new neighbourhood district centre anchored by a proposed new Metrolink stop which could provide opportunities for the integration of a range of social infrastructure

As illustrated above, the Victoria North development presents several opportunities for the provision of new social infrastructure like health and education facilities. These opportunities are being explored with partners, taking account of population modelling projections and the potential relationships with other pipeline developments in North Manchester, including the Strangeways and Cambridge Strategic Regeneration Framework and Manchester City Council's District Centres Programme.

4. Regeneration and inclusion

4.1 Social value delivery

The North Manchester Social Benefit Framework articulates social value priorities, opportunities and outcomes around which partners are mobilising their social value efforts. This has been adopted by the major parties working across the North Manchester Strategy. The framework spans the five themes of education, employment and skills; health and wellbeing; community resilience; digital; and zero carbon 2038. A wide range of activities have taken place across these themes and, in the period from April 2021 to 30 September 2023 (the latest timescale for which data is available), the following cumulative social value measures have been reported:

- 2,553 jobs. 14% secured by North Manchester residents. 45% secured by residents

from North Manchester, Manchester, Bury, Oldham, Rochdale, Salford

- 54 apprentices employed
- 100% of employees across all projects paid the Real Living Wage
- 3,110 hours of volunteering
- 25m (£25,341,799) monetary value of social value activity to date

4.2 Inclusive communications and engagement

The North Manchester strategy is underpinned by ambitions to partner differently and more deeply with communities. As such, the other immediate priority under the 'regeneration and inclusion' theme is the development of the next iteration of the programme communication, engagement and involvement plans. In the coming years, programme partners will be undertaking a wide range of communication and involvement activities with audiences including patients / service users, voluntary sector organisations, residents and the wider public and it is important for this to take a coordinated approach. In addition, there are opportunities for the programme to support the Locality to test new ways of working with communities through mechanisms such as the Health Determinants Research Collaboration and Making Manchester Fairer Communities and Power. Opportunities will be built into the plans as they develop.

5. Integration and reform

The integration and reform theme brings together a range of work relating to service development and transformation. A core element of this is the development of the Target Operating Model (TOM) for NMGH, which Manchester University NHS Foundation Trust is progressing as part of the redevelopment business case. This work seeks to describe how services will function in the future and the capabilities needed to deliver them. Linked to this, a first stage of work has been undertaken to understand how community services and pathways operate and need to operate in the future across the NMGH footprint – Manchester, Bury, Rochdale, Oldham and Salford – in order to enable the NMGH TOM and redevelopment plans. This work sought to understand how interventions in the community impact demand and capacity in NMGH and to identify opportunities for future areas of focus to enhance interfaces between community-based services and secondary care. For Manchester, the next steps from this work will be aligned to the further testing and development of the NMGH Wellbeing Hub concept as part of the redevelopment business case and an exploration of the service innovation opportunities of the Healthy Neighbourhood. It is important that this work is situated in the context of current city / Greater Manchester service transformation plans and the wider financial context, and there are multiple links to be made with work that is taking place elsewhere in the system.

Also of relevance to the future wellbeing model development is a three year £400k pilot which Manchester Youth Zone is undertaking to explore the health impact of youth services as a vehicle for social prescribing. Funded by a national youth charity, the North Manchester Strategy Programme supported the bid with match funding and partnership input, which was

a particular strength of the application. During 2023, Manchester Youth Zone tested tools and interventions with young people from its service user cohort to inform the project. This revealed a wide range of issues that have the potential to be supported through early intervention and social prescription. Manchester Local Care Organisation is working with Manchester Youth Zone in preparation for a launch of the pilot with GPs during 2024. The learning from this work will help to inform the model of health and wellbeing services in North Manchester and beyond.

As set out in section 3.3, work is ongoing to define the potential scope, location and investment models of social infrastructure to be delivered through the Victoria North development. In doing so, partners are considering the relationship between the service models / infrastructure at Victoria North, the NMGH site and, additionally, the wider range of potential developments that have come into the regeneration pipeline in North Manchester in recent months. This includes emerging development plans for Strangeways and several District Centres across the north of the city. Partners are working to develop a joined up approach to service planning and infrastructure investment across the pipeline in North Manchester, exploring the potential of upcoming development opportunities in the context of population forecasts; needs assessments; existing social infrastructure; service implications and funding strategies. Partners are working with the Locality Strategic Estates Group on this work. The scale and timing of opportunities in the north of the city lends itself to a North Manchester place-based approach but learning is emerging which could inform a citywide approach.

6. Innovation and technology

6.1 The Healthy Neighbourhood

A key part of the NMGH site redevelopment masterplan is the Healthy Neighbourhood concept, which responds to the North Manchester Strategy by seeking to utilise Trust land to facilitate the development of a mixed generation neighbourhood with a focus on wellbeing to meet the needs of the North Manchester community whilst also maximising the research and development opportunities the new campus will provide. The area includes significant areas of open space and will physically link to the existing residential streets and Crumpsall Park.

The Trust commissioned Manchester Metropolitan University to work with a range of stakeholders to develop the concept of the Healthy Neighbourhood. The work concluded in May 2023 and identified ‘six innovations’ that could be delivered as part of the Healthy Neighbourhood, as shown below. Work will be progressed through 2024 to inform potential development briefs to shape the redevelopment business case:

- Co-produced civic institutions
- A distributed care model
- Diversity and flexibility in residential typologies
- A coordinated social infrastructure
- Destination and connector beyond the General Hospital

- Research, development and digital infrastructure

A potential anchor element of the Healthy Neighbourhood is the (International) Centre for Action on Healthy Ageing ((I)CAHA), a developing research and innovation partnership led by Greater Manchester Combined Authority and including the NHS, universities, Greater Manchester agencies and businesses. This aims to drive innovation that improves population health across the life-course, enabling people to keep well and live independently in their own homes and communities. This could be achieved through research and development being integrated into all aspects of the Healthy Neighbourhood vision, such as novel assistive technologies, new models of care, and new residential typologies and designs. 'Think' consultancy has been appointed to lead the next steps for the (I)CAHA development, focusing on the formation of the 'value proposition' and an associated funding strategy. This piece of work is expected to conclude in May 2024.

6.2 Academic collaborations

The North Manchester Strategy benefits from strong relationships with academic partners, particularly with Manchester's two universities. Multiple academic collaborations are taking place within the programme, as illustrated below:

- The development of the Healthy Neighbourhood concept and the (International) Centre for Action on Healthy Ageing proposition, as referenced above at 6.1
- Hosting Manchester Metropolitan University Leverhulme Unit for the Design of Cities of the Future (LUDeC) PhDs; one exploring the River Irk Valley at Victoria North; another researching the role of networks in engagement with the NMGH redevelopment
- Partnering with the University of Manchester in a funding application for a CASE PhD studentship for collaborative research. If funded, this would research, "Healthy ageing and urban regeneration: improving the lives of older people living in lower income neighbourhoods", with a North Manchester spatial focus. A decision on the application is expected in early summer 2024
- Working with the University of Manchester to inform a long-term approach to measuring the impact of large-scale regeneration in the form of a 'Flourishing Index' – an asset-based approach focused on the things that shape health and wellbeing
- Working with the National Institute for Health and Care Research Applied Research Collaboration (Greater Manchester) to undertake a rapid review of research examining the effects of place-centred strategies to improve health and reduce health inequalities. This is due to report in the spring and will build the evidence base for our work in North Manchester

7. Carbon reduction

Carbon reduction and wider environmental sustainability plans are embedded in each of the capital developments. Identification of collaborative priorities under this theme will be progressed for the 2024/25 year.

Manchester
Integrated Care Partnership

8. Recommendations

Manchester Partnership Board is recommended to note the update; note the links to wider system work; and continue to support the partnership work taking place through the North Manchester Strategy.

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Manchester
Integrated Care Partnership

Manchester Partnership Board	
Report of:	Simone Spray, MPB VSCE Representative Sharmila Kar, Joint Director of Equality and Engagement
Paper prepared by:	Simone Spray, MPB VSCE Representative Sharmila Kar, Joint Director of Equality, Inclusion and Engagement
Date of paper:	29 February 2024
Subject:	Strengthening strategic partnerships across Health and Care with the VCSE sector in Manchester
Recommendations:	The Manchester Partnership Board is asked to comment on and support the paper.

CONTEXT

1.1 The purpose of this report is to raise awareness and galvanise action surrounding the immediate and ongoing issues impacting the VCSE sector[1] as a key strategic partner within the ICS. It is also to confirm the principles and agreements that will underpin Manchester's integrated collaborative response to sustaining the sector and integration of their insight, expertise and leadership in the future developments and delivery of the City's health and care priorities.

1.2 The 2021 State of the Sector report estimated there are over 3,800 VCSE sector organisations in the City, which was an increase on the previous report from 2017. There are over 160,000 people who volunteer with the VCSE sector in Manchester who give a total of 480,000 hours of time per week, valued at over £240 million per year to the City's economy, working alongside 32,246 paid staff (equal to 19,607 FTE). The vast majority of organisations are neighbourhood based, rooted in communities, and addressing significant inequalities in what they do. The strong return on investment provided by the VCSE is well evidenced with preventative and early intervention work reducing the strain on public services in both immediate demand and in achieving long term outcomes.

1.3 There is a long history of co-operation and collaboration between health and care organisations in the VCSE sector and the health and care bodies that make up the Manchester Partnership Board. Some of this has been delivered through Macc as the VCSE infrastructure organisation for the sector in Manchester but also directly on an organisation-by-organisation basis via contracts and grants. Funding has supported community engagement, patient involvement, and the delivery of services. However, we have identified a need and also an opportunity given the changes to the health and care system to further integrate the VCSE more strategically across the City - beyond transactional arrangements and consultation, moving to a more strategic approach that integrates leadership, impact and learning into future decision- making, co-design and service provision. (A report on this was produced in January 2023 by Ali Wheatley, an NHS Graduate on placement with Macc).

1.4 As we develop our locality integrated infrastructure there are opportunities to further strengthen our relationship through City-wide, neighbourhood and community initiatives and joint leadership where appropriate. Whilst there are some good examples of cross-sector and integrated approaches that benefit the people and populations of Manchester there is a shared understanding among partners that by strengthening relationships, operating frameworks, financial and operational accountability we will improve outcomes for the citizens of Manchester, sustain growth, reduce inequalities, and improve efficiency. It is fair to reflect that this is a long-standing ambition but one the local health and care system has generally struggled to embed through successive periods of change. There is an imperative to make progress on this in the embedding of the ICS model at place: with significant budget pressures and reductions in resources available, finding the most effective and efficient ways of working together to address our shared system challenges is a rare positive opportunity.

1.5 The financial resilience of the VCSE sector (including micro, small and medium local charities) in Manchester has been hit hard by both the current economic situation, the withdrawal of COVID emergency/non-recurrent funding, wider financial pressures across the health and care system, changes in governance along with decision-making at different spatial levels. The State of the Sector report reviewed 126 groups across Manchester with a similar split across areas of work. The report asked about changes in funding levels and showed that 27% of groups had decreased income with 46% reporting an increase in demand for services – there

[1] VCSE sector means charities, voluntary organisations, community groups, the community work of faith organisations and social enterprises or other non-profit making organisations with a social purpose.

is a strong view within the VCSE sector that this situation has deteriorated further as emergency funding approaches introduced during the pandemic have now ended.

1.6 The work described in this paper is set within a period of extreme demand and dependence placed on both the public and VCSE sectors. It is also a time of great uncertainty. NHS, local authority, and other public budgets are under immense pressure and that budgeting is having a *direct* impact on VCSE organisations in terms of grants and commissioning, but also an *indirect impact* (reductions and pressures in public services often displace need and put more pressure on charities and communities).

1.7 Moving forward, active involvement of voluntary and faith-based organisations, community groups and social enterprises in places and neighbourhoods will be increasingly critical to Manchester. This will allow us to be able to respond to these pressures to develop a model for health and care support which is holistic, person-centred, proactive, and preventative, while addressing the priorities of tackling inequalities, building confidence, and co-design of a sustainable health and care system. Put simply, there is a need to take a practical approach where responsibility and risk are shared, and the public and VCSE sectors work together as an ecosystem which supports places, communities, and people.

1.8 The GM VCSE Accord is a three-way collaboration agreement between the Greater Manchester Combined Authority (GMCA), NHS GM Integrated Care and the VCSE sector, overseen by the GM VCSFE Leadership Group. This Accord has also been endorsed through the Executive structures of all ten of the GM local authorities. *Further details are available in Appendix 1*.

1.9 Manchester has been clear that signing up to the Accord signals support for the VCSE sector in the ways set out within it: that the sector is a **strategic** and **delivery** partner. Alongside this comes recognition that a more detailed examination of the situation across the city. A locality-specific approach is required to bring the Accord alive in a way that is relevant to Manchester, addresses local barriers, builds on local strengths, supports and contributes to the development of the city's strategic plans, and meets the unique needs of our citizens.

1.10 There are examples of progress in terms of relationships and mechanisms in support of the VCSE in Manchester (some outlined in Appendix 2). Further work needs to be undertaken to ensure that we are engaging and commissioning the VCSE to support the delivery of MPB priorities.

2. Working with the VCSE sector across Health and Care in Manchester – progress to date

The VCSE sector in Manchester continues to evolve: as the needs and capacity of people and communities shift, so do the resources, priorities, and purpose of VCSE activity.

1.11 VCSE Involvement and Influencing - The VCSE sector has established structures through Macc such as the Health and Wellbeing VCSE Leaders' Group with a specific focus. This group originated initiatives such as the Memorandum of Understanding with MLCO and has processes in place to support VCSE representation in structures such as MPB and Making Manchester Fairer (MMF). There is scope for much greater collaborative working through this group as the key forum for public sector partners and VCSE leaders who have health, care, and wellbeing as their focus. However, there are significant challenges for the VCSE sector when it comes to capacity to work at and influence at multiple spatial levels i.e., Neighbourhood, City-wide, GM, National and we will need to work collectively with the sector to address some of these challenges.

2.2 Communication - delivering communication and engagement approaches linked to groups and communities across Manchester to improve the sharing of data and information, and better connect to public sector partners. The work that has been undertaken by CHEM with the establishment of Sounding Boards comprising VCSE organisations and community representatives, as well as statutory and health and social care representatives, is a good example of this. Though the selection of trusted *messengers* to share messages via *media* used by communities ensured that tailored public health messages were more likely to reach communities and be understood and acted on. There has been some joining up of communications in sharing through networks and channels (e.g. to promote COVID-19 vaccine uptake, address vaccine hesitancy and challenge misinformation). Prior to the pandemic there were conversations with MCC and VCSE partners about a shared approach to a "public information ecosystem" moving beyond a 'social marketing' approach towards systems and cultures to support active engagement. Work on the new structure for VCSE engagement within the ICS has not progressed, in part due to the pace of development of the overall ICS governance infrastructure but it is expected that this will progress in 2024.

2.3 VCSE Workforce Development - Through collaboration with partner organisations across GM, Macc has been leading a pioneering GM-wide workforce development programme for the VCSE sector, to boost skills, capability, and develop leadership across the sector (with a specific focus on nurturing more diversity in sector leadership). This sits alongside Macc's history of developing system leadership programmes in recent years working with partners in MFT, MLCO neighbourhoods and with GM Moving. In Manchester, MCC and Community Health Equity Manchester have developed a system leadership programme for women experiencing and impacted by racial inequality. It is open to women of colour working in women-led VCSE organisations within Manchester and aimed at both current and future leaders within Manchester.

2.4 Equality Networks - Manchester's commitment to equality and diversity is part of its fabric. The City has championed equality for generations and prides itself on being a diverse and welcoming city - a city for all where everyone can achieve their potential and where everyone is valued, and their success celebrated. We have a thriving and increasingly diverse population with a wealth of characters, cultures, and contributions. We have achieved a lot by working with our different communities to promote their identities and achievements. We will continue to maintain and build on this, going even further to celebrate Manchester's diversity. We will act as a collaborative of people from a wide range of communities of identity, working closely with the sounding boards, Manchester Disability Collaborative, CHEM, GM Equality panels, North Manchester Inclusion Partnership, VSCE Equality organisations to advise, support and bring insight from diverse and intersectional viewpoints on key strategies and service design issues.

2.5 Infrastructure development – In the context of the GM VCSE Accord, the priority for VCSE infrastructure development is to ensure that every locality has a sustainable and effective model for supporting and developing the local VCSE sector. In some GM boroughs there is a long history of infrastructure support (e.g. Salford CVS) while in some there is no VCSE infrastructure organisation and in others this gap has only recently been filled with the development of a new organisation (e.g. Sector3 in Stockport). It is well understood that without such support, there is an inability to convene the sector to work strategically and enable more effective collaborative ways of working, a loss of capacity to draw in additional resources (funding opportunities, partnerships and volunteers). In Manchester, Macc was restructured in 2012 in order to address such gaps and is locally (and nationally) recognised as an exemplar of VCSE infrastructure.

More broadly, there is ongoing work to strengthen the strategic approach which underpins the VCSE sector across Manchester. Whilst not specific to just health and care the Our Manchester Voluntary and Community Sector (OMVCS) Fund is MCC's largest grant funding programme to the VCSE sector. OMVCS was originally established in 2018; the 2023-2026 programme was co-designed with the sector during 2022 to ensure it was focused on the top priorities for the city and the sector. The three core aims of the new programme are to support *health and wellbeing, help address poverty, and tackle inequalities in the city*.

2.6 Inclusive Economy - The Accord includes a commitment to grow the role of the VCSE sector as an integral part of a resilient and inclusive economy where social enterprises, co-operatives, community businesses, charities and microsocial businesses thrive. This aligns well with Manchester's aim to develop a more inclusive economy as part of the city's new economic strategy. Manchester has a strong track record of leadership in adopting social value approaches as part of commissioning and procurement. There is an opportunity to strengthen this with further emphasis on investing in locally-run and community-owned organisations. VCSE organisations provide local employment and bring additional investment all of which stays in the local economy. There are further opportunities to build social value into supplier procurement as well – e.g. recycling services, cleaning services and ways to create additional social value through activities such as the work Sow the City are doing with MFT on creating more green spaces in their estate.

2.7 As well as hosting the GM Social Value Network (which is open to public, private and VCSE partners to explore ways to increase use of social value approaches), Macc has developed the Manchester Social Economy Alliance to nurture new local entrants to the social enterprise space. There are therefore good conditions for MPB to develop a plan for increasing what it can do through social value approaches (in line with the GM Strategy and GM Anchor Institutions work) and as part of a strategic approach to working with the VCSE sector.

3. Key Challenges and Issues

2.8 While there are positive developments as noted above, overall, it is acknowledged that more need to be done to further embed integration of the VCSE as valued and equal strategic partners in Manchester, whilst recognising the impact that improved relationships could have on the citizens of Manchester.

2.9 VCSE organisations are currently facing severe financial pressures and risks which are affecting their capacity to deliver the support and services required across the city. This includes a significant amount of short term and uncertain funding currently supporting delivery. This is set against significant increases in need, leading to demand that is too great for current VCSE provision to meet and plan for.

2.10 Changes to commissioning and investment decision-making as part of the GM ICB restructure has brought uncertainty particularly as the sector is party to significant contracted health-related activity established on the basis of non-recurrent, often annualised agreements. This is a risk to the sector risk given the ICB's significant funding pressures which could impact on the VCSE sector support that is commissioned or grant funded. A number of these arrangements are intended to be time limited, however, many are non-recurrent for historic reasons which do not align with the ongoing nature of the intentions for service provision. The impact of these financial challenges for the Manchester locality and NHS in particular along with further pressures expected on Local Authority budgets in the next few years will need factored in when resourcing VCSE infrastructure together.

2.11 This comes at a time when the long-term effects of austerity, the pandemic and the cost-of-living crisis mean that VCSE providers are less able than ever before to bear the risk of such uncertainty: they have used their reserves to meet increased volume and complexity of demand and spiralling running costs. This was already strongly in evidence before the pandemic (see State of the Sector reports) but is now much more pronounced with the impact that VCSE leaders are becoming understandably cautious about setting budgets to maintain provision at current levels.

2.12 As with other sectors the VCSE workforce capacity is stretched but this is exacerbated by inflation costs hitting the sector hard without proportionate uplifts in grant and contracts locally and nationally – further limiting capacity, recruitment, and retention. Pay rates in the VCSE sector are no longer benchmarked alongside the public sector[2]. This disparity is now increasing year-on-year, leading to wider inequality, and exacerbating the cost-of-living crisis for the sector and the city. One example of the impact that this is having can be seen in relation to payment of the Real Living Wage (RLW). VCSE organisations in Greater Manchester have been leading the way in terms of payment of the RLW and have set a target in the Accord that 100% of employees in the sector are paid at least the RLW by 2026. However, many grants and contracts were developed before the current period of inflation and the uplift in the RLW to £10.90 from April 2023 is appearing to be unaffordable for many VCSE organisations. This will be further compounded if, as expected, the RLW rate jumps by a significant amount from 2024. Similarly, while many VCSE organisations have traditionally used the NJC pay scales (albeit with lower grading of roles on the scales), many have been forced to step away from this alignment when pay uplifts agreed nationally have not been reflected in increases in grants and contracts. This creates an existential dilemma for VCSE managers: it is now impossible for many organisations to maintain staff pay in real terms while also maintaining service provision at current levels.[3]

2.13 The VCSE sector has been facing spikes in demand for services caused by a number of factors including the cumulative impact of the Covid pandemic, the cost-of-living crisis, increases in refugees and asylum seekers, increases in housing and homelessness issues each leading to increased, intersectional, and complex physical and mental health issues. The sector has been experiencing people seeking alternative forms of support due to reductions in public services over the last 14 years and this now reaching an all-time high as public services becomes further squeezed difficult to access.

4. Opportunities

4.1 The VCSE sector comprises a wide and diverse range of organisations that sit alongside statutory services in Manchester. A key feature of the VCSE sector is its scale and diversity: from larger organisations to small grassroots groups; from organisations that support communities at a local level, to those that advocate for and seek to meet the needs of defined and often marginalised groups. As part of the wider health and care system, the VCSE sector delivers key services that support the health and wellbeing of the population. In addition, it contributes vital insight and intelligence on the needs of the people and communities it engages with and is frequently a route to engaging with communities, which we can further build on within the Manchester locality.

[2] With a limited number of exceptions in social work or healthcare professional roles where pay is determined by nationally set rates.
[3] This also creates a longer-term challenge of attracting new talent into the VCSE sector and an increased risk of losing existing staff to other sectors better able to maintain pay and conditions.

4.2 The VCSE sector has been recognised as a key partner across Health and Care in support of its aims to tackle health inequalities, improve outcomes in population health and health care, and enhance productivity and value for money.

4.3 We can enhance this further by closer working with the VCSE sector as a strategic partner in shaping, improving, and delivering services; and in developing and delivering plans as set out in MPBs priorities. The scale and contribution of the VCSE sector means it can play a key role in finding solutions for, and addressing system issues which can include local approaches to tackle barriers to access and improve outcomes to reduce health inequalities along with opportunities to capture and share learning.

4.4 Embedding co-design and co-production –many challenges can be mitigated by involving the VCSE sector early in planning, design and decision-making. This provides time and space to consider the given parameters of an issue and raise suggestions or requirements for making things work in practice. This is particularly important when decisions involve or directly impact on VCSE organisations.

4.5 Seeing design and delivery as an ongoing rather than one-off process – many barriers and challenges can be mapped to different parts of the process of planning and delivering care. Currently, these processes tend to present as one-way transactions between statutory functions and VCSE organisations, however, they can be optimised by adopting an iterative and developmental approach to working together. Underpinning this is a commitment to developing a strategic partnership over time and adopting a learning approach while having clear mechanisms for accountability.

5. Recommendations

The Board is asked to support;

The establishment a system-wide task and finish group to work on a Manchester-specific VCSE Strategic Plan to support the delivery of MPBs priorities and align the GM Accord in a way that is relevant to Manchester, addresses local barriers, builds on local strengths, supports the city's strategic plans, and meets the needs of our citizens. The scope of the group should include:

- a set of shared expectations for the role and contribution of the VCSE sector to the delivery of the Partnership Board's priorities
- principles for joint working
- identifying if and how different types of VCSE organisations are currently able to contribute to or be involved in work of MPB partners and where there are gaps or current arrangements are not working well
- Develop an approach for embedding VCSE sector representation at a strategic level where appropriate – e.g. on particular work programmes, boards, or subgroups – with a role for VCSE representatives to bridge divides between statutory functions and VCSE organisations
- An interim update on progress of the task and finish group will be shared with MPB at the end of June 24

4.2 Undertake a risk analysis and/or Equality Impact Assessment across the partnership of VCSE commissioning, investment arrangements, including those held at place and or/ICB, which includes an analysis of need versus capacity and a lens on prevention and de-escalation. This will enable the Partnership to better understand, predict and mitigate the scale of impact for people, workforce, and wider system sustainability across Manchester.

4.3 MPB partners to work with VCSE colleagues to map out and agree an approach that increases and coordinates opportunities to build up collaborative working relationships across sectors. This will enable VCSE leaders to engage with and extend VCSE leadership involvement across the sector.

Appendix 1

SYSTEM AGREEMENTS & FRAMEWORKS TO SUPPORT SUSTAINABILITY

There are several key agreements and documents relating to partnership working with VCSE which should be acknowledged and operated through commissioning, co-design, contracting and procurement arrangements.

The VCSE Accord

- Commitment 1 - We will work together to achieve a permanent reduction in inequalities and inequity within Greater Manchester, addressing the social, environmental and economic determinants of health and wellbeing.
- Commitment 2 - We will embed the VCSE sector as a key delivery partner of services for communities in Greater Manchester
- Commitment 3 - We will build a financially resilient VCSE sector that is resourced to address our biggest challenges of ending poverty and inequality in Greater Manchester.
- Commitment 4 - We will grow the role of the VCSE sector as an integral part of a resilient and inclusive economy where social enterprises, co-operatives, community businesses, charities and microsocial business thrive.
- Commitment 6 - We will put into place meaningful mechanisms to make co-design of local services the norm, including expanding channels for service design to be informed by 'lived experience'.
- Commitment 7 - We will fulfil the potential for building productive relationships between the VCSE, public and private sectors to address inequity and build back fairer

National Compact

In 2010 Government agreed a Compact between the Coalition Government, and their associated Non-Departmental Public Bodies, Arm's Length Bodies and Executive Agencies, and civil society organisations (CSOs) in England. The agreement aims to ensure that the Government and CSO

work effectively in partnership to achieve common goals and outcomes for the benefit of communities and citizens in England.

Changing / ending a funding relationship

- Where there are restrictions or changes to future resources, discuss the potential implications as early as possible
- Assess the impact on beneficiaries, service users and volunteers before deciding to reduce or end funding.
- Offer an opportunity for the funded party to respond.
- Give a minimum of three months notice in writing, apart from in exceptional circumstances
- Provide a clear rationale for why the decision has been taken.

Commissioning & procurement processes

- Robustly consider the impact of the chosen approach on the supplier market.
- Each stage (funding options, specification, pre-qualification, invitation to tender and tender evaluation) should be fair, proportionate, transparent, well communicated, clear, accessible, and appropriately supported.
- Processes should not create unnecessary barriers that disadvantage competent VCSE providers from applying

Funding Period

- Commit to multi-year funding where appropriate and where it adds value for money.
- The funding term should reflect the time it will take to deliver the outcome.
- If multi-year funding is not considered to be the best way of delivering the objective, explain the reasons for the decision

Funding and payment models

- Consider a wide range of ways to fund or resource VCSE, including grants, contracts, loan finance, use of premises etc.
- Work to remove barriers that may prevent VCSE accessing statutory funding
- Use funding and financing models that promote VCSE inclusion, for example outcome based payments and payment in advance of expenditure.

GMCA Fair Funding Protocol

The GMCA has proposed to put in place a principles-based ‘Fair Funding’ Protocol between GMCA and the VCSE sector, which further develops Commitment 3 of the VCSE Accord: We will build a financially resilient VCSE sector that is resourced to address our biggest challenges of ending poverty and inequality in Greater Manchester.

This supplementary agreement “Protocol” will be used to guide how the CA plans its grant funding, commissions, and manages contracts with VCSE organisations, and will have the following intended benefits:

- Support improved trust, partnership working and co-creation of services between GMCA and the VCSE sector,
- Enable fairness and transparency in the financial relationship between the VCSE and GMCA,
- Reduce the likelihood of unrealistic financial expectations by either partner,
- Enable risk sharing between GMCA and the VCSE sector and improve the ability of the VCSE sector to provide publicly funded services in communities, and the resilience of those services.

Recognising that many VCSE organisations are commissioned both by the GMCA and NHS GM, it is recommended that NHS GM considers the adaptation and adoption of the Fair Funding Protocol to support a consistent application of commissioning and funding principles in line with the existing Accord.

Appendix 2 – Examples of structured, collaborative working between the VCSE and Health and Care organisations

Public Health and Population Health management – strengthening relationships between the VCSE sector and the public health system, including increasing the sector's delivery role in early intervention and prevention; building working relationships and referral pathways between Primary Care Networks, GP Practices and local VCSE organisations (not just health and care); improving data, research and intelligence sharing, and participation in system design.

Community Health Equity Manchester - was originally set up to inform our response to COVID-19, and the widening impact gap on different Black, Asian and Minority ethnic communities and disabled people. Members are now having broader discussions around the indirect consequences of the pandemic and broader social, health and wellbeing priorities for their communities. They have been and will continue to be vital in delivering our vaccine equity commitment as well as annually agreed priorities which align with the MPB priorities with the aim of building;

- TRUST between communities and statutory organisations.
- Share and amplify community VOICE and to provide INSIGHT.
- Be led by the DATA.
- Work in Collaboration and Partnership

The group achieves its objectives through collaborative whole system working, influence and advocacy as well as direct actions through its programme of work. CHEM is a good example of where these improvements have built critically important trust with our communities and key stakeholders realising positive results. The CHEM programme through targeted engagement grants and the Sounding Boards which are facilitated through VCSE organisations have become a critical part of our system infrastructure for addressing health inequalities, even more so in light of 2021 Census data for Manchester.

Representation covers groups and communities facilitated through VCSE organisations; disabled people including people with learning disabilities, communities experiencing racial inequality, which include Pakistani, Bangladeshi, Black African and Caribbean sounding boards, Inclusion Health group and people or groups that experience multiple forms of discrimination that intersect or combine (intersectionality). We will soon be setting up an LGBTQ+ engagement group. This will be kept under review based on emerging and evolving understanding of our communities. It is important to note that whilst needs of other at-risk groups e.g., people who are homeless, older people, are being addressed through other work streams we will continue to share the learning and good practice.

Making Manchester Fairer - Making Manchester Fairer (MMF) is the city's action plan for tackling health inequalities. It brings together coordinated action across eight wider determinants of health: work and employment; poverty, income, and debt; preventable deaths; homes and housing; places, transport, and climate change; systemic and structural racism and discrimination; communities and power; and early years, children and young people. Two workstreams in the MMF action plan have a clear focus on engaging and working with different communities across the city.

- Communities and Power – having connected communities where people feel valued, listened to and involved in decision making is important to ensuring communities feel nurtured and providing more control over the decisions they make in their own lives leading to better health outcomes

- Tackling Structural Racism and Discrimination – Health inequality and racism are

inextricably linked therefore addressing the wider determinants of health without addressing racism is unlikely to mitigate these inequities and may even further perpetuate and worsen existing health disparities.

North Manchester Engagement – Given the increasingly important role of the VCSE in health and social care, Macc's State of the Sector reports since 2012 and research by Manchester City Council in 2019 have consistently identified a disparity in that provision; the VCSE sector in North Manchester receives lower levels of investment than other areas of the city. This led to a multi-agency enquiry into the reasons for this lack of investment and an action plan to address these issues. In response to this the North Manchester Together (NMT) initiative was launched, including health organisations, MCC, other statutory services and VCSE partners. Whilst this work stalled during Covid, it has recommenced and forms an important co-ordination role in the area and the potential to bring additional resource for wider VCSE engagement and capacity building. Work to date has focussed on building relationships: bringing people together, developing improved ways of working and addressing barriers to productive working. It is already making progress towards the creation of a thriving VCSE sector that is involved, empowered and responsive, and therefore better able to support diverse communities on whom the pandemic and cost of living crisis were having an unequal impact.

In May 2022 NMT updated its recommendations to support across 4 themes to develop North Manchester VCSE groups:

- Organisational development – to develop and maintain robust organisations with good governance
- To increase numbers of people involved from volunteers to corporate partners
- To increase funding for the sector including skills and access to grants
- Improve communications across the sector and stakeholders

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Paper D

NHS
Greater Manchester
Integrated Care

Manchester Partnership Board
System & Locality Position

Part of Greater Manchester
Integrated Care Partnership

Introduction

- MPB is asked to:
  - Note the financial position at Month 9 across the system
  - Note the 23/34 running costs for Manchester Locality
  - Discuss mitigations to reduce the forecast overspend on running costs for 24/25
  - Discuss further the approach for any additional allocations that may come into the system re. UEC Discharge & Capacity monies

SYSTEM FINANCIAL POSITION

NHS Greater Manchester Integrated Care

In Month 9 NHS England confirmed a revised deficit forecast position of £(180.0)m for the GM system for 2023/24. This recognises the risks the ICS has reported this financial year and those which could not be mitigated. The original plan for the GM system was a breakeven position, with NHS GM planning a £122.0m surplus (including the £130m system efficiencies target) offset by £(122.0)m deficit within NHS providers. The revised forecast position agreed with NHS England is a £(180.0)m deficit, with a split proposed for NHS GM £(34.7)m deficit and for NHS providers £(145.3)m.

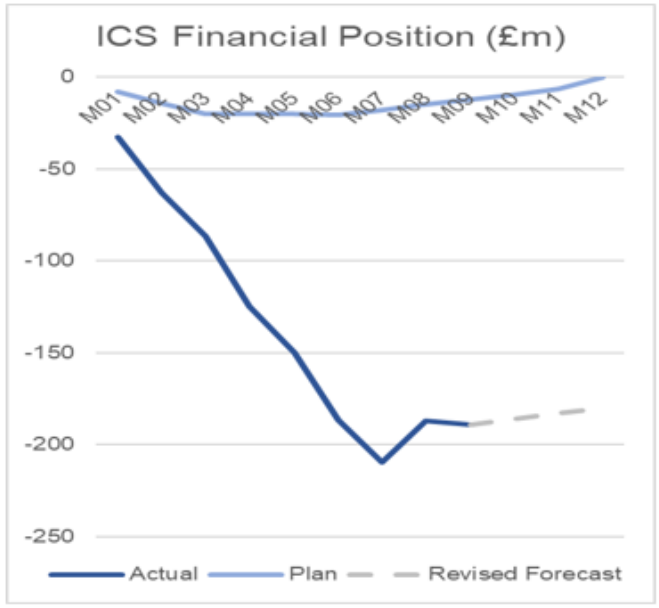
The £(180.0)m deficit was agreed on the assumption of no further industrial action. However, there has been industrial action in both December and January, at a cost of £(21.2)m which have been reported nationally by providers as requested by NHSE to determine the future funding of these costs. As a result, the forecast outturn reported to the national team is a deficit of £201.1m. However, the system will continue to be monitored against the delivery of the £(180.0)m deficit outturn position.

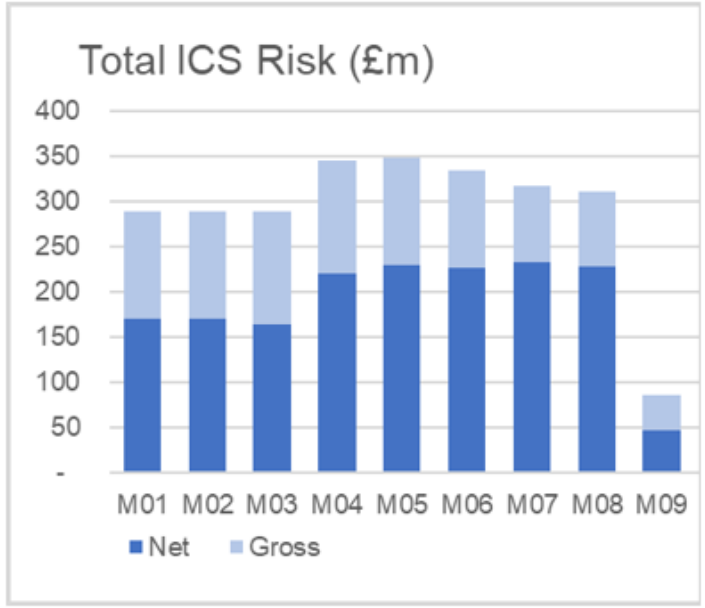
At Month 9, NHS GM is forecasting a deficit of £(33.5)m and NHS providers are forecasting a deficit of £(146.4)m, which is a holding position whilst the final elements of the expected improvements are confirmed to achieve the £(180.0)m deficit.

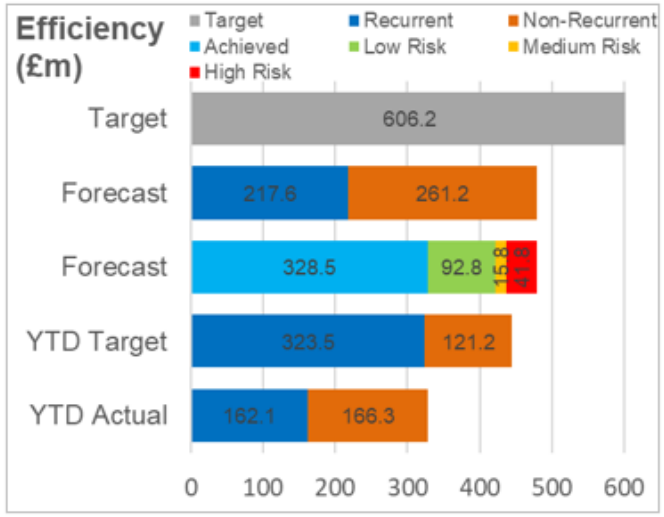
	YTD Month 9					Full Year Forecast				
	Budget £m	Actual £m	Less IA Dec £m	Revised Actual £m	Variance £m	Budget £m	Full Year £m	Less IA Dec & Jan £m	Revised Full Year £m	Variance £m
GM NHS Providers	(103.4)	(165.8)	5.7	(160.1)	(56.7)	(122.0)	(167.6)	21.2	(146.4)	(24.4)
NHS GM	(3.5)	(28.9)	(0.0)	(28.9)	(25.4)	(8.0)	(33.5)	0.0	(33.5)	(25.5)
System efficiency	95.0	0.0	0.0	0.0	(95.0)	130.0	0.0	0.0	0.0	(130.0)
Total ICS Surplus/(Deficit)	**(11.9)**	**(194.7)**	**5.7**	**(189.0)**	**(177.1)**	**0.0**	**(201.2)**	**21.2**	**(180.0)**	**(180.0)**

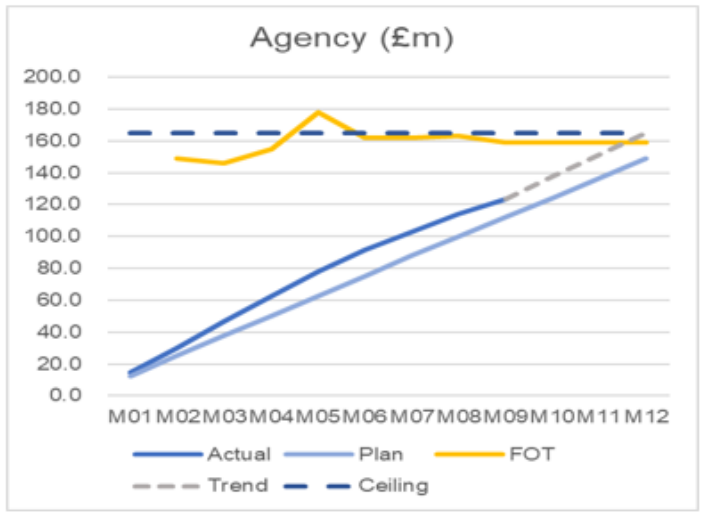
SYSTEM FINANCIAL POSITION

NHS Greater Manchester









System financial position

- Greater Manchester ICS has agreed a revised forecast deficit position with NHS England for 2023/24 of £(180)m, with a proposed split for NHS GM at £(34.7)m deficit and NHS providers £(145.3)m deficit.
- At Month 9, NHS GM is forecasting a deficit of £(33.5)m and NHS providers are forecasting a deficit of £(146.4)m, which is a holding position whilst the final elements of the expected improvements are confirmed to achieve the £(180.0)m deficit.
- The YTD actual position at M9 is £(189.0)m, comprising:
  - NHS GM: £(28.9)m
  - NHS providers: £(160.1)m
- Pressures across the system remain consistent with previous months.

Total ICS risk

- Total ICS risk has significantly reduced at M9 to £87.0m from £311.4m at M8. This is due to the agreement of the revised forecast deficit position. Therefore, pressures previously reported as risk are now included in the position.
- At M9 ICS total gross risk is £87.0m and net risk of £47.9m. Residual net risk in the ICS position relates to efficiency risk (see below), risks in respect of prescribing, ERF and industrial action.

Efficiency

- This chart details the recurrent and non recurrent split, along with a RAG rating of deliverability of savings targets.
- YTD efficiency delivery is below target by £(116.2m):
  - System risk – (£95.0m)
  - Providers – (£21.2m)
- Full year efficiency target of £606.2m will not be delivered in full, with a shortfall relating to system efficiency reflected in the position.
- Gross risk for both provider and NHS GM have improved since M8.

Agency

- Projected forecast costs for agency reduced in M9 to £159m (M8: £163m) which is below the ICS agency ceiling of £164.7m. The current full year trajectory based on YTD spend indicates c£164m for the year, which is a reduction in comparison to M8.
- Variances above plan for agency costs are mainly at two providers – NCA and GMMH.
- These figures exclude bank costs.

NHS GM Provider Financial Position

NHS Greater Manchester Integrated Care

The following table summarises the overall provider position reported at Month 9 and forecast outturn.

GM Providers Income Statement	Year to date			2023/24		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	5,447.9	5,536.1	88.2	7,268.7	7,394.1	125.3
Pay	(3,498.7)	(3,593.0)	(94.3)	(4,660.9)	(4,794.1)	(133.2)
Non-Pay	(1,979.3)	(2,044.2)	(64.9)	(2,630.9)	(2,669.3)	(38.3)
Non Operating Items	(73.4)	(59.1)	14.4	(98.9)	(77.1)	21.8
TOTAL Provider Surplus/(Deficit)	**(103.4)**	**(160.1)**	**(56.7)**	**(122.0)**	**(146.4)**	**(24.4)**
Surplus/Deficit Breakdown						
MFT	(14.5)	(39.3)	(24.8)	0.0	(5.0)	(5.0)
Christie	(6.0)	(1.0)	5.1	(8.0)	5.9	13.9
NCA	(20.6)	(53.6)	(33.0)	(32.2)	(67.2)	(35.0)
Bolton	(9.3)	(9.2)	0.1	(12.4)	(10.5)	1.9
Tameside	(23.8)	(23.4)	0.4	(31.5)	(30.7)	0.7
WWL	(4.3)	(7.4)	(3.1)	(6.5)	(10.2)	(3.7)
Pennine Care	(1.3)	0.0	1.4	0.0	2.1	2.1
Stockport	(23.6)	(24.0)	(0.5)	(31.5)	(31.1)	0.3
GMMH	0.0	(2.3)	(2.3)	0.0	0.4	0.4
Provider Surplus/(Deficit)	**(103.4)**	**(160.1)**	**(56.7)**	**(122.0)**	**(146.4)**	**(24.4)**

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Manchester
Integrated Care Partnership

Manchester Partnership Board

Report of:	Julia Bridgewater – Deputy Chief Executive (MFT)/Chair of Manchester Provider Collaborative Board Cllr Thomas Robinson – Executive Member for Healthy Manchester and Social Care/Chair of Manchester Provider Collaborative Board
Paper prepared by:	Julie Taylor – Locality Director of Strategy/Provider Collaboration (MICP)
Date of paper:	29 February 2024
Subject:	Provider Collaborative Board (PCB): Update
Recommendations	The Manchester Partnership Board is asked to note the key discussions that took place at the January 2024 meeting of PCB, as follows: - • Update on the Thriving Families work and the Cost Benefit Analysis approach; • Discussion regarding system preparedness for the implementation of Right Care, Right Person by Greater Manchester Police (GMP), including a request for a short delay in implementation; • Agreement to support further work to develop an enhanced community mental health offer for Manchester.

Manchester
Integrated Care Partnership

Provider Collaborative Board: Update

1. Executive summary

1.1 The purpose of this briefing paper is to update the Manchester Partnership Board (MPB) on the work of the Provider Collaborative Board (PCB), as part of the agreed reporting cycle to MPB. This report covers the outputs of the meeting held 18th January 2024.

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

- An update on the Thriving Families work and the Cost Benefit Analysis approach;
- A discussion regarding system preparedness for the implementation of Right Care, Right Person by Greater Manchester Police, including a request for a short delay in implementation;
- Agreement to support further work to develop an enhanced community mental health offer for Manchester.

2. Provider Collaborative Board meeting 18th January 2024

2.1. Thriving Families

Paul Marshall presented an overview of the Thriving Families work, which was being piloted in South Manchester, providing a multi-disciplinary approach to supporting vulnerable families. PCB noted the indicative Return on Investment (RoI) that had been calculated for the initiative, achieved through enabling children to stay at home with their families and the avoided costs of additional interventions.

2.2. Right Care, Right Person

Sian Wimbury (Greater Manchester Mental Health - GMMH) updated PCB on the approach being taken in Manchester to prepare for the implementation of the Right Care, Right Person policy, which was scheduled for 1st April 2024.

PCB noted the preparatory work that had been undertaken across the system, with a range of partners, but felt that more time was needed in order to be fully ready for the planned 'go live' date. It was noted GMP were prepared to manage a short delay to the implementation date, providing they were assured that a credible plan was in place. This was under active discussion.

It was recognised that there was a gap in commissioned provision within the Manchester system to meet the needs of people with mental health conditions, often in crisis, that do not meet the threshold of Community Mental Health Teams. This

need has been recognised for some time but previous discussions had been interrupted by Covid. It was noted that the planned investment in the Living Well model would potentially have bridged this gap, but there was doubt about the allocation of the Mental Health Investment Standard monies for the next financial year. Tom Hinchcliffe agreed that an enhanced community Mental Health offer would be a priority for 2024/25 and he would take that forward with system partners.

3. Recommendations

The Manchester Partnership Board is asked to note the key discussions that took place at the 18th January meeting of PCB, as follows: -

- An update on the Thriving Families work and the Cost Benefit Analysis approach;
- A discussion regarding system preparedness for the implementation of Right Care, Right Person by Greater Manchester Police, including a request for a short delay in implementation;
- Agreement to support further work to develop an enhanced community mental health offer for Manchester.

Julia Bridgewater & Cllr Thomas Robinson
January 2024

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Manchester
Integrated Care Partnership

Manchester Partnership Board	
Report of:	Manchester GP Board
Paper prepared by:	Dr Vish Mehra – Chair, Manchester GP Board Jenny Osborne, Assistant Director, Population Health & Integration
Date of paper:	29 February 2024
Subject:	GP Board Highlight Report
Recommendations:	Manchester Partnership Board is asked to note the report.

Manchester
Integrated Care Partnership

Update on the work of General Practice (GP) Board

Manchester GP Board meets on a monthly basis to discuss a range of current and future priorities relevant to primary care. At the meeting in February 2024 the main items for the Board focused on the following areas:

1. Workforce and Additional Roles Reimbursement Scheme (ARRS)

The Board received an update on the projected spend position for Manchester ARRS roles within PCNs, which at 99% has improved year on year. The final year allocations are unlikely to be different from this year.

The Manchester Training Pod has been successful and trained 34 Healthcare Assistants, 91 Nursing Associates, 17 GPN Foundations. The Greater Manchester Training Hub (GMTH) are collaborating with the Prince's Trust to create a pre-employment opportunity for individuals to gain knowledge, skills and experience within the primary care sector while helping to support, and grow the non-clinical workforce, placements required.

2. Measles

The Board received a presentation on the emerging situation with Measles, the system response and the readiness requirements of General Practice. This included:

- An update on the situation in the West Midlands, North West, Greater Manchester and Manchester
- The command and control structure for the system response and GM system priorities:
    - Ensuring the system-wide pathways are in place to enable people to access measles, mumps and rubella (MMR) vaccination
    - Providing assurance about immunoglobulin pathways and stock
    - Maximising staff vaccination and occupational health requirements
    - Infection, prevention, and control (IPC) procedures and effective case/contact management
    - Outbreak response plans and capacity
- Current and proposed vaccination offer within Manchester including primary and secondary schools and potential pilots within Community Pharmacy and with specific communities
- The Board as General Practice leaders were asked to discuss and support all Primary Care Networks (PCNs)/GP practices with readiness preparation including GP Workforce vaccination; IPC guidelines inc. Personal Protective Equipment (PPE) & triage and isolation measures; UK Health Security Agecy (UKHSA) notification and risk assessment; diagnostic polymerase chain reaction (PCR) test /swabbing; referral pathways; workforce vaccination options & assurance; call and recall capacity

planning; additional clinic capacity at practice and PCN level; vaccine ordering and supply.

3. Primary & Secondary Care Interface

The group received a further update on the developing work across Manchester & Trafford and a request for comments.

4. GP Board Development

Two half day development sessions have been arranged to support the Board with its development, in line with all GP Boards within GM and including GM GP Board. These will take place in March and April.

5. System Board updates

The Board received updates and feedback from the Manchester Partnership Board, Provider Collaborative, GM GP Board, Manchester Strategy & Planning Board and Population Health Management Group and the Manchester Health & Wellbeing Board.

Recommendation

Manchester Partnership Board is asked to note the report.

Manchester
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Manchester Partnership Board	
Report of:	Dr Sohail Munshi - Chief Medical Officer, Manchester Local Care Organisation
Paper prepared by:	Dr Sohail Munshi - Chief Medical Officer, Manchester Local Care Organisation
Date of paper:	29 February 2024
Subject:	Update on the work of the Clinical and Professional Advisory Group
Recommendations:	For information

Manchester
Integrated Care Partnership

Clinical and Professional Advisory Group (CPAG)

Meeting Agenda and Summary of Discussions January 2024

NHS-GM Associate Medical Director update

- The Clinical Effectiveness Group (CEG) is considering a merger with the Manchester Prescribing Group due to shared focus and agendas.
- CEG reviewed and commented on proposals for using Diabetes Network funding for a) developing patient resources b) practice education around patient engagement c) targeted support to some Primary Care Networks (PCNs) to improve uptake of diabetes care processes.
- The CEG group heard from Manchester University NHS Foundation Trust (MFT) about a proposed Artificial Intelligence (AI) pilot in dermatology starting in February 2024.

Healthy Hearts

- An overview of the Healthy Heart programme was received, including updates on the funded projects working with VCSE organisations in North Manchester and with the Black Caribbean population in key wards with the poorest heart health outcomes.
- A Healthy Hearts Programme Manager is now in post on a 2 year fixed term contract which will enable a more structured approach to our system work to improve Diabetes and Heart Health outcomes.
- CPAG noted more work on metrics and measures was planned once the new NHS-GM data and dashboard is launched (expected in February 24).

Population Health Management (PHM)

- A presentation update was received from the Strategic Lead for PHM reminding the group that PHM is the use of data and insight to identify and understand a local health inequality, and based on that understanding plan, deliver and evaluate actions to reduce the targeted inequality.
- 24/25 priorities will be a continuaton of existing ones (Diabetes, Hypertension and Bowel Cancer Screening). In addition children and young peoples asthma will be a priority for a few key neighbourhoods with the highest prevalence in the City.
- Work on outcomes and future costs avoidance is being actively supported by the MFT Health Inequalities Finance Fellows with an initial review of the hypertension data undertaken.

Artificial Intelligence (AI)

- There was a discussion about adoption of AI as an enabler in clinical settings. The Medical Director at North Manchester General Hospital (NMGH) reported that they

had met with Microsoft to discuss AI opportunities and the Local Care Organisation (LCO) has explored some opportunities around medicines management and AI with MFT Research and Innovation. There was discussion about following industry standards to ensure patient safety. An action was agreed to add AI to the forward plan for CPAG as an agenda item during 24-25.

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Manchester
Integrated Care Partnership

Manchester Partnership Board

Report of:	Tom Hinchcliffe Deputy Place Based Lead, Manchester
Paper prepared by:	Owen Boxx – Senior Planning and Policy Manager (Manchester) NHS Greater Manchester Integrated Care
Date of paper:	29 February 2024
Subject:	Delegated Assurance Board Meetings Update Report, reporting on the meetings of 17 January 2024 and 7 February 2024.
Recommendations:	Manchester Partnership Board is asked to note the report including the items for escalation.

Manchester
Integrated Care Partnership

1.0 Introduction

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

2.0 DAB Update – 17 January 2024 & 7 February 2024

The DAB met on 17 January 2024 and 7 February 2024, and discussed the following key areas:

2.1 Items for Escalation

Two risks have been agreed to be escalated by the DAB to Manchester Partnership Board. These risks relate to the Mental Health and Quality resource which is available within the locality. The details of these risks are contained within the risk escalation forms that are included in the Appendix at the end of this report.

2.2 Finance & Contracts

- The locality reported a £11.946m forecast outturn overspend as at month 9, which is a reduction of £3k from month 8.
- The full year Quality, Innovation, Productivity and Prevention (QIPP) efficiency programme is forecasting an overachievement of £1.325m for 2023/24.
- A review of all Section 75 agreements is being undertaken by NHS GM. The locality / MPB will be informed if any changes to the agreement are needed.
- A review of contracts has commenced for contracts expiring in March 2024, with action being taken to renew contracts as required through the NHS GM procurement processes, including the need to complete the System for Thorough Assessment of Resources (STAR) procurement process.

2.3 Safeguarding, Quality and Nursing

- DAB members were updated on the plans to address the backlog of CHC annual reviews, which included three additional agency staff contracted for 12 weeks.
- The Joint Targeted Area Inspection (JTAI) for Serious Youth Violence has been completed for Manchester, and an action plan is being developed in line with recommendations.

- Patient Safety themes: suicide and self-harm is the largest serious incident category recorded by Greater Manchester Mental Health (GMMH). GMMH are progressing changes to their incident management process, with the aim being that care groups will have greater oversight. Panels will be based on specific service areas in order that specialist assurance can be provided.
- Each of the 10 GM localities have been asked to complete a self-assessment to test whether statutory duties relating to CQC expectations are being met. The initial Manchester locality self-assessment has been submitted to NHS GM.

2.4 Patient and Public Involvement

The Patient and Public Advisory Group (PPAG) met on 4 January 2024.

- PPAG raised concerns about how service changes are communicated to the public.
- PPAG acknowledged and thanked staff for the hard work that has gone into the disaggregation of North Manchester General Hospital (NMGH) to NHS Manchester University Foundation Trust (MFT).

2.5 Primary Care

- A paper was presented to DAB that recommended approval of the preferred option for Withington Medical Practice to relocate to Withington Clinic.
- An update was provided on the Recovering Access to Primary Care delivery plan. The plan aims are to tackle the early morning rush for patients to try to access primary care and for patients to have a better understanding of how their requests for access are managed. A key focus is for patients to manage their own health more - including the use of the NHS App, to implement Modern General Practice Access, to deliver more appointments and to improve the interface between primary and secondary care.
- The Locality Management Team (LMT) were informed that a Quarter 3 Primary Care Quality Recovery Resilience Scheme update had been provided to Primary Care Commissioning Committee on GP practice progress against the Manchester scheme for 2023/24. The current data shows some variation in achievement. Support is to be provided to GPs to maximise achievement and reduce unwarranted variation.

2.6 Right to Choose Autism and ADHD Children and Young People (CYP) & Adults

- Information was provided about the Right to Choose which gives a patient the option to go anywhere in the country to access services from consultant-led or Mental Health practitioner-led services. Manchester has seen a marked increase in referrals requesting an assessment for Attention deficit hyperactivity disorder (ADHD), which is driven in part by increased awareness.

- GMMH is commissioned to deliver ADHD assessments, but at levels which are not currently sufficient to meet demand. Greater Manchester approaches to address the long waiting times for assessment were discussed which include the adoption of a risk stratification approach, although further assessment of this approach is required.

Manchester
Integrated Care Partnership

Appendix 1 – Items for Escalation

Locality Risk Escalation Form

Date:	**23/01/2024**
Locality Governance approval	07/02/2024 – Delegated Assurance Board (DAB) meeting
Risk Function area/s	Mental Health
Form completed by:	Fiona Meadowcroft - Associate Director, Integrated Care Team – Manchester Locality
Next update expected:	06/03/2024 - Delegated Assurance Board (DAB)

Risk Reference (Taken from Risk Register)	**Rationale for Escalating to ICB** • Risk unable to be managed entirely in place • Awareness • Intervention	**Desired outcome of escalation** (Please indicate any action you would like from the Committee)
Datix ID 1115	• Risk unable to be managed entirely in place • Awareness • Intervention	Escalation to GM ICB to secure funding. CMHTs have no operational mitigating actions that can be taken at locality level. GM must also be aware of potential impact on performance & patient safety.

*A full copy of the risk is also needed from the relevant risk register should also be included to enable full details to be shared with the relevant committee

Risk Title	Description	Locality Risk Lead	Inherent (Unmitigated) Risk Rating (Likelihood x Consequence)	Controls in place	Sources of Assurance	Current (Mitigated) Risk Rating (Likelihood x Consequence)	Target Risk Rating (Likelihood x Consequence)	Gaps in Controls	Mitigating Action(s)	Date by which target rating is expected to be achieved?
Reduction in anticipated MHIS Funding Datix ID 1115	***There is a risk that patients in the community will deteriorate as a result of this lack of support and this is further compounded by a lack of care coordinators in the Manchester community.*** ***Additionally, there is both a financial risk to the system (increased admissions) and a reputational risk as a result of the impact of gaps in community mental health provision.*** ***Expanding Living Well would improve opportunities for people being treated more effectively in the community - the impact of not expanding the programme would be worsened outcomes for the population and would result in widened inequity across GM.*** Since 2015/16, NHS in England has met its commitment that the increase in local funding for mental health (excluding learning disabilities and dementia) is at least in line with the overall increase in the money available to integrated care boards (ICBs). This is called the Mental Health Investment Standard (MHIS). From 2019/20 onwards, as part of the NHS Long Term Plan, the NHS has made a renewed commitment that funding for mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. The MHIS also includes a further commitment that local funding for mental health will grow by an additional percentage increment to reflect additional mental health funding being made available to ICBs (previously CCGs). The Manchester locality's request for £2million in 2024/25 (Manchester's anticipated share of the MHIS monies) to roll-out Living Well across Manchester has not been approved to date; we are currently piloting in 3 areas only & as a result of this decision we cannot roll out in any other Primary Care Networks (PCNs). This will mean that the Living Well approach will not be able to alleviate the pressure on Community Mental Health Teams (CMHTs) or improve the working relationship between Primary Care & Greater Manchester Mental Health (GMMH). Other GM localities were progressed in earlier waves of the programme and have received full funding required for Living Well provision and an inflation uplift.	Fiona Meadowcroft	20 (5x4)	Existing CMHT & Primary Care Services	Mental Health Performance & Quality monitoring - will demonstrate impact of gap in service and pressures on related services	20 (5x4)	16 (4x4)	Funding decisions lie outside of the control of the locality Controls in place have limitations & challenges (800+ patients awaiting allocation of care coordinator)	**Action 1** Description: Escalation to GM ICB to secure funding. Synopsis: CMHTs have no operational mitigating actions that can be taken at locality level. GM must also be aware of potential impact on performance & patient safety. Action Due Date: 01/02/2024	31/03/2024

Locality Risk Escalation Form

Next update expected:	**06/03/2024 - Delegated Assurance Board (DAB)**
Locality:	Manchester
Date:	12/02/2024
Locality Governance approval	07/02/2024 – Delegated Assurance Board (DAB) meeting
Risk Function area/s	Quality
Form completed by:	Carolina Ciliento - Associate Director of Safety, Quality & Nursing (Manchester)
Next update expected:	06/03/2024 - Delegated Assurance Board (DAB)

Risk Reference (Taken from Risk Register)	**Rationale for Escalating to ICB** • Risk unable to be managed entirely in place • Awareness • Intervention	**Desired outcome of escalation** (Please indicate any action you would like from the Committee)
Datix ID 1116	• Risk unable to be managed entirely in place • Awareness • Intervention	Escalation to GM ICB to secure additional Quality staff for Manchester. There are no operational mitigating actions that can be taken at locality level. GM must also be aware of potential impact on quality assurance as well as oversight of patient safety.

*A full copy of the risk is also needed from the relevant risk register should also be included to enable full details to be shared with the relevant committee.

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Title	Description	Risk Owner	Inherent (Unmitigated) Risk Rating (Likelihood x Consequence)	Controls in place	Sources of Assurance	Current (Mitigated) Risk Rating (Likelihood x Consequence)	Target Risk Rating (Likelihood x Consequence)	Gaps in Controls	Mitigating Action(s)	Date by which target rating is expected to be achieved?
Quality Datix ID 1116	6 pan-GM staff originally allocated to Manchester. Only 2 are in place, timeline of how further appointment of staff will occur is unclear. What this means is that many elements of the GM Quality Strategy will not be implemented in Manchester until capacity is resolved. This is a significant risk leaving gaps in oversight (e.g. Mental Health, Independent Sector, Community services, etc) and patient safety. This is also placing substantial pressures on existing Quality staff as well as staff in other functions within locality. There is a reputational risk in not meeting competing locality as well as GM priorities.	Carolina Ciliento	16 (4x4)	Prioritisation of work on a weekly basis for existing Quality staff - no other controls available at this time	Delegated Assurance Board receive regular reports of gaps	16 (4x4)	6 (3x2)	Due to lack of Quality staff unable to establish relevant quality oversight of many parts of the system Lack of available resources from other parts of the organisation.	Description: Escalation to GM ICB to secure additional Quality staff for Manchester. There are no operational mitigating actions that can be taken at locality level. GM must also be aware of potential impact on quality assurance as well as oversight of patient safety.	01/04/2024

Manchester Partnership Board	
Report of:	Tom Hinchcliffe, Deputy Place Based Lead, Manchester
Paper prepared by:	Carolina M. Ciliento, Associate Director of Safety, Quality and Nursing, (Manchester)
Date of paper:	29 February 2024
Subject:	Palliative and End of Life Care in Manchester – Health Scrutiny Committee paper presented on 7th February 2024.
Summary responses from Health Scrutiny Commitee:	Health Scrutiny Committee reflected the positive opportunity to have a discussion on this subject and particularly to understand and appreciate the wide-ranging effect this subject has on people's lives. Moving forward, the committee identified the areas below: 1) Committee is keen to see work already conducted through MacMillan, MLCO and other partners in Manchester brought together within a codesigned approach **(Manchester Palliative and End of Life Care Partnership Group)** 2) Committee was interested in establishing priorities and would welcome a specific action plan setting out workstreams that will be taken forward **(Manchester Palliative and End of Life Care Partnership Group)** 3) Health Inequalities was recognised as a strong theme with links into Making Manchester Fairer and Anti-Poverty Strategy 4) Marie Curie raised the need to mobilise the public/community voice and to ensure lived experience shaped service design, Manchester has well established routes through Patient and Public Advisory Group, Community Health Equality Manchester and Making

	Manchester Fairer which will be utilised for Palliative and End of Life Care. 5) Committee recognised the importance of the proposed "Champion" role across all partners. Cllr Chambers has offered to step into role as "Member Champion" and is meeting with the Associate Director of Safety, Quality and Nursing to take this forward. 6) Committee has requested a follow up paper for discussion in the Autumn.
RECOMMENDATIONS	The Manchester Partnership Board is asked to: Note the report and in particular the findings from Marie Curie in section eight and the next steps for Manchester partners, which are set out in section nine.

Manchester
Integrated Care Partnership

Manchester City Council
Report for Information/Resolution

Report to: Health Scrutiny Committee – 7th February 2024

Subject: Palliative and End of Life Care in Manchester

Report of: Manchester Deputy Place Lead and Marie Curie Lead

Summary

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

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

Recommendations:

The Committee is asked to:

1) Consider and comment on the report and in particular the findings from Marie Curie in section eight and the next steps for Manchester partners, which are set out in section nine.

Wards Affected:

All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city	Supporting people to die in their own homes and in their communities of choice, supports the zero-carbon agenda for the city. In addition, the provision of high-quality, targeted and accessible information to unpaid carers through a streamlined network ensures sustainability and support for carers of people who are in receipt of palliative and end of life care.
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments	There is still unwarranted variation for people with life limiting illness in accessing coordinated and streamlined palliative and end of life care, and in many cases, much earlier in the progression of disease or illness. Additionally, there are variations in experience for those with protected characteristics. The ambitions of the GM Palliative and End of Life Care programme as well as the Manchester Palliative and End of Life Care Partnership is to reduce health inequalities through collaboration, system co-production, understanding the needs of all communities and promoting an inclusive approach. All locality partners aim to engage with and involve patients/the public on the commissioning of a service and design of pathways to ensure that services meet the needs of Manchester people and align with other programmes of work such as Making Manchester Fairer and the Anti-Poverty Strategy as well as Community Health Equity Manchester, Manchester's Patient and Public Advisory Group and the Manchester Disability Collaborative.

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

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

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

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

Financial Consequences – Capital
There are no financial consequences for the capital budget.

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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.

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

CQC_A Different Ending_3.pdf

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

Better End of Life - Marie Curie

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

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

Bereavement is everyone's business – UK Commission on Bereavement

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

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

1.0 Introduction

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

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

1.3 Using this definition quality palliative care should:

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

2.0 Background

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

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

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

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

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

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

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

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

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

3.0 Marie Curie- 'Better End of Life Programme'

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

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

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

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

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

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

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

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

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

3.5 Inequality & Inequity

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

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

3.6 Support for carers

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

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

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

3.9 <u>Bereavement support</u>

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

4. UK Commission on Bereavement

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

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

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

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

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

5.0 GM Developments

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

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

5.3 The Greater Manchester Commitments to palliative care individuals

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

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

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

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

5.6 The programme is working with the GM system to support the use of the electronic palliative care coordination system (EPaCCS) as part of the Greater Manchester Care Record (GMCR) to enable the sharing of electronic records

and advance timely decisions for people approaching end of life. The programme has undertaken scoping against the speciality palliative care nursing workforce and a service mapping to identify gaps in 24/7 provision and continue to work with the system to identify workforce solutions. The programme supports discussion for all sectors in sustaining specialist palliative care services to support the population of Greater Manchester.

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

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

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

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

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

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

6.0 Manchester Developments

6.1 Carers

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

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

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

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

6.2 Primary Care

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

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

6.2.2 This is an iterative process and plans are updated regularly as needed. GPs work closely with community teams, especially district nurses, to support patients to die in their preferred place of care. This includes prescription of anticipatory medications. For more complex patients GPs will contact the community palliative care team for advice and referral.

6.2.3 Challenges

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

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

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

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

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

6.3 Manchester Palliative and End of Life Care Partnership

6.3.1 A number of tools and information sources have been used to gain a better understanding of areas of care in Manchester that work well, where pathways

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

Table 2:

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

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

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

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

6.3.4 The ambitions of the Partnership are to:

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

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

a) *Improving earlier identification in Primary Care*: this is linked to improving registered patients being placed on GP Palliative Care

Registers at the earliest point to signal they have specific needs now or in the future in this area. Being placed on this register will trigger advance care planning discussions with GPs, Social Care and other professionals involved.

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

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

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

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

which system issues can be addressed with a feedback loop into quality assurance mechanisms.

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

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

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

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

6.5 Challenges

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

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

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

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

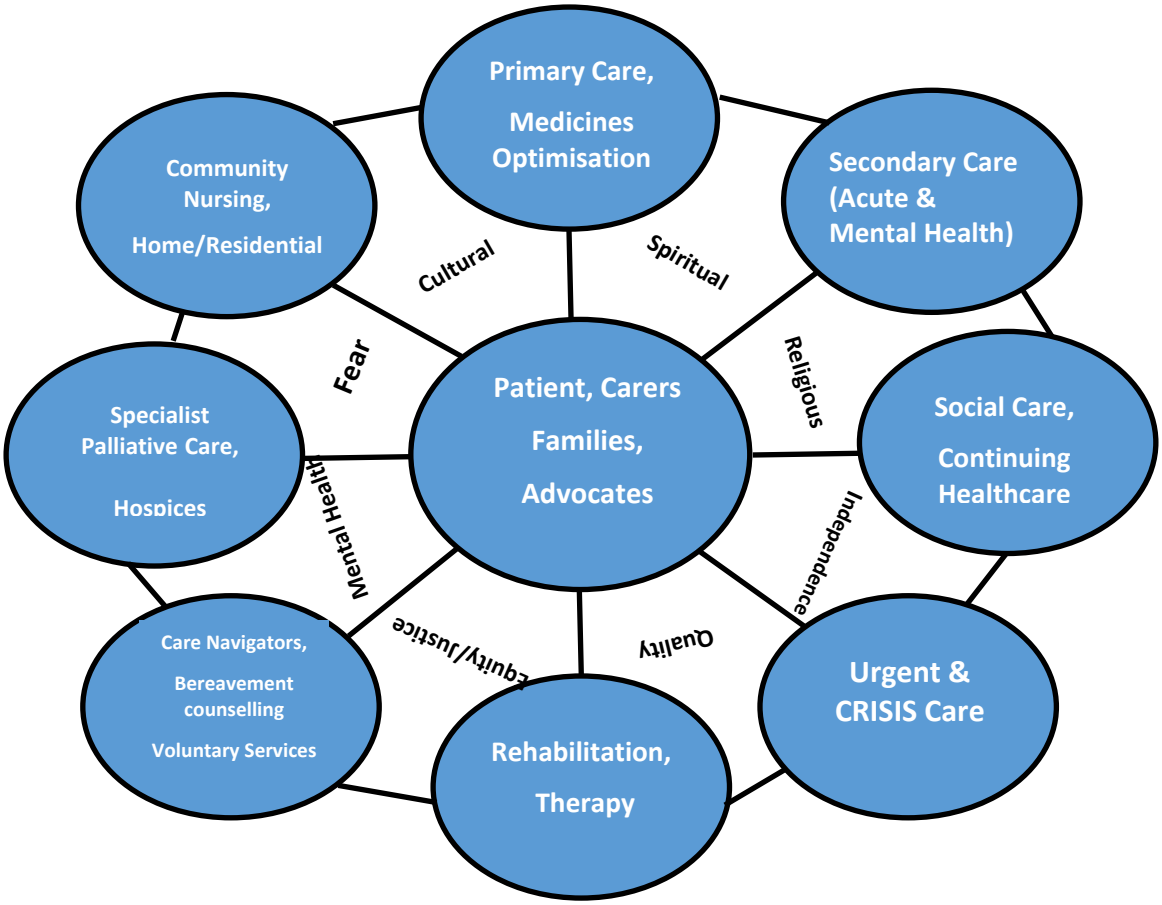
7.0 Summary

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

7.2 This report has raised a number of issues regarding equitable access across conditions and minoritised communities. However, the needs of less visible communities such as people with learning disabilities, those who are homeless, people from travelling communities, those in prison, those with

mental illness and detained under the Mental Health Act, and those with substance misuse problems with life limiting physical conditions also need consideration.

7.3 System Structure: Interdependencies across system elements



8.0 Marie Curie Findings

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

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

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

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

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

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

8.3 To address health inequalities and inequities:

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

8.4 In order to better help support carers:

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

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

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

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

9.0 Next steps for the Manchester system

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

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

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

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

10. Recommendations

The Committee is asked to:

j) Consider and comment on the report and in particular the findings from Marie Curie in section eight and the next steps for Manchester partners, which are set out in section nine.