Manchester City Council
Report for Information

Report to:	Health Scrutiny Committee – 4 September 2024
Subject:	An update from the Manchester Population Health Management Board and Long-Term Conditions programme on how partners in the City are responding to the conditions that affect a significant proportion of the Manchester resident population
Report of:	Chief Executive, Manchester Local Care Organisation

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Summary

Manchester residents are more likely to develop long term health conditions such as type 2 diabetes, hypertension (high blood pressure) and COPD (chronic lung disease) at a younger age, and in greater numbers, than other similar populations in the Country. Children and young people are more likely to be affected by respiratory problems such as asthma than other similar areas. People are also more likely to be diagnosed later and have poorer day to day management and treatment of their conditions, leading to a greater number of people living with complications. Serious consequences are also more likely to arise such as heart attack and stroke in adults, and asthma attacks in children and young people. The purpose of this report is to update the Committee on work underway in Manchester to improve health outcomes and address health inequalities in the prevalence and management of these long-term health conditions through the work of the Population Health Management Board and the Long-Term Conditions programme overseen by the Manchester Provider Collaborative.

Recommendations

The Committee is recommended to consider and comment on the information in the report.

Wards Affected: All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city	No impact
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments	Addressing health inequalities and inequity is a key aim of the long-term conditions programme and Population Health Management Board. The ward you live in, your ethnicity, your housing and your income will all significantly impact your likelihood of developing a long term health

	condition. It will also affect how well you are able to access treatment and care to support you to manage your health condition and continue to work and engage in normal family life. Using data and insight our programmes of work are specifically focused on supporting people and communities with poorer health outcomes to access the treatment and care they need as well as improving health outcomes overall.

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	Poor health is a major driver of economic inactivity with people with poorer health being less likely to remain in employment and being less likely to regain full-time or permanent employment. Supporting and enabling people with long term health conditions to better manage and reduce the likelihood of complications developing is an important factor in supporting people to access and stay in work.
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	Addressing health inequalities and improving health equity is a key aim of the long-term conditions programme and Population Health Management Board.
A liveable and low carbon city: a destination of choice to live, visit, work	The varying geography of poor air quality is one of the key drivers behind inequalities in the prevalence of asthma and other respiratory conditions, especially among children and young people, both within Manchester and between Manchester and other parts of the country. Improving air quality is one way to reduce this health inequality.
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 are no new revenue commitments made as part of the long-term conditions programme.

Financial Consequences – Capital

There are no new capital commitments made as part of the long-term conditions programme.

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Background documents (available for public inspection):

None

1.0 Introduction

1.1 This report provides an update on the work taking place to address health inequalities and improve health outcomes overall for people in Manchester living with long term conditions (LTCs). The LTCs programme has been agreed as a priority by the Manchester Partnership Board and Manchester Local Care Organisation was asked to lead on this work. The LTCs programme and Population Health Management approach are key enablers of the first strategic aim within the Manchester University NHS Foundation Trust (MFT) strategy - *Where Excellence Meets Compassion*. The objective to work with partners to help people live longer healthier lives is underpinned by key actions to address health inequalities and target the biggest causes of illness in our local population.

1.2 The standard national NHS offer of care for people with LTCs is through the Quality and Outcomes Framework (QOF) for General Practice. Appendix 1 explains QoF in more detail. The relevance to this report is that it covers support for diabetes, asthma, COPD and chronic kidney disease amongst other conditions. For a variety of reasons linked to the wider social determinants of health, a significant minority of patients with LTCs do not engage with the offer. Those that do not engage may as a result receive little or no input into either the prevention or management of chronic health conditions. Importantly, we know that some communities and some parts of the city will be over-represented among those that do not engage. This is the focus of our work on reducing health inequalities.

1.3 In Manchester we have established two key programmes of work to consider how we can better serve and engage with people about their LTCs with a focus on addressing health inequalities through prevention, improving condition management and reducing complications. The Healthy Lungs programme is focused on COPD in adults and asthma in children and young people. The Healthy Hearts programme is focused on type 2 diabetes and CVD (cardiovascular disease) prevention in adults.

1.4 These are supplemented by the Population Health Management (PHM) programme led by the Local Care Organisation working with Primary Care. PHM uses data and insight to create understanding and visibility of who is at risk of LTCs and enables a more proactive whole system approach to preventative healthcare tailored to specific communities and groups. The methodology enables the identification of communities over-represented among those most at risk and then the measurement of any reduction in the gap in outcomes between them and the population as a whole as a consequence of PHM interventions.

1.5 PHM is being promoted by NHS England as a tool to address health inequalities. In most areas programmes are led by commissioners but in Manchester it is being driven by a collaboration between providers, led by the LCO, Primary Care Networks (PCNs) and GP Practices, the local voluntary and community sector and Manchester City Council's Public Health Team. The programme is overseen by the Manchester PHM Board reporting to the

Manchester Provider Collaborative. Current priorities for the PHM programme are the take-up of bowel cancer screening, children and young people's asthma, and hypertension case finding in adults.

2.0 Background

2.1 LTCs are defined as diseases which cannot be cured but can be managed successfully with medication and other treatments. LTCs are amongst the most preventable diseases and most people with long term conditions can be supported and enabled to live well with a good quality of life.

2.2 The following LTCs which have been prioritised for action are those that particularly impact our local population in terms of higher prevalence than expected, and poorer outcomes than other similar areas in the UK.

- *Type 2 Diabetes* is where the level of sugar (glucose) in the blood becomes too high, caused by problems regulating Insulin, a natural hormone produced by the body. Many people with type 2 diabetes have no symptoms but without medical treatment and self-care, there are increased risks of getting serious problems with your eyesight, feet, heart and nerves.

- *Cardiovascular Disease (CVD)* is a general term used to describe conditions affecting the heart or blood vessels. It is usually associated with the build up of fatty deposits in arteries (atherosclerosis) and an increased risk of blood clots. CVD can also be associated with damage to arteries in organs such as the brain, heart, kidneys and eyes.

- *Chronic Obstructive Pulmonary Disease (COPD)* is the name for a group of lung conditions that cause breathing difficulties. COPD is a common condition that mainly affects middle aged and older people who are or were smokers. Many people do not realise they have the condition. The breathing problems tend to progress over time gradually limiting normal activities.

- *Asthma* is a common lung condition that affects both adults and children, causing occasional breathing difficulties. Asthma is caused by swelling (inflammation) of the breathing tubes which carry air in and out of the lungs. Common triggers for asthma and a narrowing of the airways include smoke, pollution, cold air, allergens such as dust mites, mould or animals for example.

2.3 Core20PLUS5 is the NHS England and NHS Improvement approach to support the reduction in health inequalities at both national and local system levels. Launched in 2021 the approach defines a target population cohort (Core20) of the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMDB). It also identifies 5 focused clinical areas which require accelerated improvement. For adults the focused clinical areas include chronic respiratory disease and hypertension case finding. For children the focused clinical areas include asthma. In Manchester we have identified and prioritised type 2 diabetes as a condition which

disproportionately impacts our local population and with significant health inequalities in treatment and outcomes.

2.4 LTCs are also covered in one of the 8 key themes in the city's 5 year action plan, Making Manchester Fairer (MMF): "Preventing illness and early death from big killers, heart disease, lung disease, diabetes and cancer". The activities and interventions described in this report contribute to this theme. A specific action described in MMF is the introduction, development and embedding of PHM as one system-wide method to tackle health inequalities.

2.5 In North Manchester, under the umbrella of the new hospital development plans, there is an element around health and wellbeing and the potential for a future hub/framework for the development of this offer for North Manchester residents. There is a small amount of funding allocated to this, and in the absence of this as yet being physically built or developed, this funding is being utilised to improve the health and wellbeing of the local communities.

2.6 Projects include improving early detection of atrial fibrillation (AF) and cholesterol screening; a generative artificial intelligence (AI) pilot project to use an app to assist with translation for medicine usage for people whose first language is not English; investment in preventative care for people with long term conditions and to prevent people from developing them – this focuses on smoking cessation, weight management and healthy eating; children and young person's asthma and how we can improve the health of those affected using a neighbourhood approach to reduce health inequalities. Alongside these planned projects we are working with Manchester Metropolitan University (MMU) to look at evaluation of the work done and the learning to support quality improvement.

3.0 Long Term Conditions work programmes

3.1 The Healthy Lungs (Adults) programme is focused on supporting adults with COPD (chronic obstructive pulmonary disease) to reduce their risk of hospital admissions and better manage their condition. COPD is the name used to describe a range of lung conditions where people have difficulty breathing because of long term damage to their lungs typically caused by smoking.

3.1.1 The MARIS (Manchester Acute Respiratory Service) has been running as a winter scheme in primary care since 2022/23 providing additional capacity and support for adults and children with acute respiratory problems. In the most recent reporting period, November 2023 to end of January 2024 an additional 9,958 appointments were offered:

- 85% of appointments offered were taken up (8,493)
- 3% of appointments booked were not attended by patients (216)
- 98% of appointments were face to face (8,291)
- 88% of appointments were for respiratory conditions including COVID and suspected COVID (7,488)
- 35% of the additional appointments were for children (2,950)

3.1.2 Breathe Better Get Togethers are a new community-based approach to support people with COPD struggling with breathlessness to remain active. The Manchester Active team, in collaboration with MFT Community Respiratory teams, have been piloting monthly meet-ups for patients in three neighbourhood areas with high COPD prevalence over the last year. GP Practices in each area are inviting their patients with COPD to join the monthly groups which all include activities, education about living with COPD and an opportunity to socialise. Take up of this new offer is growing and feedback has been extremely positive from patients in terms of supporting them to become more physically active, gaining knowledge about their health condition and being less socially isolated. Plans are in development to extend the Breathe Better Get Together events and meet-ups to more neighbourhoods and venues over the coming year.

3.1.3 Asthma and Lung UK currently estimate that 1.7 million people are living with COPD, and that around 600,000 people are living undiagnosed. There is currently no long-term funding nationally to deliver testing for lung conditions in primary care and there are extremely long waits to access specialist secondary care support. Recent investment in Community Diagnostic Hubs in Manchester (at Withington Hospital and Harpurhey North Family & Fitness Centre) has provided some additional capacity for lung function testing to support diagnosis of lung conditions. NHS-GM are also currently reviewing out of hospital, primary care based, lung testing provision with a view to commissioning a standard approach and offer for the whole Integrated Care Partnership area.

3.2 The Healthy Lungs (Children and Young People) programme is focused on identifying and supporting children and young people (CYP) to improve the control and management of their asthma. Asthma is the most common long-term condition in UK children with around 1 in 11 CYP living with asthma. Manchester has among the highest rates of paediatric asthma hospital admissions in the UK with more than double the England rate.

3.2.1 Research shows that the main causes of poor asthma outcomes are:

- Poor understanding of asthma, with most CYP not being aware of their personal asthma action plan and over reliance on their reliever (blue) inhaler.
- Limited take up and variable quality in the annual asthma review in primary care.
- Inconsistent inhaler technique with limited knowledge of correct technique amongst CYP, families and wider healthcare professionals.

3.2.2 The Healthy Lungs CYP programme is currently in development. It will be focusing on the three areas of Manchester with the poorest CYP asthma outcomes and high levels of health inequalities: Cheetham and Crumpsall, Levenshulme and Longsight, and Wythenshawe Woodhouse Park. The projects in each area will use GP held data and insight from local residents and families to inform local action plans to support and enable CYP to better manage their asthma.

3.2.3 The PHM methodology will be used to support this work by focussing on those children and young people with the poorest asthma control and therefore more likely to have poor school attendance and to attend A&E. We will use the number of reliever (blue) inhaler prescriptions as a proxy indicator of poor control. There are two types of inhalers: 1. preventative inhalers that if used properly help manage the condition and reduce the number of exacerbations and 2. reliever inhalers that are used during an asthma 'attack'. Therefore, a high number of reliever inhaler prescriptions is an indicator of poor control and a reduction an indicator of improvement. The LCO's neighbourhood teams in the three areas of Manchester mentioned above are leading a process with their PCNs and the LCO's Children's Community Nursing Team to produce improvement plans for submission to the PHM Board by the end of September 2024.

3.3 The Healthy Hearts (Diabetes) programme was established in January 2024 to bring together several projects and initiatives already underway focused on improving diabetes outcomes in the City. The COVID19 pandemic worsened diabetes outcomes nationally due to significant delays in diagnosis and people being unable to access their usual care and treatment appointments. In response to this NHS England provided national funding to all Integrated Care Systems in years 22/23 and 23/24 to fund recovery in diabetes care processes and increase uptake in structured diabetes education.

3.3.1 Priority diabetes projects in Manchester include:

- Engagement and insight work to increase referrals and uptake of the National Diabetes Prevention Programme (NDPP) offer.
- Funding for workforce education and skills development, supporting staff across the system to access specialist diabetes training.
- Primary Care Networks working to reduce health inequalities in the uptake of the 'eight care processes' recommended by the National Institute for Health and Care Excellence (NICE). These care checks and processes ensure that people living with diabetes are monitored closely to prevent their condition from getting worse and leading to further complications.
- GP Practices reaching and supporting more patients with diabetes to be treated to NICE recommended targets for HbA1C (blood sugar), cholesterol and blood pressure.
- Improving uptake and completion of structured diabetes education courses, particularly focused on people and communities with the poorest diabetes outcomes.

3.4 The Healthy Hearts (CVD Prevention) project reflects the national NHS cardiovascular disease prevention recovery plan which highlights three treatable conditions known as the A-B-C conditions which are the major causes of CVD, namely atrial fibrillation (irregular heart beat), high blood pressure and high cholesterol. Many people are unaware that they are living with these conditions with existing health inequalities exacerbated by the pandemic as fewer people accessed routine / non-urgent care where the early signs of CVD are often picked up.

3.4.1 Manchester has been successful in receiving grant funding from NHS England to specifically focus on narrowing health inequalities in disadvantaged communities with respect to hypertension (high blood pressure) case finding and high cholesterol case finding. Through the Winning Hearts and Mind programme, we have been working with local VCSFE groups to support people in the Black Caribbean community engage around CVD prevention. There is a second CVD prevention health inequalities project focused in North Manchester working with different communities to increase awareness and uptake of blood pressure checks.

3.4.2 The PHM methodology will also be used to focus on hypertension (high blood pressure) case finding with an explicit focus on those communities most likely to have undiagnosed hypertension. The LCO is working very closely with MCC's Public Health Team to agree a focus for this part of the programme. Together we are considering how a PHM analysis can deepen our understanding of inequalities in the likely prevalence of undiagnosed hypertension in the city against which the current hypertension related programmes can be mapped. This will provide the means to ensure there is a systematic, coordinated and targeted citywide strategy and plan that ensures best use is made of finite resources available across the health and care system to reduce gaps in outcomes for Manchester residents in a way that can be measured.

3.5 The third PHM priority is the take-up of bowel cancer screening, with an explicit focus on the groups of patients aged 60-64 who are over-represented among those that have not taken up the national screening offer. This is the second full year for this priority, but we have not yet been able to assess the impact of the neighbourhood PHM plans in 2023/24 because of a delay in accessing data held within the new integrated GM system. Although the system is now set up, some data quality issues were uncovered earlier in the summer. It is understood that they have very recently been resolved which means that the data teams can now undertake the analysis of the impact for 2023/24, which will also form the baseline for 2024/25 and the neighbourhood plans due to be submitted at the end of September, assuming no further delays in accessing the data.

4.0 Recommendations

The Committee is recommended to consider and comment on the information in the report.