MPB Priorities Delivery Plan: How we will measure progress

September 2023

Manchester

Integrated Care Partnership

Part of Greater Manchester
Integrated Care Partnership

Manchester's plan on a page for 2023 to 2026

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Strategic aims:

- Improve the health and wellbeing of people in Manchester
- Strengthen the social determinants of health and promote healthy lifestyles
- Ensure services are safe, equitable and of a high standard with less variation
- Enable people and communities to be active partners in their health and wellbeing
- Achieve a sustainable system

Our two priorities for 2023-26 are:	As a result, people will:	We will deliver through action on:
1. Improve physical and mental health and wellbeing, prevent ill-health and address health inequalities	• Live longer in good health, wherever they are in the city	• Effective prevention and management of long term conditions to keep people healthier • Targeted work with communities, regeneration and improving the social determinants of health • Joined up health and care services in neighbourhoods, which meet people's physical, mental and social needs
2. Improve access to health and care services	• Be able to access the right care, at the right time, in the right place, in the right way	• Improving speed and methods of access to primary care and mental health services • Optimising capacity in the community to reduce demand for hospital care and expedite hospital discharge • Enabling self care and promoting independent living • Improving workforce sustainability via local recruitment

What does this mean in practice? Delivery plan

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Improve physical and mental health and wellbeing, prevent ill-health and address health inequalities, so that people live longer in good health, wherever they are in the city	**Improve access to health and care services, so that people can access the right care, at the right time, in the right place, in the right way**
• Population health management • Long term conditions management • Making Manchester Fairer (health inequalities, preventing early deaths and long term condition focus) • Core20PLUS5 (children and adults) • Healthcare-led regeneration in North and South Manchester • Neighbourhood level service integration and transformation	• Primary care access • Mental health access and quality • Children and Young People Reform programme • Locality urgent care strategy and resilient discharge • Aligning demand and capacity for community bed-based services • Enabling self care and promoting independent living • Local workforce recruitment

Delivery and sustainability of the plan is dependent on the enabling functions of workforce, digital, business intelligence, finance, estates, equality and inclusion, community involvement and development, and service improvement and commissioning

To deliver across the locality, relationships and interdependencies with the GM Strategic Clinical Networks, Health Innovation Manchester, GM Integrated Care Partnership Strategy and Our Manchester Strategy will be key, as well as alignment to the GM Integrated Care Equality Objectives. Engagement and co-production with patient and community groups will inform equality actions which will embedded as key outcome measures.

Improve physical and mental health and wellbeing, prevent ill-health and address health inequalities, so that people live longer in good health, wherever they are in the city

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Programme	Overall Aim of programme	How we will measure progress
Long term conditions management Established programme with workstreams in delivery stage, and others newly developed to be refined.	The overall aim of this programme is to reduce the numbers of preventable and early deaths for Manchester residents from heart disease, lung disease, diabetes and cancer. It will reform community care for people with long term conditions	• Reduction in A&E attendances for people with respiratory conditions • Flu vaccination uptake (2022/23) • Prevalence of Asthma per 1000 people • Prevalence of COPD per 1000 people • Prevalence of Smoking per 1000 people • Percentage of asthma & COPD patients who have not had a review • Respiratory non elective admissions • Deliver primary prevention / increased update of physical activity • Referral rate for patients to Post Covid clinic • Long Covid referral rates by ethnicity • Number of new people identified with prediabetes • 75% of people with diabetes to have annual health check • Increase in % of patients who receive all 8 checks • Overall achievement of multi morbidity reviews (as per PQRRS) • Overall achievement of multi morbidity review in chosen cohort as defined by plan • Work towards achievement of bowel cancer screening acceptable standard of 60% take up • Overall achievement of Bowel Screening Uptake aged 60 – 74 • Overall achievement of Bowel Screening Uptake aged 60 – 64
Core20PLUS5 New approach to be developed and brought together into a single framework	Core20PLUS5 is a NHS approach to tackling health inequalities. It involves adopting a Population Health Management approach and is linked to long term condition management to reduce inequalities. The workstream will be to agree an overall framework for the city for Core20PLUS5 which will capture existing work taking place across the city .	• SMI health checks • COPD annual health checks • Hypertension annual heath checks • Diabetes annual health checks

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Healthcare-led regeneration in North and South Manchester (Established programme)	Deliver the North Manchester strategy to improve residents health and wellbeing through better health and care facilities, promoting healthy lifestyles and driving social value through skills and jobs for local people.	• Monetary value of social value activity • Number of jobs created • % of jobs secured by NM residents • Number of apprentices employed
Neighbourhood level service integration and transformation (Established programme)	An established neighbourhood development programme is in place, led by the MLCO, based on the Neighbourhood model of 'bringing services together for people in places. This next steps will build on this offer, going further, faster, to enhance working relationships across the neighbourhoods and continuing to enable existing relationships to flourish.	• 12 Neighbourhood plans in place • Hypertension annual health checks • Diabetes annual health checks • Bowel cancer screening take up

Improve access to health and care services, so that people can access the right care, at the right time, in the right place, in the right way

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Primary Care Access (Established programme)	The collaborative focus of this workstream is being defined – it will look on the interface with primary & secondary care, and identify 'demonstrator' projects for focus. Existing work relating to demand and capacity within primary care including: • Primary Care Access – Capacity & Access Planning, Delivery, Digital Transformation, Estates, • Additional Roles Reimbursement Scheme (ARRS)	• Improve the delivery of Advice and Guidance towards national target of 26% • Proportion of regular general practice appointments delivered within 14 days of request • Utilisation of Additional Roles Reimbursement Scheme (ARRS) funding allocation (minimum 95%) • Number of new ARRS roles recruited to.
Mental Health access and quality (Established programme)	Deliver GMMH improvement plan with the aim to improve patient safety, clinical and professional standards, and having an empowered workforce and improved governance	• Increase in Personal Health Budgets (for people with Mental Health conditions) • % of routine referrals seen by Community Mental Health Teams (CMHT) in 28 days (95% target) • Care Programme Approach (CPAs) compliance over last 12 months

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Programme	Overall Aim of programme	How we will measure progress
Children and Young People's (CYP) Reform programme (Established Programme)	The CYP Reform Programme is focused on stakeholders working in partnership to deliver effective interventions resulting in positive changes for Manchester children. A systemwide approach is being taken to transform and build community care to deliver more CYP care services at home and in the community	• Paediatric inpatient activity - day case. • Paediatric outpatient activity • Identify the number of families that are being case managed as part of Confident Parents
Locality urgent care strategy, resilient discharge and admissions avoidance (Established programme with expanded scope in development)	The locality strategy includes the Resilient Discharge Programme (RDP) which provides a system-wide approach to support improved patient flow and increase the number of safe discharges and an admissions avoidance plan to enable people to remain at home rather than attending acute hospitals.	• 16 Back to Basics wards operational • Reduction in average length of stay for patients on complex care wards (where Back to Basics in operation) – up to 8 days • Reduction in length of stay on targeted wards (average 8-day reduction) • >75% of discharges home from target wards on back to basics • Increase in Hospital at Home activity in line with locality trajectory • Reduction in average bed days (LoS) to patients discharged to Virtual Wards (compared to control) • Reduction in delays in accessing Pathway 2 • 60% reduction in delays to accessing P3 • Increase in % of P2/P3 discharges which are to P2 • Reduction in Length of Stay (LoS) within Intensive Care Units • Reduction in No Reason to Reside on ICT units • Increase in % of people discharged to bedded care able to return home • The number of patients with no reason to reside (NRTR). • Average Length of Stay • Bed days lost by patients who have No reason to Reside • Patients NRTR with no discharge date • Number of out of area delays • Reduced time from referral to transfer to Pathway 3 beds • Reduce D2A average LoS

Improve access to health and care services, so that people can access the right care, at the right time, in the right place, in the right way (continued)

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Programme	Overall Aim of programme	How we will measure progress
Aligning demand and capacity in bed-based provision (Established programme)	Developing 10 year care home capacity strategy to meet the needs of residents with complex needs.	• 5-10% reduction in demand for care home provision compared to 2021. • Deliver 1000 additional apartments across 15 sites including 3 specialist dementia development • Increase number of care home beds rated good or outstanding • Manage capacity and demand through Care Home data monitoring.- procurement of additional nursing care provision
Enabling self care and promoting independent living (New programme to be developed)	A framework will be developed to provide an understanding of the overall contributions and intended outcomes of the established programmes and measures agreed.	• Increased access to clinical assessment - 50% of 111 traffic to be online • Increase in virtual ward beds • Virtual ward beds - measure to view increase in activity • Proportion of virtual ward beds occupied • Non-elective admissions • Monitoring of failed discharges • Monitoring of 2-hour crisis response rates
Local workforce recruitment (New programme to be developed)	A working group is being set up between system partners to develop a locality approach to link in with GM. This will include an analysis of workplace gaps/ vacancies to inform the approach. This will lead to an increase in local employment by delivering targeted employment opportunities, linked to system partners being key Anchor institutions focused on local wellbeing.	Number of Manchester residents employed by system partners across the Manchester Health and Care system.