GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP

THEME 1 EXECUTIVE

Date: 2nd November 2016

Subject: Greater Manchester Population Health Plan 1st Draft: For comment and discussion

Report of: Wendy Meredith Director of Population Health, Greater Manchester Health and Social Care Partnership

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PURPOSE OF REPORT:

The attached 1st draft Population Health Plan is presented to the Theme 1 Executive for comment and discussion, and to seek support for a final delivery plan being produced and brought back to this group at the end of November.

RECOMMENDATIONS:

The Theme 1 Executive is asked to:

(i) Consider and comment on this first draft of our Population Health Plan and formally endorse work to produce a final plan for late Novembers Theme 1 Executive meeting.

(ii) Note the forums below to which the plan will be presented to prior to endorsement at the Greater Manchester Strategic Partnership Board executive in December.

- Theme 1 Exec 02/11
- Reform Board 04/11
- DPH 04/11
- AGG 15/11
- WLT 15/11
- Provider Federation 18/11
- PMB 18/11
- Primary Care Advisory Group 23/1

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Delivering a Radical Upgrade in Population Health and Prevention

Our Greater Manchester Population Health Plan

2016 - 2021

Contents

Foreword

In Greater Manchester (GM), we are committed to using the opportunity afforded us by devolution to change our system to one which makes the greatest and fastest improvement to the health, wealth and well-being of the 2.8 million people who live here; To put tackling the “causes of the causes” of poor health at the centre of all our plans.

Michael Marmot talked about People, Places and Power as the essential ingredients for a different “health creating” system. We’ve taken his message to heart and we’re re-designing all our public services – not just health and social care - to bring this about. Our focus is unashamedly on people and places, not organisations. We know that people who have good jobs and good housing and are connected to their families and communities, feel and stay healthier.

The long term health and wellbeing of people will only be secured through a new relationship between public services and the public. We are brokering a new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.

GM is a great place to live and work. We have all the benefits of a global city with easy access to areas of outstanding natural beauty. However, these benefits are not shared by all our citizens and too many people are still experiencing poor health. We are therefore making tacking health inequalities the central aim of our plan. We recognise that this means we will have to make difficult choices but we are clear that tackling worklessness and creating opportunities for enterprise are essential to our vision of flourishing people in prospering communities throughout GM.

The choices we have made in the plan are based on the best available evidence of impact and seek to achieve a balance of sort, medium and long term impacts. There will be some programmes which we will work up in future years and others which we take forward through our commissioning plans and by working with localities.

Executive Summary

To be added

1. The Greater Manchester Context

The GM Strategy, '*Stronger Together'*, placed public service reform at the heart of our strategic ambition. The subsequent Growth and Reform Plan, devolution agreements, and the Health and Social Care Strategic Plan '*Taking Charge'* have restated that commitment to reshaping our services, supporting as many people as possible to contribute to and benefit from the opportunities growth brings.

With local services working together, focused on people and place, we want to transform the role of public services and take a more proactive approach rather than responding to crises. We want to transform the way we use information, empowering our frontline workforce to make more informed decisions about how and when they work with individuals and families.

Building on the principles of early intervention and prevention, GM aims to deliver the appropriate services at the right time, supporting people to become healthier, resilient and empowered.

To support delivery of this ambition GM requires a radical approach to transforming population health and prevention that demands radical action. This document will describe how we will deliver on our bold vision to radically upgrade our population's health.

Our plan for population health and prevention will help us deliver the GM strategic objectives by supporting our residents to: 'start well, live well and age well'. This life course approach has structured our proposals, underpinned by an approach which will empower individuals and communities to 'take charge' of and improve, their health and wellbeing. Healthy and independent people play a key part in enabling us to achieve our ambitions for a growing and sustainable GM in the future.

We know that poor health and disadvantage are inextricably linked and that disadvantage starts before birth and accumulates throughout life. The proposals we have set out are based on the best available evidence and have been structured to deliver benefits over short, medium and long-term time horizons.

We recognise that skilled, healthy and independent people are crucial to bring jobs, investment and therefore prosperity to GM. We know that people who have jobs, good housing, are connected to families and community feel, and stay, healthier. So we need to take action not just in health and social care, but across the whole range of public services so the people here can start well, live well and age well.

Aligning Reform

Why we're taking an aligned approach to reform

Consequently, GM is not just taking charge of health and social care provision. Fundamental to the success of the groundbreaking agreement between the Government and GM will be our ability to draw together a much wider range of services that contribute to the health and wellbeing of GM people. The impact of air quality, housing, employment, early years, education and skills on health and wellbeing is well understood.

Across GM we are reforming public services. We are developing new approaches to services in areas such as health and social care, family support services, employment programmes, housing, skills, debt advice, and justice and rehabilitation provision. Across all our reform work we are working to a core set of principles. We are seeking to achieve:

- **A new relationship** between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- **An asset based approach** that recognises and builds on the strengths of individuals, families and our communities rather than focusing on the deficits.
- **Behaviour change in** our communities that builds independence and supports residents to be in control
- **A place based approach that redefines services** and places individuals, families, communities at the heart
- A stronger prioritisation of **well-being, prevention and early intervention**
- An **evidence led** understanding of risk and impact to ensure the right intervention at the right time
- An approach that supports the development of **new investment and resourcing models**, enabling collaboration with a wide range of organisations.

We want to ensure people across GM are able to access the right services, at the right time, in the right way to help them tackle challenges they may face and to build on the strengths in their lives. We must do this in collaboration, across sectors so that people no longer have to navigate fragmented systems and services.

People across GM are just that, people. They are not 'learners', or 'patients', or 'tenants', or 'unemployed', or 'offenders'. Our residents are people who live in communities across our city-region. They are people with assets but they are also people who at times need the support of public services. The support they need will often be drawn from a range of services that require coordination and sequencing if they are to help people achieve sustained improvements in their lives.

Achieving improved population health outcomes means supporting more people to enter and sustain good employment, it means supporting people to achieve higher skills levels, have good housing, are motivated to lead healthy lifestyles, and – if they do face challenges in their lives – are supported to address these in an integrated way.

Our Plan for Population Health and Prevention is strongly aligned to the wider public service reform work by supporting people to start well, live well and age well. By doing so, we are able to maximise the full potential of our programme and wider reform work to create more opportunity for the people of GM and contribute to the economic future and growth of our conurbation.

People's lives do not neatly fit into public service sectors. Aligning our reform strategies means we are placing people at the heart of what we do rather than expecting people's lives to neatly map to our organisational boundaries.

How we're aligning reform

To deliver an aligned approach to reform we are:

- Aligning governance and GM-wide strategic development at a GM level, ensuring the decisions we take together are cognisant of broader activity across our system.

- Aligning locality governance, strategy and implementation planning, ensuring we reduce duplication across our systems and free up capacity to increase our focus on early intervention and prevention.
- Taking a collaborative view on the outcomes we are seeking to achieve across GM, ensuring that all the work we do is focused on supporting the achievement of those core outcomes that will improve the life chances of people across GM. This is helping us focus our activity.

GM Health and Social Care Devolution: Aligning transformational change themes

Health Challenge

GM is a great place to live and work for many of our citizens and has the fastest growing economy in the country and yet people here die younger than people in other parts of England. We spend millions of pounds dealing with illnesses caused by poverty, loneliness, stress, debt, smoking, drinking, air quality, poor nutrition and physical inactivity and recognise that we need to focus on the causes of the causes of poor health.

Cardiovascular and respiratory illnesses mean people become unwell at a younger age, and live with their illness longer, than in other parts of the country. Our growing numbers of older people often have many long term health issues to manage and our services are not sufficiently focused on prevention and early intervention with thousands of people treated in hospital when their needs could be better met elsewhere.

For instance, around 680,000 people live in areas which fall into the 10% most disadvantaged areas in the country and three local CCGs are in the bottom 10 nationally for healthy life expectancy at birth.

Older women in Manchester have the worst life expectancy in England. The high prevalence of long term conditions such as cardiovascular and respiratory disease mean

that GM people not only have a shorter life expectancy, but can expect to experience poor health at a younger age than in other parts of the country.

Our population has aged and our older population will increase by 25 per cent by 2025. As more people have developed multiple long term conditions the focus has shifted from curing illnesses to helping individuals live with chronic ill health. There is a rising burden of illness caused by lifestyle choices like smoking, drinking and obesity. These changes have put the NHS and social care under increasing pressure and a growing number of people with multiple problems receive care that is fragmented or leads to wasteful duplication.

Children who do not achieve a good level of development at age five will struggle in later years with social skills, reading, maths, physical skills and overall educational outcomes. They are more likely to experience difficulties with the criminal justice system, have poorer health and job prospects and ultimately die younger.

We know that people in work tend to enjoy healthier lives than those out of work, and people with health conditions such as back pain, stress, depression and high blood pressure, find that getting back to work is often the best way to recover and that it isn't always necessary to be 100 per cent fit before returning.

GM has an ageing population and we know we need to focus on helping older people stay well longer and supporting them to cope better if they have a long term illness, especially dementia. Unemployment imposes a significant burden on health and care services and the numbers in this age group are set to grow by 20 per cent in the next decade.

This Plan shows the opportunity devolution brings to improving the population health of GM and demonstrates our ambition across the life course.

Taking Charge Ambition

GM is embarking on a large scale programme of whole-system public service reform, bringing together decision making, budgets and frontline professionals to shape services in ways that better support local people and communities.

Our progress in achieving wider public service integration is key to securing the health benefit of non-medical support and helping our health and care system function better. This can span from early help to crisis response across the whole public service, alongside the voluntary and community sector, to ensure our blend of support is as effective and appropriate as it can be.

For example, connecting health and care to housing providers will extend their established role in building communities and improving individual wellbeing by working in partnership across the region to support health services, particularly around prevention, early intervention and reablement.

By upgrading prevention and self-care we are proposing to change the way GM people view and use public services, creating a new relationship between people and public services. This means more people managing their health, people looking after themselves and each other. This means increasing early intervention at scale and finding the people missing from services. We want to work across GM to have standardised support that helps people to start well, live well and age well.

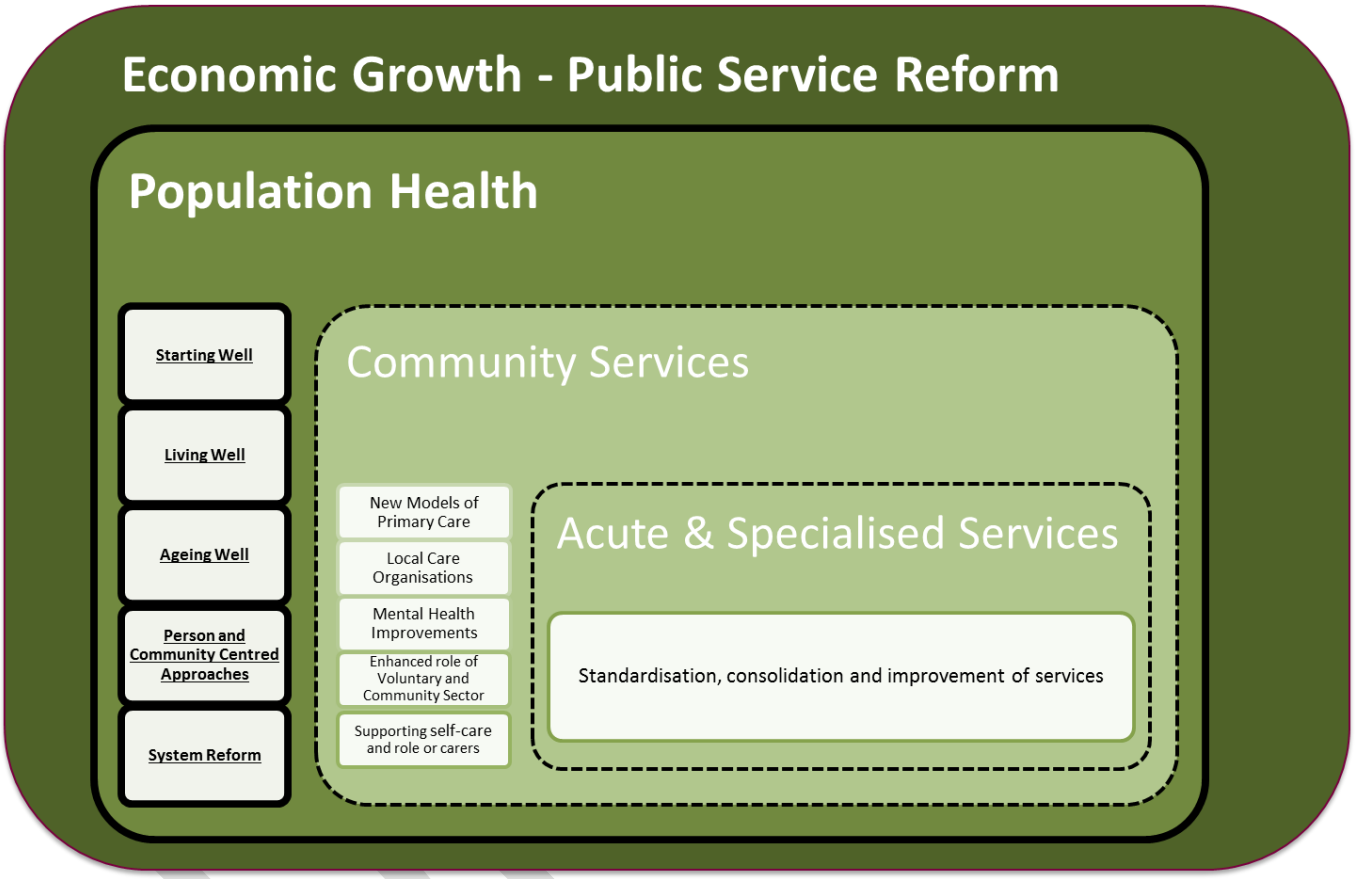
The 'Taking Charge' Plan recognised that we have some of the worse health outcomes in England. It set out how we would concentrate our efforts closing the gap between GM and

England by raising population health outcomes to those projected for England in five years' time, in other words we will go further, faster.

We will work to create the conditions, which support people and communities to become healthier, be in control of their lives and their care, be more empowered and resilient. Our aim will be to improve health across the life course by demonstrating a significant contribution to achieving the strategic outcomes for GM set out in 'Taking Charge'.

2. Programme Overview

Our Programme



Our vision is to achieve the furthest fastest improvement in health and well-being of our 2.8million citizens. We will do this by connecting our citizens to the opportunities of growth and reform and reorienting our health and social care and other public services towards prevention and early intervention.

Devolution has given us the opportunity to develop new ways of working and to build on firm foundations in describing a transformation programme, developed with GM, to be delivered by GM.

During 2016 we have:

- Swiftly set out our five transformation work programmes ‘start well’, ‘live well’, ‘age well’, ‘person and community centred approaches’, and ‘system reform’.
- Developed a set of proposals, which we will deliver with the system.
- Developed a programme governance to support decision making and delivery.
- Aligned our programme to other transformation work that forms ‘Taking Charge’
- Built cohesion across the wider public service reform programmes, ensuring decisions we take together are cognisant of broader activity across our system.

- Taken a collaborative view on the outcomes we are seeking to achieve across GM ensuring all the work we do is focussed on supporting the achievement of the GM strategic outcomes that will improve the life chances of people in GM.

Our five work programmes include:

Start Well

Building on the principles of early intervention and prevention, our early years plan aims to establish a framework for the delivery of appropriate services at the right time, supporting children and families to become healthier, resilient and empowered. Our Early Years New Delivery Model is based on universal and targeted services, using evidence based assessments to identify and intervene effectively to avoid or minimise escalation of need.

Live Well

This programme recognises that good work is an essential pre requisite of health and socio-economic outcomes. The wealth of evidence to support employment as a health outcome makes our Work and Health proposal a priority within our population health plan.

Whilst recognising the importance of the wider determinants of health in improving outcomes, we recognise that we could do a lot more to help people change their behaviour. Our crowd sourcing conversations with the people of GM told us that people would like more support. We also know that people generally know what healthy lifestyles are but sometimes find this knowledge difficult to put into practice. Our proposal to develop a GM digital platform will support behaviour change on tobacco, physical activity, food and alcohol and we are working with localities to develop a set of standards for integrated local wellbeing services for those people who need a bit more support.

Age Well

Age Well aims to support people to maintain good health, wellbeing and independence for as long as possible. The programme focuses on interventions which, if delivered consistently and effectively at scale will enable people to stay well and live independently for as long as possible. Year one of the programme prioritises housing and health, nutrition and hydration, and falls prevention.

Person and community centred approaches

Using person and community centred approaches we will begin to rebalance the relationship between people and public services. We aim to put people and communities at the heart of what we do, concentrating on what is most important to them, what skills and attributes they have and what strengths exist naturally in people and places. This programme explores asset based working and the power of social movements to promote and strengthen factors that support good health and wellbeing. We want to foster communities, individuals and services through a fundamental shift in approach and control especially for public services.

System reform

It is clear that an ambition of this magnitude requires the support of a public health system which is organised to deliver at pace and scale.

In GM we have the chance to radically reframe the role of Public Health in the context of a devolved system, creating a unified system across ten localities and GM that is better able to achieve improved health outcomes. We will create a leadership, governance and delivery model with clear lines of accountability and responsibility for achieving GM's population health ambitions that delivers financial sustainability and is able to future proof against future funding changes.

How our programme outcomes contribute towards the GM and 'Taking Charge' ambition

Stronger Together	Taking Charge	GM Population Health Plan Objectives
GM is a fairer, healthier, safer & more inclusive place to live	**Start Well**	**Start Well** • To support localities to implement the core elements of the GM Early Years model including the development of a IMT proposition to improve data processes to track progress and allow earlier intervention. • To develop a sustainable, resilient and consistent GM approach to stopping smoking in pregnancy. • To Implement evidence-informed interventions at scale in a targeted and consistent manner across GM to improve oral health and reduce treatment costs within 3-5 years.
Reform health & social care- improved access to quality, integrated services; greater independence, improved wellbeing & stronger communities	More GM children will reach a good level of development cognitively, socially and emotionally	
	Fewer GM babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system	
Improve early years-support parents to give children the best start in life & help workless parents towards work.	**Live Well**	**Live Well** • To build and test an approach to work and health which improves the integration and alignment of health, employment and other services, • To test and evaluate the Focus Care approach model in 10 deprived practices in GM with a view to supporting the future expansion and mainstreaming of the new care model including exploration of sustainable funding mechanisms. • To develop a whole systems approach to lifestyle and wellness services, including innovative digital options for incentivising and supporting lifestyle behaviour change
All people are valued & able to fully participate in & benefit from the city region's success- support unemployed residents into work & enable progression into higher skilled, higher paid roles.	More GM families will be economically active and family incomes will increase	
	Fewer people will die early from cardio-vascular disease	
GM is known for excellent, efficient, value for money services-encourage self-reliance and reduce demand.	Fewer people will die from cancer	**Age Well** • To facilitate the roll out, testing and evaluation of an approach to tackling issues around poor quality housing • To facilitate the roll out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford • To facilitate the roll out testing and evaluation of FLS integrated with locally designed falls prevention services in a number of GM boroughs
	Fewer people will die from respiratory disease	
Create the conditions for growth & place GM at the leading edge of science & technology-expand & accelerate the commercialisation of research.	**Age Well**	**Person and community centered approaches** • To support capacity and capability building for asset based approaches in GM • To develop a network of cancer champions and apply learning for wider use of social movements
Collaboration & partnerships-strong collective and individual leadership	More people will be supported to stay well and live at home for as long as possible	**System reform** • To develop a population health commissioning plan, and develop and test a proposal for a new GM population health function including future resourcing model • To deliver the cancer prevention work stream of the national cancer vanguard by April 2018, testing and evaluating innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle based secondary prevention • To help develop a GM City Region approach to eradicating HIV within a generation

The principles that guide our approach

The GM 'Taking Charge' strategy set out our ambition to radically transform population health and prevention. This has driven our programme of work which has been structured around four key principles which are set out below.

Each of these principles are underpinned by a strong evidence base where available or utilising innovation to test new approaches to service delivery

Work already underway

Building on a strong foundation where work is already in train and is showing potential benefit we have aligned our population health programme to ensure a coherent approach across all reform and transformation work e.g. Early Years.

Quick wins

Where a strong evidence base exists to support local best practice, we have identified a number of interventions that are scalable across GM and have potential to be implemented in the short term e.g. nutrition and hydration.

Common themes in locality plans

Areas of common interest across all localities in GM have been prioritised through an audit of locality plans. These areas offer opportunities for implementing standardised approaches across GM to improve outcomes and provide economies of scale e.g. falls.

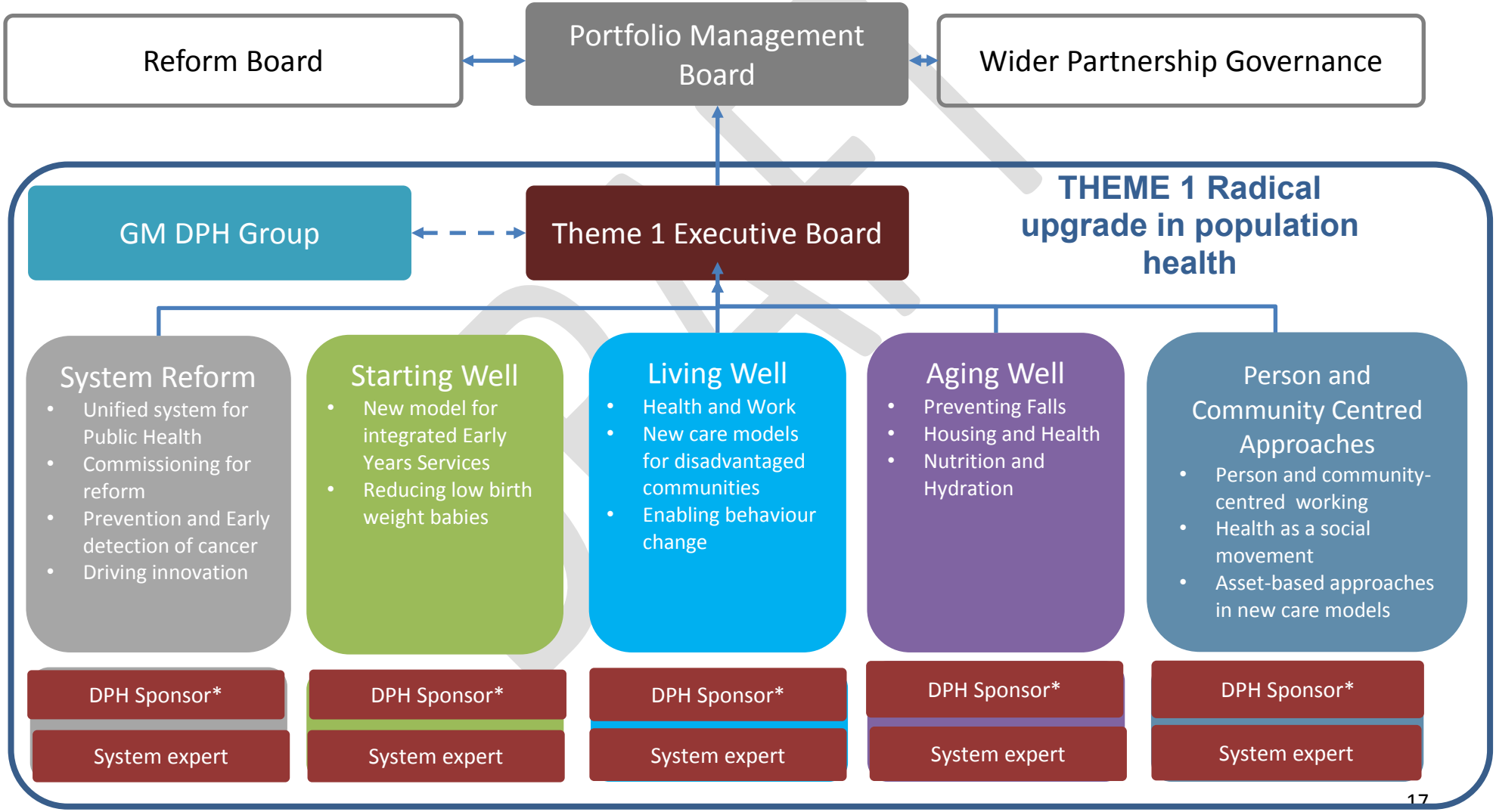
Economics of Prevention

The priorities we've agreed are designed to achieve high impact at scale and are based on the best available evidence. We have structured priority interventions to deliver benefits over short, medium and long term time horizons. We call this the "Economics of Prevention" developed by the New Economy Manchester and Public health England.

This approach has adapted a comprehensive framework for the economics of prevention that groups interventions by their gestation or notional rate of return in order to recognise that dividends for different interventions are likely to be realised over different time periods. This framework proposes that because health, education, work and social status have substantial interdependence, addressing morbidity and pre-morbidity in specific sub-groups of the population can accelerate the rate of return across all time frames. Therefore, this represents the best investment for a devolution proposal designed to achieve whole system and sustainable transformation

Delivery Governance

Our Population Health Plan will be driven through clear system engagement at all levels of governance from locality SRO's on the Portfolio Management Board, to sector leads on the Theme 1 Executive and finally through nominated locality leads on the various task and finish groups. The diagram below sets out the governance that will see this plan through to delivery.



*DPH sponsor report s into the Theme 1 Exec

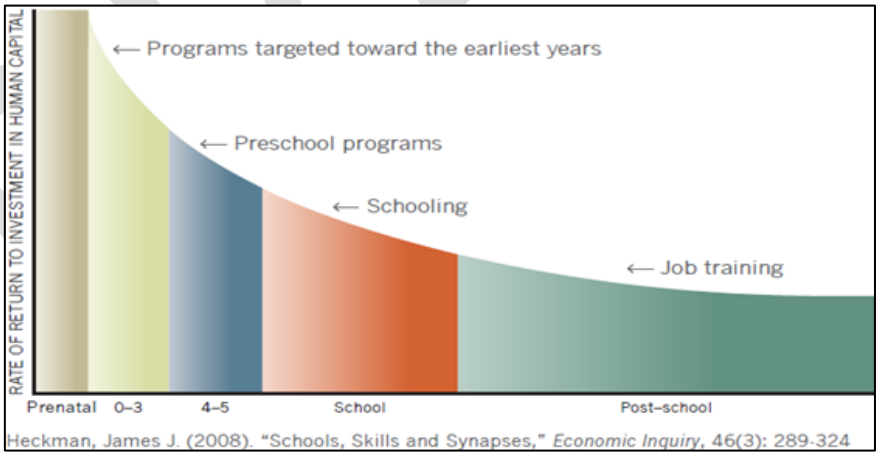
3. Starting Well

Early Years Strategy

Background

It is much more difficult and costly to repair the damage done by child maltreatment in later life than to prevent it during the Early Years. It is reported that 40% of public funds are currently being spent on problems that could have been prevented but were not. Those who suffer multiple adverse childhood events achieve less educationally, earn less, and are less healthy, making it more likely that the generational cycle of harm is repeated.

The Marmot Review (2010) recommended 'giving every child the best start in life' was the highest priority to tackle health and social inequalities. In 2012, the Wave Trust concurred with these findings and further articulated that conception to age 2 is the crucial phase of development and is the time when evidence-based interventions will reap great dividends for society. How we support 0-2 year-olds shapes their lives and ultimately our society. These reports clearly identify the window of opportunity from early pregnancy to age five that establish the foundations for life, including physical and mental health, social and communication skills, behaviour and future academic success. Early Years investment is proven to be the best route to overcoming intergenerational inequalities. The chart below illustrates the rates of return to education and training over a person's working life. The earlier the investment is made, the higher the return on this investment.



GM Context

We want every child in GM to have the best start in life. This means that every child grows up in an environment that nurtures their development, derives safety and security from their parents / care givers, accesses high quality early years services and has a belief in their goals and their ability to achieve them. Our ambition is that every child in GM acquires the skills necessary to negotiate early childhood, primary and secondary school and education and employment.

In GM school readiness figures are lower than the national average with the percentage of children age 5 achieving a Good Level of Development (GLD) in 2015 at 62.4% compared to 66% nationally. This means that almost two in every five children in GM do not reach a GLD this increases to one in every two children in receipt of free school meals. Raising overall attainment for the most disadvantaged and vulnerable groups of children is a challenge for every locality.

At the heart of the Health and Social Care reform ambitions is the recognition that we need to see a significant shift in activity; shifting the balance from reactive, crisis services to preventative services that help reduce escalation of need. The Start Well Early Years strategy was approved by the GM Strategic Partnership Board in June 2016 and sets out the GM vision for transformational system change and a long-term and sustainable shift from expensive and reactive public services to prevention and early intervention. The strategy aims to reduce duplication and make more efficient use of resources to achieve better outcomes wherever possible within existing budgets, including a vision for integrated leadership, commissioning and delivery.

The need for targeted and specialist services is acknowledged, however the strategy recognises the requirement for a core universal offer to all GM families in the Early Years to identify abuse, neglect, developmental delay and special educational needs and / or disability at an early stage to ensure swift access to support and interventions.

The overall objective of this work is to increase the number of GM children who are school ready and over the next five years we intend to close the gap between current GM performance and the national average for the following selected outcomes:

- To increase the percentage of children achieving age-related expectations at 2 -2 ½ years (measured using the 'Ages and Stages Questionnaire' (ASQ 3).
- To increase the percentage of 2 and 3 year old children who take up their free entitlement in schools and settings that are judged 'good' or 'outstanding' by Ofsted (with a particular focus upon vulnerable groups).
- To improve the percentage of children achieving a good level of development at the end of the Early Years Foundation Stage.
- To improve the percentage of children in receipt of 'free school meals' who achieve a good level of development at the end of the Early Years Foundation Stage.
- To reduce the number of full-term babies with a low birth weight.
- To increase breastfeeding rates at 6-8 weeks.
- To reduce the rates of smoking at time of delivery.
- To reduce levels of overweight and obesity at age 4-5 years.
- To reduce the number of decayed, missing and filled teeth in children aged five years.
- To reduce attendance at Accident and Emergency for children aged 0-4 years.
- To protect vulnerable children and families by ensuring that all General Practice's meet national targets for childhood routine vaccinations and pre-school flu vaccinations.
- To improve parent infant mental health.
- To safely reduce the number of Looked After Children (LACs).

Opportunity

The GM devolution agreement, the transfer of Health Visiting and Family Nurse Partnership commissioning to local Authorities, free early education places for disadvantaged 2 year olds, the Early Years Pupil Premium, Public Sector Reform work, The GM Children's Services Review and the development of integrated services for 0-19 years present a

golden window of opportunity to ensure a concerted approach to improving child development.

To reduce the steepness of the social gradient in child development, actions must be universal, but with a scale and intensity that is proportionate to the level of need. The universal components of the GM Early Years Delivery Model (EYDM) were fully implemented prior to the transfer of the commissioning responsibility for Health Visiting to Local Government in in October 2015. Numbers of Health Visitors in GM rose by 57% since between 2013 and 2015 with substantial increases in the delivery of evidence-based assessments and an additional 40% investment of £13million from NHS England. During the same period Family Nurse Partnership (FNP) programmes were implemented in every GM locality increasing access by almost 300%. Significant workforce transformation to identify need earlier has also been delivered. This increase was urgently required to meet universal requirements; however there is still a significant amount of unmet need in localities. A self-assessment undertaken within localities has identified that each locality is well placed to build upon this strong foundation by implementing the evidence based targeted interventions identified as part of the GM Early Years model.

There have been significant changes to the provision of free early education during the last 3 years, including new places for 2 year olds and an Early Years Pupil Premium for the most disadvantaged 3 and 4 year olds. Since September 2014, 55% of 2-year-olds in GM have been entitled to 15 free hours of free early education per week for 38 weeks of the year. Take-up of 2 year old places across the 10 localities varies with an average 71% of eligible children taking up their free entitlement across GM with a local variance of 63-85% (2015).

It is widely accepted that GM will not meet the challenges it faces over the next five years through incremental change and no single locality can deliver the scale of reform required acting alone. Major transformation is required to co-design and implement a different model to standardise support that helps children and families to start well. There is a requirement to develop a mandate for co-production and shared responsibility for transformational change across the Early Years sector to make the most effective use of current resources with shared system leadership and accountability for early years outcomes.

Whilst there will be significant short-term gain, the principal impact of savings to the Public Sector will be realised up to 10 years after the early years period. In the longer term, a failure to effectively intervene to address the complex needs of an individual in early childhood can result in a nine fold increase in direct public costs. Significantly the organisations that benefit most from the interventions are not the organisations that traditionally fund the services. Devolution arrangements provide an opportunity to address this. The devolution commitment to integrated partnership working provides significant incentives to invest in transformational reform, removing those barriers that precluded investment in preventive approaches, particularly those where investments provided benefit to other agencies

Plan

Objectives

It is now well understood across GM that investing in new models for Early Years services is the right thing to do from a moral, financial, performance and resilience perspective. The next stage of the work will seek to give confidence to system investors that the early years model will deliver improved outcomes.

- Objective 1: Implement the core elements of the GM Early Years model (see below) within all ten GM localities.
- Objective 2: Develop a sustainable, resilient and consistent GM approach to stopping smoking in pregnancy.
- Objective 3: Develop IMT proposition to improve data processes to track progress and allow earlier intervention.
- Objective 4: Implement evidence-informed interventions at scale in a targeted and consistent manner across GM to improve oral health and reduce treatment costs within 3-5 years.

Approach to delivering objectives

Objective 1: Implement the core elements of the GM Early Years Model (see below) within all ten GM localities.

The programme will seek to:

- Identify local gaps in the delivery of the Early Years model and develop locality implementation plans
- Formulate investment proposals to pursue and agree funding options.
- Update the Cost Benefit Analysis model.
- Undertake a commissioning options appraisal.
- Develop an engagement strategy around achieving the aspiration of the Start Well Early Years Strategy. Specifically it will seek to scope the vital contribution of schools, community and voluntary organisations and a Public Health maternity workforce in achieving the objectives of the Start Well Early Years Strategy.

Objective 2: Develop a sustainable, resilient and consistent GM approach to stopping smoking in pregnancy.

The programme will seek to:

- Scope current approaches to commissioning stop smoking services in pregnancy.
- Review the evidence and formulate sustainable investment proposals.
- Commission a GM approach to stop smoking services in pregnancy to ensure consistency.

Objective 3: Develop IMT proposition to improve data processes to track progress and allow earlier intervention.

The programme will seek to:

- Work with GM Connect to identify the potential scale, impact and efficiency savings.
- Explore the opportunities identified within capturing data, storing data and sharing data.
- Identify localities to test a proof of concept.
- Develop a GM model which will realise efficiencies and enable the workforce to spend more quality time working with families.
- Objective 4: Implement evidence-informed interventions at scale in a targeted and consistent manner across GM to improve oral health and reduce treatment costs within 3-5 years.

Objective 4: Implement evidence-informed interventions at scale in a targeted and consistent manner across GM to improve oral health and reduce treatment costs within 3-5 years.

The programme will seek to:

- Develop a programme which reinforces the view that oral health is everyone's agenda with child oral health improvement messages communicated effectively to the public and wider stakeholders.
- Ensure that the early years and dental workforce have access to appropriate evidence based oral health improvement training.
- Ensure that approaches to oral health improvement are based on a sound evidence base which is sufficiently informed by improved oral health data and information.

Target outcomes for (16/17) and (17/18)

2016/17:

- Develop locality plans in all localities.
- Develop investment proposals to deliver core Early Years model in pioneer localities.
- Develop investment proposition for a GM stopping smoking in pregnancy service

2017/18:

- Commission a GM stopping smoking in pregnancy service.
- Develop investment proposals in remaining localities.
- Progress IMT roll-out in initial areas.
- Develop evaluation process to give confidence in investment.

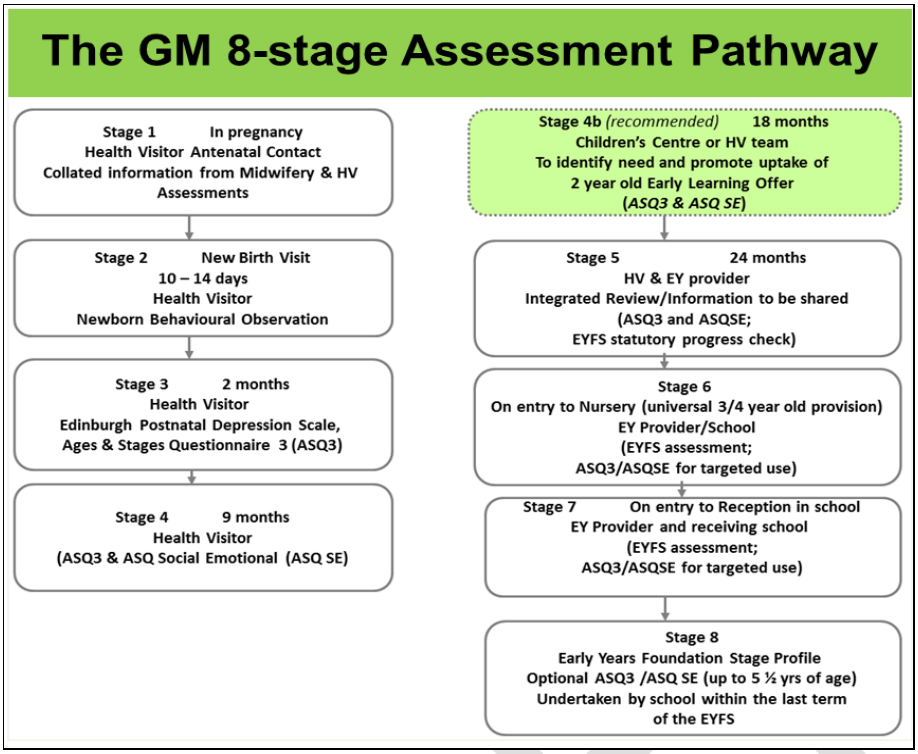
Programme of work – Scope

The GM EYDM is an ongoing universal and targeted pathway based on consistent, integrated age-appropriate assessment measures promoting early intervention and prevention, implemented through assertive outreach and improved engagement with families with young children from pre-birth to school. Assessments will be evidence-based, timely and ongoing from pre-conception to five years (see diagram below). Services will identify need early and intervene effectively to minimise the escalation of need. This is reinforced by a series of evidence based interventions supporting short and long-term benefits. Implementation of the EYDM has progressed at different rates across all areas of GM.

There is a requirement to focus on remodelling existing early years services within budgets which are under pressure. This requires new multi-agency delivery models, reducing commissioned activity with no evidence base and moving public sector money associated with poor outcomes into programmes that rapidly improve the performance across GM.

The GM Early Years Delivery Model comprises of three key components:

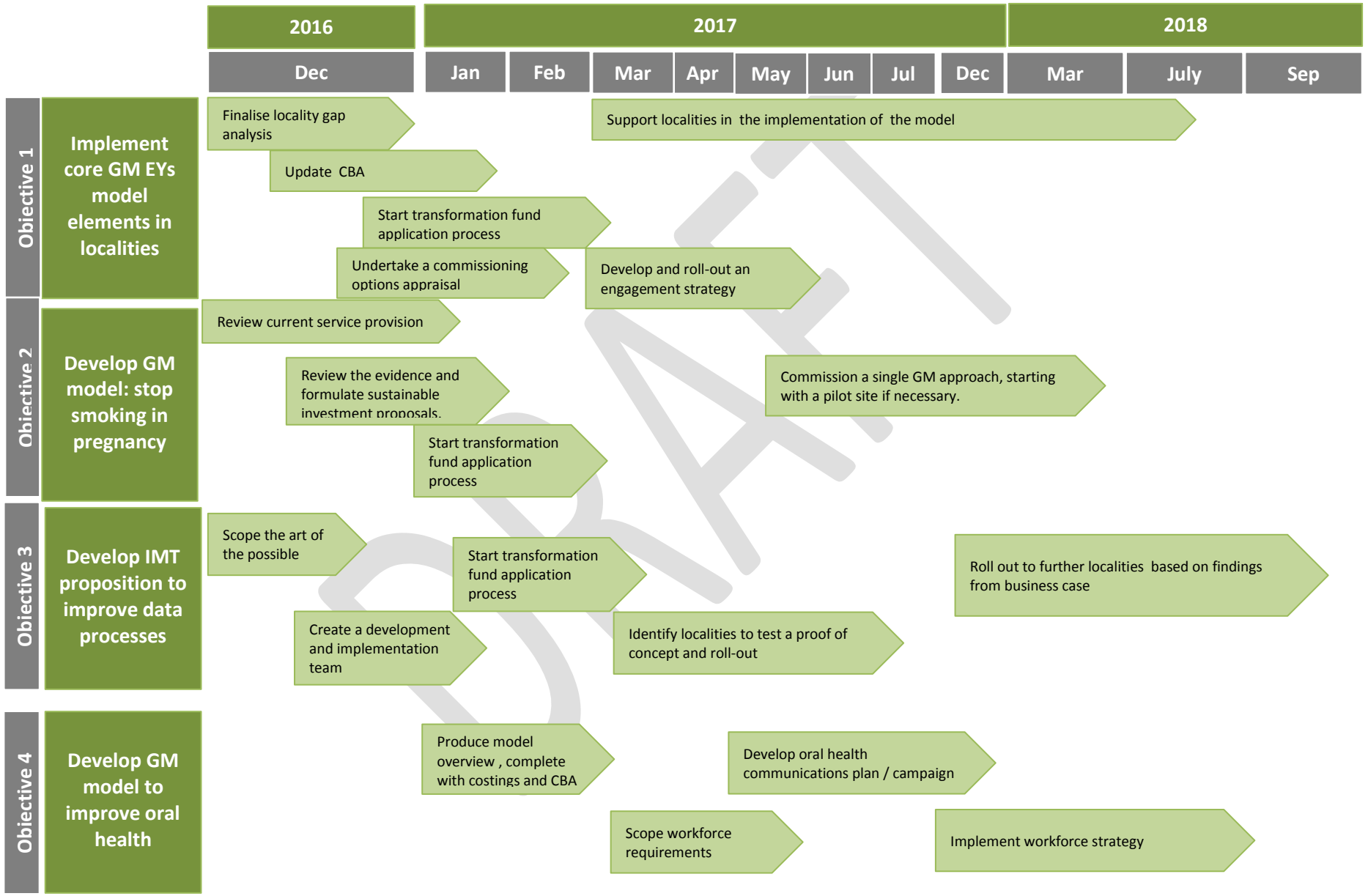
1. 8-stage assessment pathway (see below)
2. A range of multi-agency pathways
3. A suite of evidence based assessment tools and targeted interventions.



When the EYDM is implemented across GM to a standard of the highest performing localities, families will be in receipt of a proportionate multi-agency tailored response relevant to their level of need. The EYDM has the full engagement of all authorities but commissioning, service delivery and provision remains inconsistent across GM with progress hard to evidence. To increase momentum there is a need to develop a new approach to commissioning Early Years services across GM, specifically integrated commissioning of the GM EYDM.

The GM EYDM will require integrated commissioning arrangements to include a local commitment to commission and deliver all core model elements (1) and (2) within each locality delivered by multi-disciplinary integrated teams. If evidence-based local targeted variations are in place it is recognised that there may be a desire to retain these at the expense of specific core model elements (2); the model intends to support this flexible approach. Examples of these are listed within local elements (3). Significantly any services agreed as core components (1) and (2) of the model should not be decommissioned at a local level.

Timeline on a page – Early Years



4. Living Well

Work and Health

Background

There is a strong association between worklessness and poor health. Being out of work can lead to poor physical and mental health, across all age groups, with major impacts for the individual concerned, their spouse and family. Getting back into work improves people's health, as long as it is good quality work.

There is strong evidence that unemployment is generally harmful to health, and leads to

- Higher mortality;
- Poorer general health and long-term limiting illness;
- Increased alcohol and tobacco consumption, decreased physical activity
- Higher rates of medical consultation, medication consumption and hospital admission rates
- Unemployment increases the risk of fatal or non-fatal cardiovascular disease and events, and all-cause mortality, by between 1.5 and 2.5 times

The evidence base also demonstrates the impact on mental health in terms of poorer mental health, psychological distress, minor psychological/ psychiatric morbidity.

- One in seven men develop clinical depression within six months of losing their job
- Prolonged unemployment increases the incidence of psychological problems from 16 per cent to 34 per cent, with major impacts on the individual's spouse
- Young people are particular at risk. Attempted suicides 25 times more likely for unemployed young men than employed young men, mental health problems in general much higher amongst unemployed populations

There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss. The exception to this can be young people.

- Unemployed young people, and particularly affected by 'scarring': effects of a bad early experience in the labour market can last for 20 – 30 years and restrict ability to progress
- Young people who are not in education, employment or training (NEET) for a substantial period are less likely to find work later in life, and more likely to experience poor long-term health

Prevention from leaving the labour market is key. NICE evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to employment, and after two years are more likely to die than return to employment.

In terms of the national context, there is national recognition that employment is a primary determinant of health. The NHS Five Year Forward View gives a clear statement on the need for the NHS to do more to help people to get into, and remain in, employment. It

articulates the fiscal impact of health-related absence and benefit claims to employers and taxpayers, and the low employment rate of people with mental health problems. The role of employers, and the NHS in supporting employers, is identified as key to supporting a healthier workforce and reducing long term costs.

In Autumn 2015 the UK Government has announced an ambitious target to halve the gap between the UK disabled and non-disabled employment rates. The Department of Health and Department for Work and Pensions established the Joint Work and Health Unit to lead the drive for improving work and health outcomes for people with disabilities and long term health conditions, as well as improving prevention and support for people absent from work through ill health and those at risk of leaving the workforce. A Green Paper is due out later in the year. GM has an on-going strategic dialogue with the Joint Unit regarding development of collaborative proposals.

The Scottish Government has established a national Health, Disability and Employment (Early Interventions) Programme, sponsored by which is sponsored by Director Generals of Health, and Learning and Justice. This is developing a programme to focus on early interventions to improve employment outcomes for people with health conditions and disabilities, in recognition of the strategic challenge poor work and health outcomes present.

GM Context

Very high rates of health-related worklessness have persisted in GM regardless of the economic climate, and the number of health-related benefit claimants has remained high even during times of economic growth.

GM Health and Social Care devolution, as demonstrated in the vision document Taking Charge - the GM Health and Social Care Strategic Plan, presents opportunities to further test and embed approaches which integrate employment and health. It is well understood that employment is a key determinant of health at strategic level, despite this there is still a journey to make sure it is given the priority it should have in relation to patient care. This includes a recognition that more should be done around early interventions to improve employment outcomes for those residents at risk of falling out of work due to health/disability and those recently unemployed/inactive due to health/disability.

The scale of the challenge in GM is significant. There are approximately 225,000 people in GM claiming out of work benefits, and of these, 140,000 claim as a result of a health condition. Since 2012 unemployment in GM has been reducing overall, but disability-related worklessness has not. A further 200,000 families in work and reliant on Working Tax Credits to move them out of poverty. The cost to GM of worklessness and the impact of low-pay has now reached over £2 billion a year.

- In GM mental health and musculoskeletal issues are the main health problems cited by workless claimants of sickness-related benefits. GM Working Well demonstrates that 68% of clients state that poor mental health and 62% cite physical health as their biggest barriers to employment, whist 41% state that both mental and physical health issues are equally considered the largest barrier to employment.
- Twenty six per cent of the GM economically inactive population are inactive due to long-term sickness, compared to 22% in England as a whole. Again, levels are highest in Rochdale (32%), and lowest in Stockport and Trafford (20%). Temporary sickness

accounts for 3.4% of GM economically inactive population, well above the England average of 2.3%.

- In 2015, nearly a third (31%) of the GM working-age population had a health condition or illness lasting more than 12 months, compared to the England average of 29%. However, the GM average masks considerable variation across localities, ranging from 27% in Manchester to 37% in Tameside.
- Data from the 2011 Census show that 7.4% of the GM working-age population reported that they had a long-term health problem or disability that limited their day to day activity 'a lot'. There is similar variance by locality, ranging from 5.6% in Trafford (equal to the England average) to 8.7% in Rochdale.
- It is estimated that less than 30% of presenting issues at GP surgeries actually require clinical intervention, and 70% of appointments are actually down to issues around wider social determinants ('social prescribing'); furthermore, this figure rises in more deprived areas.

Strong progress has been made with Government to co-design testing of an alternative approach to welfare to work. The Working Well Programme assists those with health-related barriers, and other complex benefit claimants, to secure and sustain employment. Notwithstanding GM Working Well's success, it is critical to note that the Working Well, and its successor the Work and Health programme, will not have the capacity to address the issue of health-related worklessness at the scale required to make the impact we need in the numbers of claimants within GM. The new DWP/GM work and health programme aims to deliver to circa 20,000 claimants over 5 years, which reaches only a small proportion of those with health conditions that need support to return to work. There is a need to focus on what can be achieved *at scale* through a greater focus on work as a health outcome within the mainstream health and social care system.

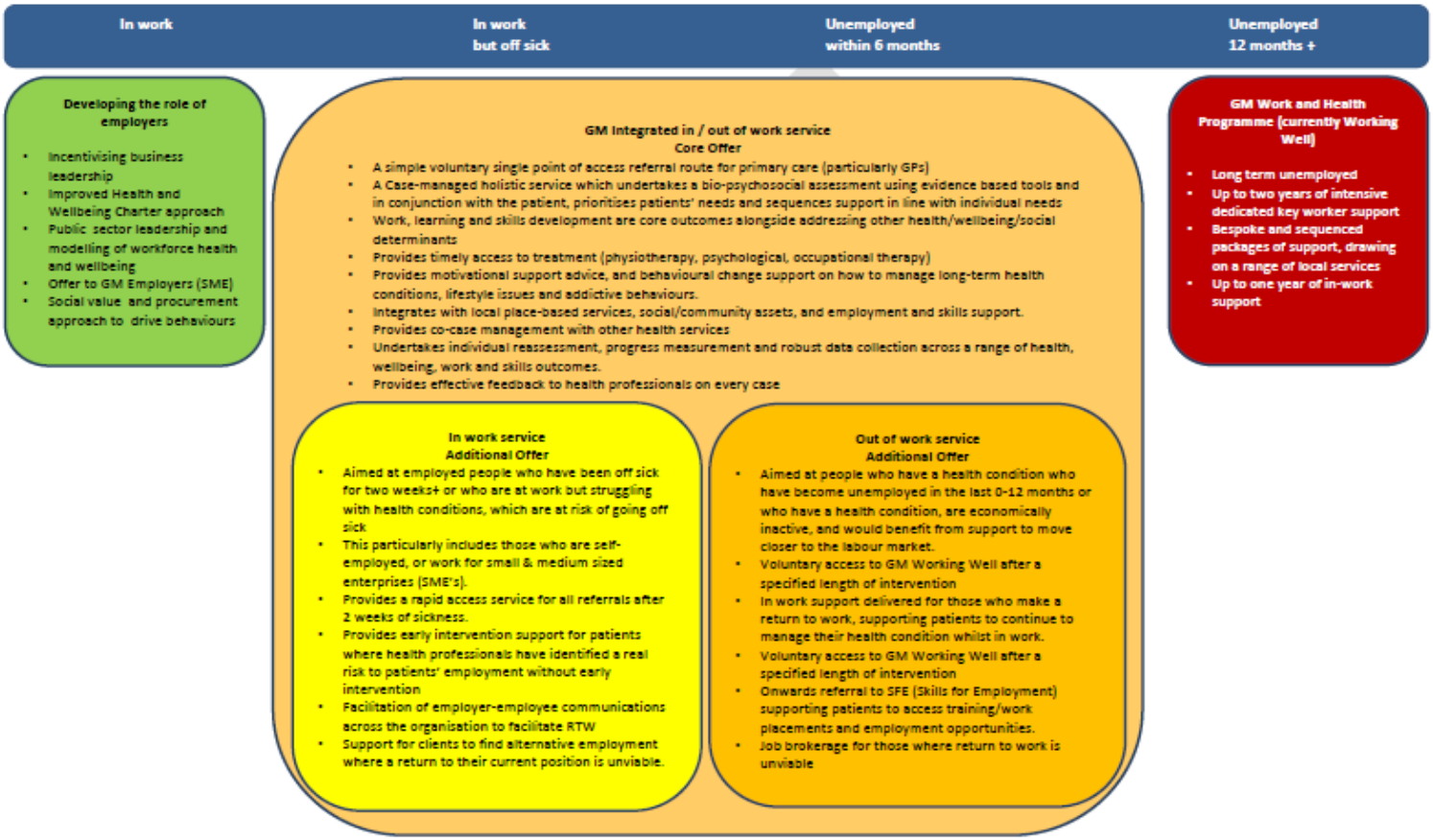
Intervention at scale to integrate work and health and thereby improve health and employment outcomes for the current and potential GM workforce will yield significant fiscal and economic benefit. Fiscal benefits flowing to government as a result of reduced worklessness and tax credit payments, and increased tax receipts, might potentially be encompassed in future devolution agreements under which GM receives a share of the up-side flowing to government and is then able to reinvest a proportion of these monies in further transformation activity.

Benefits flowing to the GM health and social care system as a result of reduced demand for reactive services will contribute to the future sustainability of GM and locality systems and help to narrow the estimated £1.2bn GM health and social care financial gap. In addition to these fiscal benefits, significant economic benefit will flow to local employers as a result of increased productivity and reduced sick pay payments, contributing to achievement of GM's wider growth ambitions.

Opportunity

Through the GM Population Health Plan there is an opportunity for work for health to be given the priority it should have in relation to patient care and approaches to improve population health within GM. A systematic approach to integrate healthcare provision with programmes designed to address the social and economic determinants of health will better support health outcomes for the individual, and realise the ambitions set out in the GM Strategy.

In terms of the opportunities available when looking at the different segments of the population, the two keys areas are those employees who become ill and are at risk falling out of employment and those who have become recently unemployed/ economically inactive.



In work but at risk: There current national offer is not meeting local need. The National Fit for Work Service, which is available to employers, employees or GPs to refer once the person has been off sick for four weeks or is likely to be, has struggled to engage General Practice or receive referrals employers. It does not provide rapid access to treatment.

There is evidence from the Manchester Fit for Work Service, which demonstrates that an earlier intervention offer which meets GP and patient need can be effective. The local service has 86% of Manchester GP practices making regular referrals and is achieving effective outcomes through a biopsychosocial approach. The return on investment demonstrated in an initial CBA suggests that this model offers good value for money.

We should look to test the approach at a wider scale in conjunction with discussion around devolution potential of the national scheme.

Out of work: The most significant gap is systematic support for those with health conditions who are recently unemployed, or economically inactive and not meeting the access criteria for Working Well. There is no single pathway for those with health conditions to access employment and skills support, condition management and other social determinants, at the scale required.

For both of these priorities, the key system interface at this critical risk point is the GP who holds responsibility for issuing Fit Notes. In most cases, there is little a GP can offer beyond medical services to expedite a return to work. Local examples from Salford, Bury and Manchester demonstrate that a trusted health and work pathway from primary care can be effective and well-used by GPs for those in or out of work with a health condition.

Initial CBA of the Manchester Fit for Work model suggests that it offers good value for money. For a relatively low unit cost per client, significant fiscal benefits were delivered, including reduced worklessness and associated benefit payments (flowing to government), and reactive cost savings (flowing to local partners) associated with reduced mental health disorders, GP and physio appointments, and alcohol dependency. The gross five-year fiscal return on investment for Manchester's In-work service was an estimated 1.25, and 1.35 for the Out-of-work service; for both services, payback (when the benefits begin to outweigh the initial investment) should be achieved in four years. The wider public value delivered by the Manchester initiative incorporates increased economic output and reduced costs to employers, along with softer social benefits related to improved individual well-being – the public value return on investment was estimated at £5.74 for the In-work service and £2.36 for the Out-of-work.

Predictive CBA for a GM scaled-up proposition is currently being undertaken. Whilst it is too early to report outputs from the modelling, the fiscal return on investment is expected to be higher than that reported for the Manchester interventions, not least due to the economies of scale and potential efficiency savings that delivery on a GM platform might generate.

Opportunities still to be scoped

The significant efforts made at both Manchester and GM level to move people back into employment will not achieve maximum gain if the work is not 'good work'. The role that employers can play is critical and significantly under developed, both in terms of protecting health, supporting skills development and career progression, and promoting longer, healthier lives. There is an economic case for stronger leadership across public, private and third sector partners at city and sub-regional levels.

Further work will take place over the next 12 months to scope the opportunities to supports employers to provide 'good' work, and employees to stay well in work.

Plan

The vision of this programme is to ensure that GM Health and Social Care Partnership has effective prevention and early intervention system in place which supports as many adults with health conditions as possible to return to, and remain in, good quality work. In order to do this the programme is to build and test an approach to work and health which improves the integration and alignment of health, employment and other services, to ensure that the target group can access the support they require at an early stage and before falling into long-term unemployment. It also aims to give individuals the tools to manage health conditions longer-term, build resilience and know where to go for other support when they need it.

The programme is set up to achieve the following core objectives

Objective 1: Develop a work and health support model which addresses the needs of the identified cohorts, underpinned by data, evidence and cost benefit analysis, and secure endorsement by stakeholders across GM.

Objective 2: Scope and determine the extent of current local work and health support delivered within GM, tested against the work and health model described under objective 1, scope procurement and delivery options and GM/Locality approach

Objective 3: Support a number of Localities to implement the work and health model,

Objective 4: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion and mainstreaming of the programme across the whole of GM based on the evidence.

<u>Approach to delivering objectives</u>

Objective 1: Define the work and health support model which addresses the needs of the identified cohorts, underpinned by data, evidence and cost benefit analysis, and agree appropriate funding mechanisms. .

The programme will seek to:

- Undertake detailed cohort analysis and modelling
- Define and agree the key features which need to be in place to deliver effective services to the cohort,
- Define the metrics through which to measure success
- Develop a CBA model
- Undertake a communication and engagement exercise with GM stakeholders
- Pursue and agree funding options including:
  - Work and Health Innovation Fund
  - GM Transformation Fund

Objective 2: Scope and determine the extent of current local work and health support delivered within GM to the defined cohort, tested against the defined work and health support model

The programme will seek to:

- Work with localities to identify the 'as is', taking into account local place-based delivery models.
- Hold discussions with localities where no offer is currently in place to understand appetite for implementing model and agree participation
- Undertake an options appraisal of the appropriate procurement and funding models to progress implementation with participating Localities

Objective 3: Support a number of localities to build on existing services or implement new provision to address gaps in service for the cohort

The project will seek to:

- Secure and put in place agreements with a number of localities to implement the model and test locally.
- Undertake a procurement exercise or implement agreed funding arrangements
- Provide programme management and delivery support to assist localities to develop
- Provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 4: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the programme across the whole of GM based on the evidence.

The programme will seek to:

- Collate analysis from implementation sites from across GM
- Update and further develop cost benefit analysis
- Collate local lessons learned to inform future development of the model for wider GM adoption
- Gain agreement from the system to expand the work and health support model to ensure coverage of remaining GM boroughs
- Produce and agree a plan for GM wide coverage

<u>Outcomes</u>

The programme will work towards achieving four key outcomes:

- Outcome 1: A work and health support model which addresses the needs of the identified cohorts, has been developed, endorsed by stakeholders and is supported by through an agreed investment approach.
- Outcome 2: The 'As Is' support service landscape for the target group is understood and locality appetite to test at scale new approach model has been explored.
- Outcome 3: A number of GM boroughs are implementing and testing the model for agreed cohorts and participating in evaluation.
- Outcome 4: A Business case and plan for refinement and extension of a GM wide rollout of the model produced and agreed

<u>Programme of work - Scope</u>

Overall the programme will work to the following principals:

1. *Early intervention when employees become ill and risk falling out of employment;*
2. *Early for those with a health condition who have become recently unemployed/ economically inactive to support them to make a return to work*
3. *Support for employers to provide 'good work', and for employees to stay healthy and productive in work*

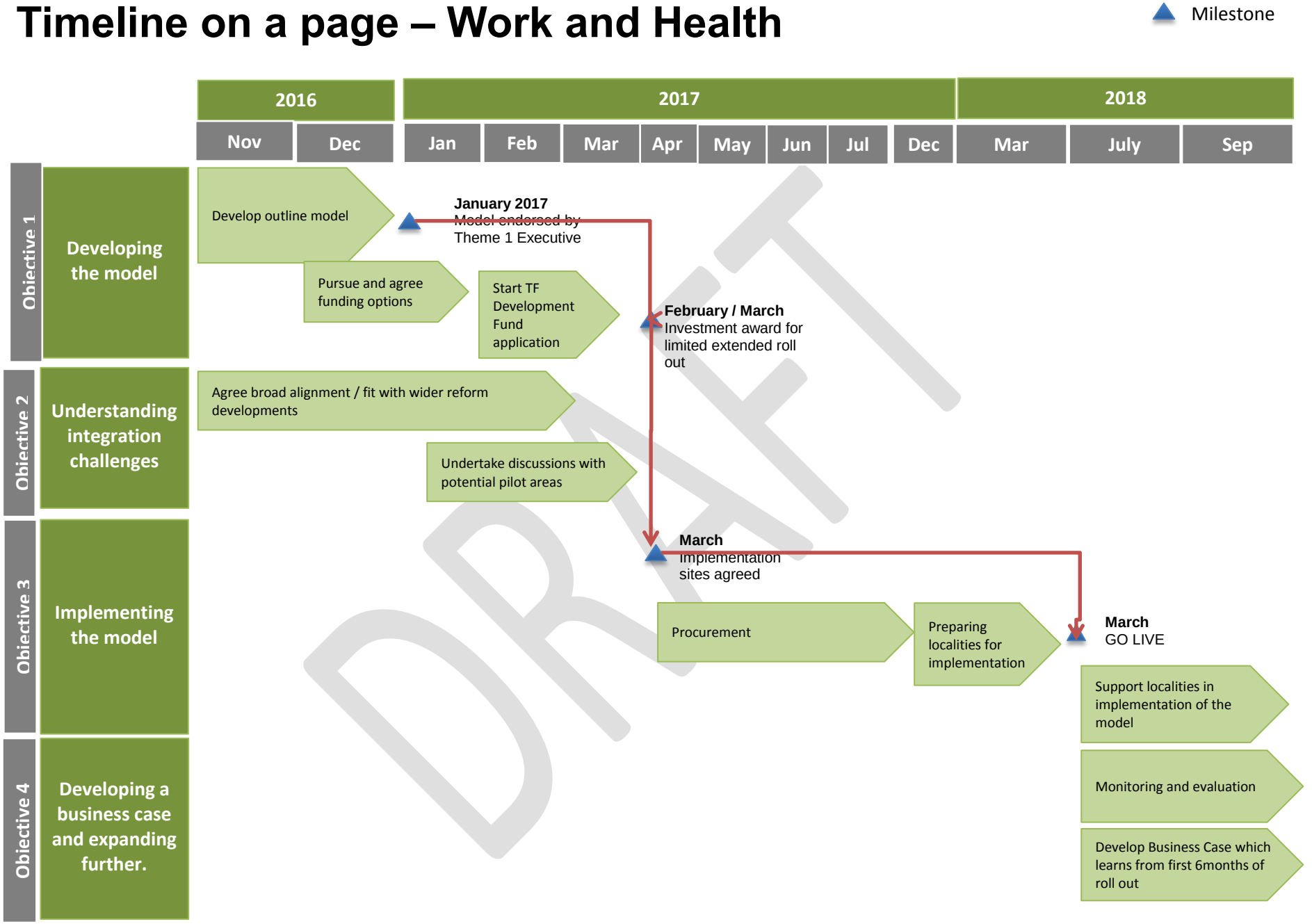
There are significant gaps within the system offer for each of these areas. Prevention from leaving the labour market is key. NICE evidence indicates that those out of work with a health condition for 6-12 months have a 2% chance of returning to employment, and after two years are more likely to die than return to employment. *Modelling from national data indicates that this is likely to be X people in GM.*

Population in scope

We are looking to test and evaluate approaches which address the work and health needs of the following groups of working age:

- Employed people who have been off sick for two weeks or more, and who require a biopsychosocial intervention to return to work as quickly as possible.
- Employed people who are at work but struggling with health conditions, which are at risk of going off sick and require a biopsychosocial intervention to remain effective and productive in work. This particularly includes those who are self-employed, or work for small and medium sized enterprises (SME's).
- People who have a health condition who have become unemployed in the last 0-12 months or who have a health condition, are economically inactive, and would benefit from support to move closer to the labour market.

Timeline on a page – Work and Health



New Model of Primary Care for Deprived Communities

Background

We know that people experiencing multiple disadvantages are more likely to have poor health, alongside a range of other challenges including homelessness, worklessness, substance misuse, mental illness, poverty, violence and abuse.

Tackling these inequalities in health requires universally proportionate services to address the larger part of the inequalities gradient. There is also a need for tailored provision for the most disadvantaged communities, where multiple social determinants of ill health, clustering of risk behaviours, and early impact of multi-morbidities come together. These communities often experience (statistically) significant differences from the rest of the population.

Intervention through services can widen health gaps, if attention is not focussed on inequalities in access and outcomes. Often it is the most disadvantaged that make the least effective use of services and this can be exacerbated if they are offered poor levels of service (the Inverse Care 'Law'). This mismatch of need and demand can be portrayed as those 'missing' from services.

People who face severe disadvantage need genuine opportunities to transform their lives. Opportunities that help the individual overcome all aspects of the disadvantage so that they can be and do the things they value in life.

Too often, people struggle to get the support they need and there is a strong chance that the disadvantages they face will become more severe. This means that when they do present to support agencies, the focus is on managing problematic behaviours and the risks these present rather than addressing the person's underlying issues. This can escalate the severity of problems even further. Rather than responding to what the person is experiencing, a range of disconnected services are delivered each tackling individual problems. This means that people who most need support find it difficult to navigate a complex structure of help, meaning they access services late or not at all.

GM Context

In spite of GM's increasing economic prosperity, health inequalities persist with 20% of our population living in the 10% of most disadvantaged areas nationally.

Across GM, we are developing models of place-based integration of services intended to identify early those people at risk of developing more complex issues that, over time, could place significant pressure on services and lead to poorer outcomes for individuals or families.

Each locality across GM is in the process of implementing an approach to place-based integration. Based on the learning from these early adopter sites, district-wide roll-out plans will then be developed. By April 2017, plans will be in place for place-based integration across each part GM.

Through GM's place-based integration work, teams are being brought together from a wide range of organisations. Bringing together police, local authority, health, housing, fire, the voluntary sector, and others as needed. They are working with local residents in a new way. Rather than assessing and referring across the system, place-based teams are working

together to agree how they can actively work with people to address the range of challenges they may face. They are sharing information, taking time to understand what may be the underlying factors contributing to the challenges faced by residents and agreeing what action to take through asset-based conversations with the residents they are working with.

This work is having positive impact. Early analysis has highlighted that up to 70% of referrals across public services are generated by other parts of the public sector. We are assessing and referring, passing people around the system rather than helping them address the challenges they may be facing. By working in a new way, by intervening early and collaborating in our approach we can cut down that referral across the system and reduce the likelihood of issues escalating for the people we are working with.

Health and social care services are already engaged in this work. However, there is scope to increase that involvement, drawing in a wider range of health and social care services. Early work has identified the value of mental health professionals being full-time members of these teams. GP engagement in place-based integration models has been invaluable in those areas that have trialled work with GPs. The link into Social Care will be fundamental to the success of this new way of working. Through aligning our population health strategy with GM's approach to place-based integration we have the capacity to enrich our collective approach to new models of support.

Through place-based integration models there is significant opportunity to address issues that contribute to poor population health outcomes. Alongside this, there is also opportunity to build system-wide alignment with other elements of our health and social care transformation work, such as social care.

Work is ongoing to support further integration and alignment of the health and social care programme with place-based integration by: developing a health and social care offer in a broader place-based early intervention model; supporting localities to identify the specific health and social care services and interventions that could strengthen place-based integration in their locality; supporting the development of a cross-sector Early Help Strategy in each locality; ensuring this work is reflected in and informed by Locality Plans.

We will ensure the GM place-based integration roll-out delivers on our GM wide reform ambitions, including the delivery of our health and social care strategy. Our goal is to ensure people will no longer need to navigate fragmented systems and services.

Opportunity

General Practice has a pivotal role to play in supporting the most disadvantaged and place based integration of services. GPs are usually the first point of contact with NHS provision, although it is set against the context of the capacity challenge associated with serving populations who have a lower healthy life expectancy and experience more years living with multiple morbidities.

The ability to be able to provide preventative interventions and continuity of care are seen as the two key assets that GPs can deploy. GPs have repeated contact with their patients and are therefore ideally placed to understand the underlying causes of poor health, whether medical or social.

However, delivering effective primary care in the poorest communities is challenging. Some diseases are more prevalent in practices serving deprived populations, particularly mental health conditions and there are higher levels of A&E attendances, emergency hospital

admissions and primary care usage amongst these communities. Consultations in these practices are characterised by: higher demand, greater time constraints, greater psychological and physical morbidity, more multi-morbidity, less enablement reported by patients with complex problems and greater GP stress. Furthermore people's medical needs are intimately inter-woven with emotional, psychological, financial and social problems.

Focused care is a model that has been developed in GM from the work of Hope Citadel Healthcare CIC. It is a response to the frustration GPs get when seeing patients experiencing multiple disadvantage knowing they cannot do much in a 10 minute appointment but recognising great need. Often these patients are the most invisible to the normal workings of the NHS but they are often very expensive. They present late with significant conditions, they turn up frequently and randomly at acute services.

Focused care is a systemised, standardised holistic approach now operating in 8 GP practices in GM. The model has been shown to change both patient and clinician behaviour and has led to improved outcomes and improved engagement and utilisation of services.

In essence, Focused Care is a holistic approach which:

- Makes the invisible visible and keep them visible
- Uses a clinical case discussion across disciplines and agencies by people who know the patient
- Keeps the responsibility for the patient at the GP surgery; the promotion of the value that these are our patients and we will do our best for them.
- Recognises the importance of relationships and that trust is a valuable commodity.
- The use of a focused care practitioner that enables households supported by mutually agreed plans
- Fosters close working relationships with other agencies.

It has been likened to a MacMillan service for very deprived communities. Early cost: benefit analysis suggests a 3:1 return on investment can be achieved.

<u>Future opportunities</u>

Expanding the Focused Care approach to facilitate General Practice involvement in place-based integration is a first step to developing an enhanced model of general medical care in which "find and treat" is supported by condition management services, social prescribing, pathways into work, active promotion of self-care and health literacy, underpinned by person-centred approach. Work has started to scope such a model.

Plan

The vision for this programme of work is to ensure that GM has an effective system in place to meet the needs of the most disadvantaged in our communities. We have developed a unique collaboration with the Shared Health Foundation, an initiative of the Oglesby Charitable Trust (OCT), which is seeking to tackle health inequalities across GM. We will develop new service responses which support General Practice to work differently for people who face severe disadvantage by enabling genuine opportunities for people to transform their lives. Opportunities that help the individual overcome all aspects of the disadvantage so that they can be and do the things they value in life.

The programme is set up to achieve the following core objectives:

- Objective 1: Provide proof of concept for the Focus Care approach by testing the model in 10 deprived practices in GM
- Objective 2: Test the Focused Care approach to facilitate General Practice involvement in place-based integration
- Objective 3: Develop a business case to support the future expansion and mainstreaming of the new care model including exploration of sustainable funding mechanisms.

Approach to delivering objectives

Objective 1: Provide proof of concept for the Focus Care approach by testing the model in 10 deprived practices in GM

The programme will seek to:

- Identify 10 suitable practices serving the most deprived areas and providing a good geographical spread across GM.
- Work with SHF to develop an appropriate delivery vehicle for Focused Care.
- Work with SHF and New Economy to develop outcome framework and key success measures.

Objective 2: Test the Focused Care approach to facilitate General Practice involvement in place-based integration

The programme will seek to:

- Identify 3 suitable practices serving the most deprived areas in place-based integration pilot areas.
- developing a general practice contribution to the health and social care offer in a broader place-based early intervention model;
- supporting the development of a cross-sector Early Help Strategy in each locality;
- ensuring this work is reflected in and informed by Locality Plans

Objective 3: Develop a business case to support the future expansion and mainstreaming of the new care model including exploration of sustainable funding mechanisms.

The programme will seek to:

- Develop a Cost:Benefit model.
- Pursue and agree funding options including: Social Impact Bonds, GM Transformation Fund, and Life Chances Fund.

Outcomes

The programme will work towards achieving three key outcomes:

Outcome 1: A systemised, standardised holistic approach which supports behaviour change in both patient and clinician resulting in improved outcomes and improved engagement and utilisation of services.

Outcome 2: The Focused Care approach to facilitate General Practice involvement in place-based integration and appetite to scale up has been explored and is understood in localities.

Outcome 3: Business case and plan for GM roll out procured and agreed.

Programme of work scope

Overall the programme will work in the following way:

Focused Care has no acceptance criteria. In an environment of social complexity and "chaoticness", referral criteria are not helpful. There is no single clearly defined population group affected. For example a single mother with 4 children might actually be thriving in life whilst a single man in his 50s may not be. Experience has shown that often patients on focussed care don't meet criteria for other services, or have been rejected for other services. Patients in this cohort often end up being passed from pillar to post.

Focussed ensures that decision making takes place and plans are made. Vulnerable patients can also be identified from practice data using proxies. In Oldham a pilot is also allowing council data to be integrated into this so for example, in areas of deprivation the reason children have not been immunised is not because their parents have read the literature and decided they are not being vaccinated, it is because life is chaotic and they have never been. This is an indication that the Focused Care approach might be needed.

Population in scope

Focussed care has a case load of 50 households per 2 days of focussed care time. In previous analysis this represents about 2-4% of a deprived practice list per year. The equation used is 2 days of focussed care per 2500 patients on a list.

Timeline

To be produced

Incentivising and Supporting Healthy Behaviours

Background

People's health behaviours are widely known to affect their health and risk of mortality. Close to half of the burden of illness in developed countries is associated with the four main unhealthy behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity

As outlined in the Five Year Forward View, the future health of the nation, the sustainability of the NHS and future economic prosperity all now depend on a radical upgrade in prevention and public health. Twelve years ago, the Wanless Review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and now we are facing a crisis in our health and social care services.

Despite improvements in population health, fewer than 70% of us still engage in two or more lifestyle risk factors. Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce deep health inequalities which can cascade down to generations. For example, smoking rates during pregnancy range from 2% in West London to 28% in Blackpool.

The number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they are in their final year, nearly one-in-five are then obese.

As our populations health risk gets worse, the burden on our health and social care system increases. To take just one example from the Five Year Forward View – Diabetes UK estimate that the NHS is already spending approximately £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic.

Our current health challenges require widespread behaviour change. We need behaviour change at scale to respond to the rise in chronic disease. New types of approaches are needed which reduce unhealthy behaviours, such as smoking, and increase healthy behaviours, such as physical activity. In particular we need to find effective ways to help people in lower socio economic groups to reduce their multiple unhealthy behaviours.

Evidence indicates that reductions in unhealthy behaviours that have been achieved to date are mostly confined to the higher socio economic groups who respond better to social marketing campaigns.

GM Context

Evidence supports the need to upscale behaviour change support services across the conurbation. There are just under two million adults aged over 19 living in GM. Among these it is estimated that:

- 730,000 adults regularly consume less than four portions of vegetables and/or fruit per day;
- 270,000 adults smoke every day

- 560,000 adults binge drink (consume twice the daily recommended alcohol levels at least once a week or once a month among men and women, respectively);
- 1m adults are physically inactive (less than two hours of physical activity per week).

The Kings Fund (2012) also estimates that 70% of adults in England engage in two or more of these unhealthy behaviours.

For many people, particularly those with entrenched behaviours, successful behaviour change relies on goal planning, social support, feedback and monitoring. Coaching may also be of benefit to build motivation and give confidence.

In addition service responses need to move away from targeting single health issues to more holistic approaches based on people and the social context of behaviour change over their lives.

Opportunity

Devolution in GM provides the opportunity to look at whole system innovative approaches to these major health risks, in order to fully harness the positive potential health impacts of the third sector, local government, employers and local communities themselves.

We will actively support comprehensive, broad based and hard hitting regional action to include: (*waiting for input from PHE - Reference work re MOU with Sport England)*

The drive to more person centred wellness and lifestyle services that recognises that many of our GM population have multiple unhealthy lifestyle risk factors, and requires person centred approaches which address the psychosocial and wider determinants of health has been around for a number of years , however progress has been slow. In addition the reach of such services into the populations most at need is limited and more work needs to be done to extend such service offers into the C2DE cohort, with particular focus on 40 to 60 year olds. Devolution offers us an opportunity to deliver a radical upgrade in lifestyle behaviour change support, that delivers innovative approaches at scale to drive long term behaviour changes and reduces current and future demand on health services from lifestyle related long term conditions.

We also want to ensure that as a public sector, and major employer accounting for over 18% of all jobs in the region that we are a positive role model for workplace health, innovating and implementing best practice to support our 219,400 staff to stay healthy and serve as health champions in their local communities.

Plan

<u>Objectives</u>

The objectives of this programme are to develop a whole systems approach to lifestyle and wellness services, including testing innovative service delivery models for incentivising and supporting lifestyle behaviour change.

- Objective 1: Work with a pathfinder local provider, to test out and develop an effective delivery model aimed at promoting a radical upgrade in self-care and lifestyle prevention, which can be tested at scale in parts of GM.
- Objective 2: Develop and test an innovative incentives based digital platform to support lifestyle behaviour change at scale aimed at GMs public sector workforce.

- Objective 3: Develop standards and a performance framework for GM integrated wellness services to ensure a more standardised offer for GM residents.

Approach to delivering objectives

Objective 1: Work with a pathfinder local provider, to test out and develop an effective delivery model aimed at promoting a radical upgrade in self-care and lifestyle prevention, which can be tested at scale in parts of GM.

This project will seek to:

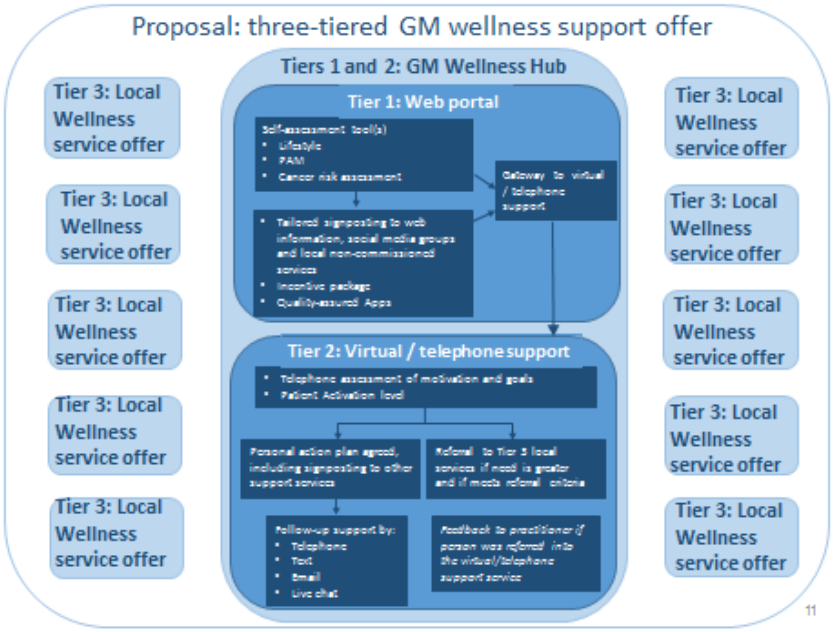
- Use national exemplars and local good practice to document a replicable and scalable model which can be tested at scale in parts of GM.
- Develop a costings model which includes staffing costs, non-pay budget to secure services of an expert reference group
- Secure local provider partners to be part of the trial
- Work with New Economy to develop an initial cost benefit analysis based on work to date and to support development of transformation bid.
- Develop a business case to support the adoption and testing of the new model across 2/3 localities and secure monies from transformation fund
- Support a number of localities to collaborate to implement the described model recognising the local variations that may be required.
- Develop a business case which builds on the evaluation of testing the model to support expansion of the project across other parts of GM.

Programme of work- scope

The proposal is to develop a three tiered behaviour change support offer across GM. This is in effect a hub and spoke model. The first two tiers including a web portal and virtual telephone support can be provided at a sector level and will integrate with the third tier which is the locality based lifestyle and wellness service offer.

A key principle is that of proportionate universalism, where the service response will be according to need.

The primary audience for the service will be the One You target demographic, which is C2DE aged 40-60, because evidence suggests a strong link between unhealthy behaviours and social class and NICE identifies the 40-60 age group as a key window of opportunity to engage adults in their own health to prevent disease in later life. This enables GM to capitalise on the current national campaign of focus (One You) and prioritise digital content to support its delivery.



Objective 2: Develop and test an innovative incentives based digital platform to support lifestyle behaviour change at scale aimed at GMs public sector workforce.

The project will seek to:

- Secure an existing developer to develop a bespoke incentivised digital health platform to support at scale self-care and pilot programme with GM public sector staff
- Undertake consumer research to ensure that the incentives package is attractive to the target audience
- Work with developer and New Economy to carry out cost benefit analysis to support bid to transformation fund
- Develop a costings model which includes staffing costs, non-pay budget to secure services of an expert reference group
- Develop and secure transformation funding to resource the development , commissioning and evaluation of a pilot programme for GM public sector staff
- Evaluate service model to inform further roll out

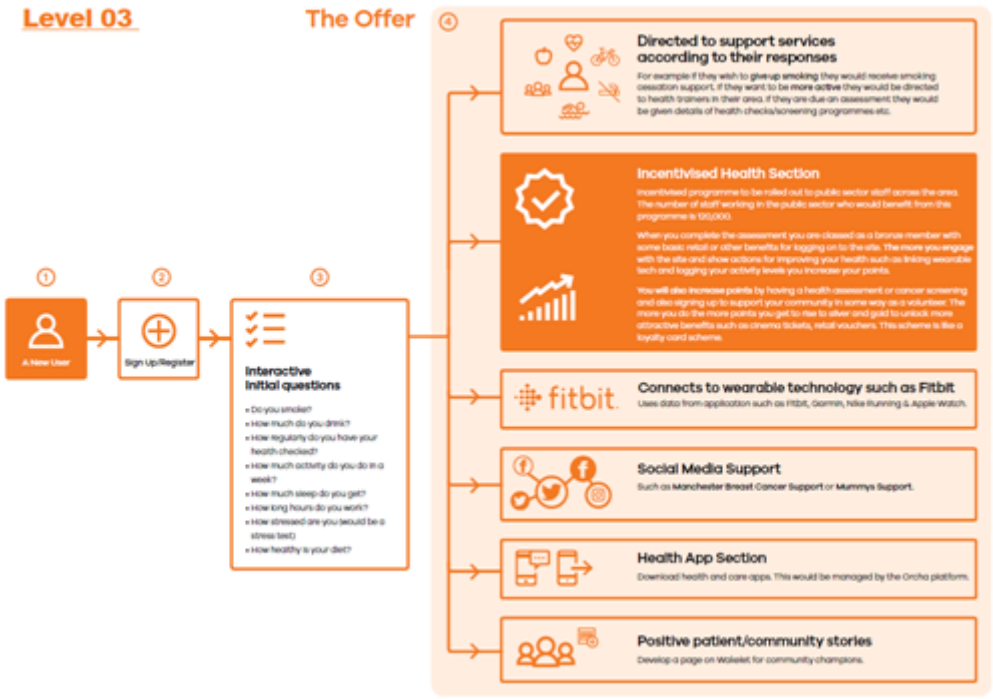
<u>Programme of work – scope</u>

This is more basic service delivery model in comparison with the lifestyle and wellness hub described above.

Its central feature is the provision of an on line incentives package which rewards participants for undertaking health promoting behaviours such as screening, or quitting smoking.

It would take the form of a digital platform, with an interactive directory and incentivised health platform.

Such a platform could also support other digital offers, such as Orcha, a Wakelet page for community champions and access to managed social media options.



Objective 3: Develop standards and a performance framework for GM integrated wellness services to ensure a more standardised offer for GM residents.

The project will seek to:

- Define key standards and performance metrics that describes a consistency of approach and quality against which services can be commissioned, monitored and evaluated
- Gain agreement from the system to adopt and implement the standards and performance framework
- Launch the framework to cement support across the system for this way of working.

Target outcomes for (16/17) and (17/18)

Outcome 1: New delivery model tested and evaluated with pathfinder local provider aimed at promoting a radical upgrade in lifestyle prevention and self-care

Outcome 2: Innovative incentives package to support lifestyle behaviour change for public sector workforce tested and evaluated

Outcome 3: GM will have a standards and performance framework for lifestyle services agreed by all commissioners to support localities

5. Ageing Well

Housing

Background

The home is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing, precarious housing circumstances or lack accommodation altogether. Generally speaking, the health of older people, children, disabled people and people with long-term illnesses are at a greater risk from poor housing conditions.

Direct effects of cold homes on a person's health can include: heart attacks, stroke, respiratory disease, flu, falls and injuries, hypothermia. The indirect effects are poor mental health and risk of carbon monoxide poisoning. This in turn can lead to greater demand for health and emergency services. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer.

Poor housing is estimated to cost the NHS at least £600 million per year.

In England and Wales trends in excess winter deaths have decreased by about 30 per cent since 2008/09, where there were 36,450 deaths attributable to all causes. In 2010/11 there were 25,700 excess winter deaths. The majority of these occurred among those aged 75 and over.

From estimates of the Excess Winter Mortality Index (EWM Index) by the Office for National Statistics, circulatory diseases caused 37 per cent of excess winter deaths in 2009/10. Respiratory diseases came in second and accounted for 32 per cent. Cold homes are one contributor to this, and increase the risk of cardiovascular, respiratory and rheumatoid diseases as well as hypothermia and poorer mental health. Older, retired people are particularly at risk.

Around 1.8 million homes had damp problems in 2009. Privately rented homes were most likely to experience damp problems: 15 per cent compared to 8 per cent of owner-occupied homes and 10 per cent of social housing. Twelve per cent of poor households lived with damp problems compared with 7 per cent of other households.

There is evidence that interventions to improve the quality and suitability of the home environment can be effective in preventing, delaying and reducing demand for social care and health care; enable people to manage their health and care needs; and allow people to remain in their own homes for as long as they choose. There are substantial health benefits associated with improvements to housing conditions, for example: cavity wall insulation can save 0.049 QALY equating to a health saving of £969.

One in three people aged over 65, and half of those aged over 80, fall at least once a year. Falls are the commonest cause of death from injury in the over 65s, and many falls result in fractures and/or head injuries. Falls cost the NHS more than £2 billion per year and also have a knock-on effect on productivity costs in terms of carer time and absence from work.

Unsuitability of housing and the need for suitably adapted property can also prevent a timely transfer of care for patients back to their home from hospital. In a six month period in 2015, 916 days where reported as delayed waiting for adaptations. A potential cost of £732,800 per year, assuming the cost of an acute bed to be £400 per day.

Housing plays a critical role in helping older people and adults with disabilities or mental health problems to live as independently as possible, and in helping carers and the wider health and social care system offer support more effectively. Evidence shows that Government investment in specialised housing for these groups is cost-effective; with a positive impact on health and social care spend, through for example, the prevention of falls, or a reduction in the levels of re-admittance to hospital. Poor or inappropriate housing has been shown to put the health and wellbeing of people at risk. Evidence also demonstrates that a wide variety of outcomes are better for those living in specialised housing compared to regular housing.

The lack of an adequate supply of specialised housing, means people are not able to make suitable housing choices, and are forced to stay in less suitable accommodation when, given the opportunity, they may wish to move. Furthermore, there is a lack of public awareness of the wider variety of housing models or solutions available.

In terms of the national policy context, the recent "Memorandum of Understanding to Support Joint Action on Improving Health through the Home" (2014), recognises that the home environment is essential to health and well-being. By ensuring homes are safe, warm and dry, it can:

- Delay and reduce the need for primary care and social care interventions, including admission to long-term care settings;
- Prevent hospital admissions;
- Enable timely discharge from hospital and prevent re-admissions to hospital;
- Enable rapid recovery from periods of ill-health or planned admissions.

The 'home' becomes a vital component in developing successful integrated services. The role that the housing sector can play, in assisting people to live independently for longer, is often underestimated and unrecognised by commissioning bodies.

The provision of adaptations to the home through Disabled Facilities Grants (DFG's) is a statutory requirement for Local Authorities. The funding stream recently became part of the Better Care Fund. The Care Act 2014 placed a responsibility on Local Authorities to ensure suitability of the living environment and recognised that preventative services such as Handyperson schemes can play a key role in ensuring people are able to live independently for longer.

GM Context

Housing growth is a priority for GM and having the right type of homes to meet the needs of the population is fundamental to this. The emerging GM Spatial Framework highlights the increasing ageing population and provisions that will need to be put in place to accommodate the changing demographic.

The GM Low Carbon Hub has a priority to reduce fuel poverty through retrofitting existing homes with energy efficient measures and behaviour change. More generally, Local Authority housing officers and Registered Providers recognise the contribution that providing good quality housing can have on an individual and their ability to live independently. However this also has an impact on the health and social care system by reducing demand for health and social care through the integration of housing interventions.

By aligning our housing priorities with the vision for health at a GM strategic level, we will be able to achieve:

- A better quality of life for our residents by 2020 and assist with closing the health inequalities gap
- A clear focus on prevention and reablement;
- Promote self- care at home and improve community resilience;
- Support effective discharge from hospital.

GM wide schemes focussed on fuel poverty and energy efficiency have been successful in the past, ensuring the delivery of a baseline offer of insulation, boiler replacements, energy switching and behaviour change advice to residents in GM. However these programmes have been reliant on government funding which have ceased and now the emphasis is to work with private sector energy companies who have an obligation to assist vulnerable households. However this tends to be restrictive and cannot deliver at the same scale as when Government funding was available.

Opportunity

The next decade will see dramatic growth in the number of older people seeking help to remain at home as long as possible, while LA's, health and social care conversely face continuing pressure to reduce costs and seek efficiencies. Home Improvement Agencies (HIA) carry out small handyperson jobs, project-manage larger repairs and adaptations, as well as providing housing information and advice, for older and disabled customers. One main source of grant funding for the sector's activities, the Disabled Facilities Grant (DFG), is now part of the Better Care Fund (BCF), and the HIA sector has a central role in the government's ambition for an integrated health and care system which promotes wellbeing at home and can provide a preventative response to reduce, delay or remove the need for costly institutional alternatives.

Integrating a Home Improvement Agency model into a much larger jigsaw will ensure a greater range of resources, products and services can be deployed to keep a person living healthily at home. For health trusts and clinical commissioning groups, HIAs provide 'home-readying' services to ease hospital discharges, prevent re-admission, and provide the means to better self-manage health conditions.

Across GM, different approaches have been taken to understanding the extent of poor quality housing and also the level of interventions available. About half of the Local Authorities run a Home Improvement Agency; however some are more comprehensive than others. A number of local authorities use Age UK's handyperson service. There are best practice examples within GM including Manchester Care and Repair, Bolton Care and Repair and St Vincent's Homecare and Repair. Please see appendix 1 for an example of Bolton and St Vincent's model.

Discussions have been undertaken with Health, Strategic Housing, Registered Providers and the Low Carbon Hub on the concept of a GM HIA model and there is broad support.

The establishment of a GM Home Improvement Agency model, which builds on existing models in operation, would ensure that all districts are able to provide a basic offer to older and disabled residents, whilst also providing a single access point for health and social care professionals to refer into. Procurement of adaptations and a handy person service for GM is also likely to lead to efficiencies. There is also scope to link GM Fire Service Safe and Well checks into the model.

Targeting of customers most likely to be living in unsuitable housing, suffering from respiratory diseases, at risk of falls etc. and in receipt of home care packages, would ensure resources are spent where most needed.

Plan

Objectives

The objectives of this programme of work is to help facilitate the roll out, testing and evaluation of an approach to tackling issues around poor quality housing based on the work already taking place across GM, in line with the other theme 1 proposals aimed at promoting an effective response to population ageing. The project is set up to achieve the following core objectives

- Objective 1: Develop and document a replicable and scalable model, which can be tested at scale in a cluster of districts in GM
- Objective 2: Support a number of localities in implementing the described model recognising the local variations that may be required
- Objective 3: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of GM based on the evidence.

Approach to delivering objectives

Objective 1: Develop and document a replicable and scalable model, which can be tested at scale in a cluster of districts in GM.

The project will seek to:

- Describe a GM vision around tackling issues of poor quality housing and a GM HIA.
- Work with GM districts who already have a HIA in operation to carry out an initial cost benefit analysis based on the finding to date and agree metrics for evaluation of future GM implementation sites
- Develop a costings model which includes staffing costs, service provision and interventions and identify sources of funding.
- Develop and secure transformation funding to fund roll out in totality for X localities to adopt and test the model

Objective 2: Support a number of localities in implementing the described model

The project will seek to:

- Secure and put in place agreements with a number of localities to implement the model and test locally.
- Provide programme management and delivery support to initial and roll out model across each of the boroughs (this could be shared across more than one borough)
- Provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of GM based on the evidence.

The project will seek to:

- Collate analysis from implementation sites from across GM
- Update and further develop cost benefit analysis developed for the model
- Collate local lessons learned to inform future development of the model for wider GM adoption
- Gain agreement from the system to fully roll the model out to the remaining GM boroughs
- Produce and agree a plan for GM wide roll out.

Target outcomes for (16/17) and (17/18)

The programme will work towards achieving three key outcomes:

- Outcome 1: Partnership working with existing HIA's and New Economy Manchester have developed a replicable and scalable model, which can be tested at scale in other parts of GM using Transformation Funding
- Outcome 2: A number of GM borough have implemented the model
- Outcome 3: A Business case and plan for the GM wide rollout of the model produced and agreed

Programme of work – Scope

The GM HIA model would be available to all older people aged 60 plus and disabled people across GM. It is envisaged that there would be a core service and a menu of options that localities can adopt/commission.

Within the scope of the service, the intention is to include:

- Delivery of Disabled Facilities Grants
- Handyperson service
- Fuel Poverty/energy efficiency measures
- Home Improvements
- Project management/Handholding service
- Advice and assistance – fuel poverty, housing options, benefits.
- Referral mechanisms
- Home safety checks e.g. Safe and Well checks

There is also scope to include:

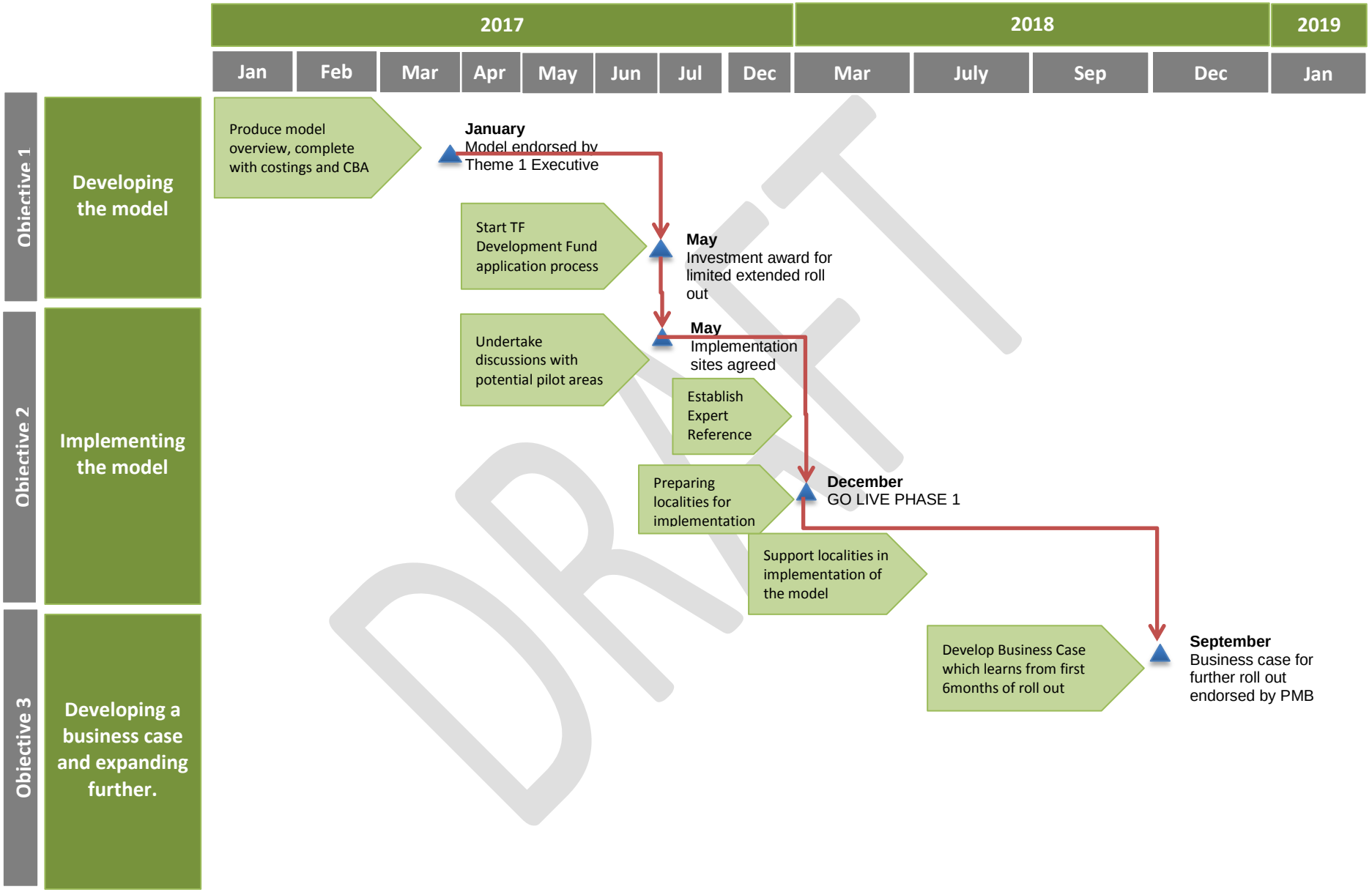
- Home from hospital/Hospital Discharge services
- Hoarding Service
- Community equipment
- Community Alarm and assistive technology services
- Falls prevention

It will be important that referrals are enabled into and out of the service by housing, health and social care workers. Self -referral and self- funding will also be integral to the model.

Funding sources are likely to be varied with a management fee taken from DFG funding being the core and sustainable contributor. Other sources of funding could include bidding

for grants, private sector and fee generation. Transformation funding is likely to be required to develop the scalable model and kick start delivery.

Timeline on a page - Housing



Nutrition and Hydration

Background

There is a good evidence base, drawing on the literature and operational experiences, relating to the role of nutrition and hydration in supporting good overall health, independence and avoidable deterioration in older age. The risk and prevalence of malnutrition increases with age so we should expect the likely rate of malnutrition to rise as the population ages (National Prescribing Centre, 2012). Some experts place the potential prevalence of malnutrition at as much as 40% of the 65+ population. NICE guidance for commissioners (2012) estimates the following prevalence in different settings: 30% of hospital admissions, 35% of care home residents, 10-14% of people living in sheltered housing and other sources suggest an assumed prevalence among older adults receiving day care and domiciliary/home care of 18%.

However, the Kings Fund observed in its 2014 report on the readiness of the health and care system to respond to an ageing population, that it is often regarded as a 'minor' factor in maintaining independence and wellbeing, alongside issues like foot health, visual and hearing impairment, incontinence and oral health (King Fund, 2014).

What is perhaps different about malnutrition and dehydration is that it can go unnoticed and therefore untreated - the majority (93%) of people at risk of malnutrition live in the community, it often develops over the medium to long-term and there is rarely a specific, treatable 'symptom' associated with it until it becomes very severe. Yet it can undermine mobility, steadiness (leading to falls), healing and recovery, mental alertness and energy levels. Outcomes are therefore much worse for older people who are malnourished and the same is true of dehydration.

In terms of the national policy context, the Malnutrition Prevention Programme overseen by the Malnutrition Task Force (MTF) was a Department of Health funded scheme to help the 1 million older people in England suffering from or at risk of malnutrition. The Programme was part of the Government's response to the Francis Report into the failings at the Mid Staffordshire Foundation Trust (see 'Recommendation 241' on the Department of Health website). The report revealed that patients, many of them older, had been unable to eat or drink properly and that nutrition and hydration was not treated as a priority. The Programme aimed to engage whole communities – local NHS trusts, City Councils, GP practices, care homes and third sector to come together to tackle malnutrition. The aim is to significantly reduce the number of people aged 65 and over in these areas who are malnourished. The pilot areas were Gateshead, Salford, Purbeck in Dorset, Kent and Lambeth and Southwark.

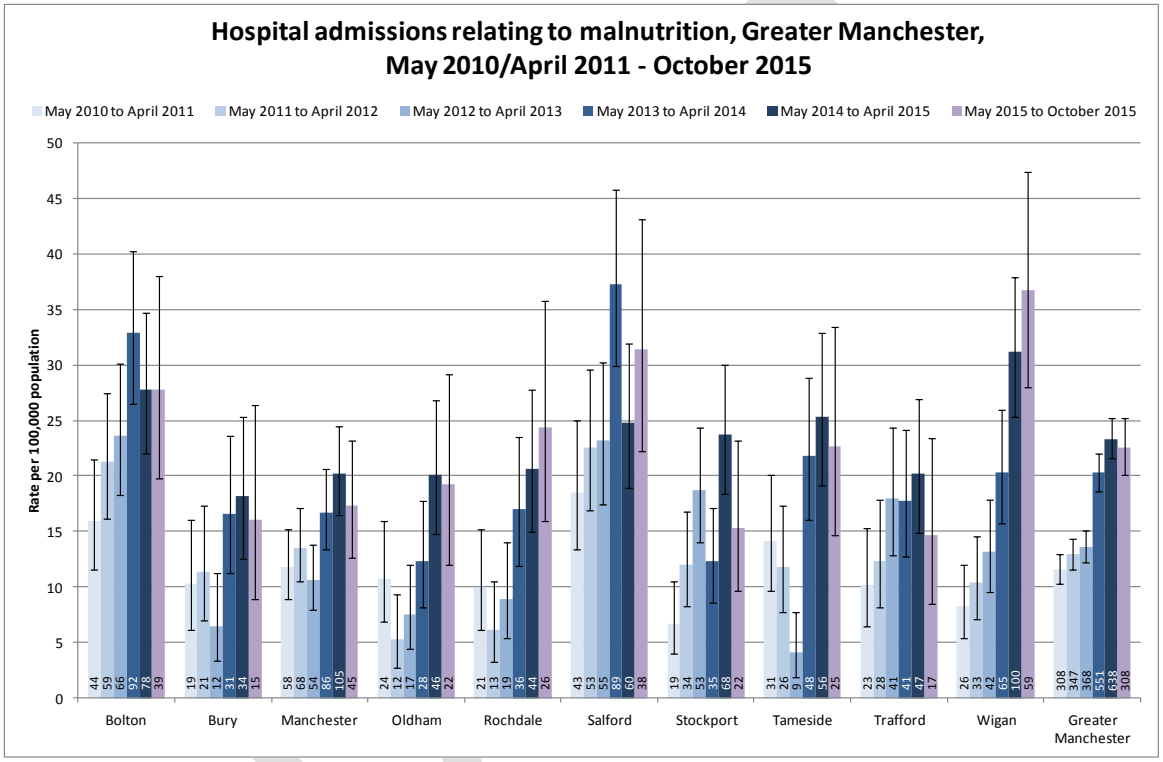
GM Context

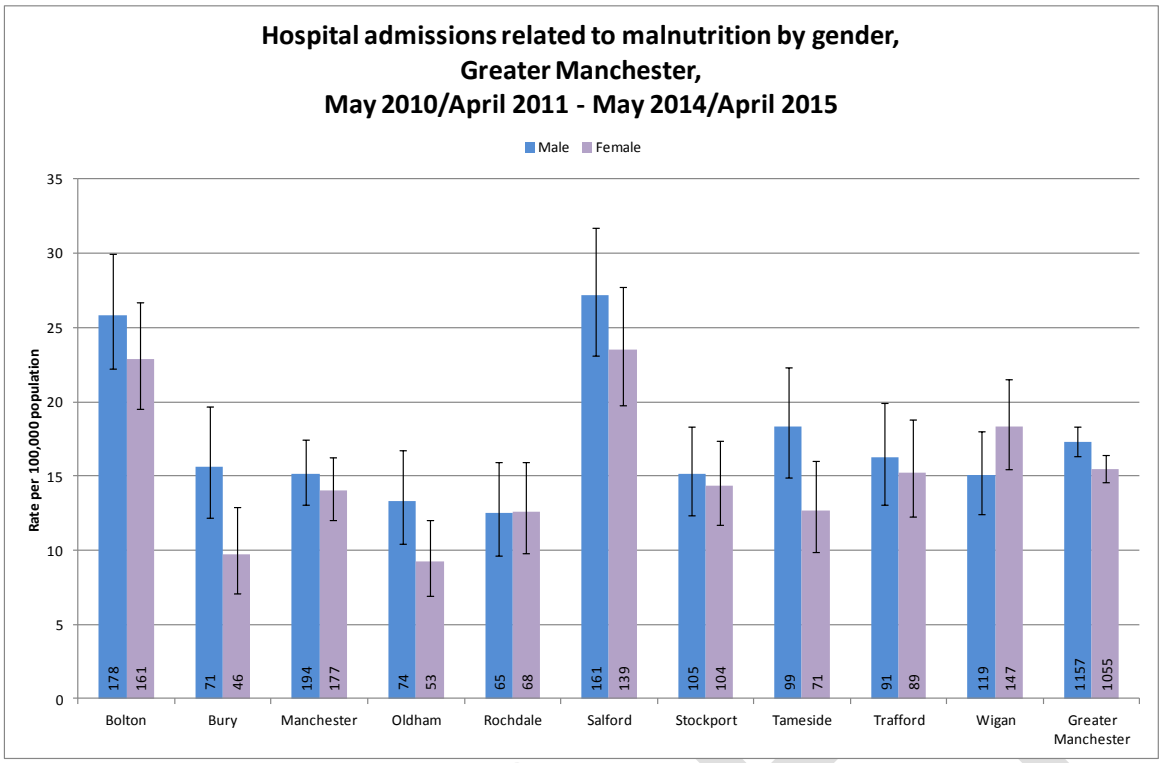
In GM, the effects of malnutrition and dehydration do seem to be recognised in parts of the health and social care system. It is seen or identified at point of hospital admission, often as a complicating factor alongside a wider set of clinical issues, and the GM Directors of Adult Social Services group also recognise it as in issue for people with eligible social care needs, in particular those people living in long-term residential care.

There are pockets of relatively recent work focusing on food and nutrition in individual GM boroughs (certainly work in Salford as part of MTF national pilot and in Manchester relating

to care homes, but possibly other boroughs too that have yet to declare an interest) but it would seem that this issue does not have a high or consistent profile across GM. Given the impact it can have on individuals and the care system, this is a potentially missed opportunity but it could equally provide a strong focus for collaboration at a GM level.

The analyses below by the Salford public health team in 2015 show hospital admissions across GM where malnutrition has been coded in the hospital admission record, with a breakdown by gender in the following table. The overall trend over 2010-2015 appears to be rising, which could be a reflection of the ageing population or an independent increase in the rate of malnutrition, probably both. The analysis gives us an insight into hospital admissions where malnutrition has been explicitly recognised, but it is important to appreciate that this cannot be used to gauge overall prevalence, which is estimated to be much higher (see previous sections).





Opportunity

A number of reports and guidance sourced around food, hydration and nutrition to date refer to the very good availability of nutritional guidelines, yet there clearly remains a gap between knowledge and application, which is confounded by the wide range of individual and environmental factors that can contribute to the development of malnutrition, usually over a long period of time.

In the community, the potential solution is to raise individual, family, carer and practitioner awareness and promote a stronger understanding of the particular groups of older people that may be especially at risk of malnutrition and hydration – they might typically include men, people living on their own, those who are recently bereaved, people with a psychological or cognitive disturbance. NICE (2012) suggests that:

Nutritional support is an ongoing process involving the following steps:

1. Raising awareness
2. Screening
3. Recognising malnutrition or the risk of malnutrition
4. Documenting nutritional support goals in a management care plan
5. Treatment
6. Reviewing nutritional care to identify and respond to changes in nutritional status.

Steps 1-3 are equally applicable to the identification of dehydration. In care home settings, and domiciliary care arrangements such as home care or extra-care, although the same issue of promotion and awareness-raising is important, because the groups of older people being support by these arrangements are likely to be much more vulnerable, needing more support with food and drink at mealtimes, alongside very specific dietary needs, the issues may need to be approached in different ways. The higher numbers of hospital admissions

from these settings, care homes in particular, and the more rapid physiological effects of dehydration generally and on more frail older people specifically, may point towards a stronger emphasis on hydration in these settings

In terms of GM, there are pockets of relatively recent work focusing on food and nutrition in individual GM boroughs (certainly work in Salford as part of Malnutrition Task Force national pilot and in Manchester, but possibly other boroughs too that have yet to declare an interest) but it would seem that this issue does not have a high or consistent profile across GM. Given the impact it can have on individuals and the care system, this is a potentially missed opportunity but we are proposing that it could equally provide a strong focus for collaboration at a GM level.

Salford has emerged as already leading and developing local good practice in the area of malnutrition in particular and, as referred to above, is a pilot site for a whole community approach to prevention under the national DoH Malnutrition Prevention Programme. They have developed the 'Salford Together Nutrition Armband' which is gaining traction nationally and has been rebranded as PaperWeight Armband ©. The team have been nominated by Barbara Keeley MP for a public health excellence award due to their work. This is a simple and non-intrusive way of gauging potential malnutrition by measuring the non-dominant upper arm. But most importantly it has proved to be a way of opening up a conversation, through a wide range of community contacts with older people, about food and nutrition in a non-threatening way and providing access to high quality, tailored information about relevant local services, support and advice on the topics.

Kirstine Farrer, one of 11 Consultant Dieticians nationally who is based at Salford Royal, and partners in Salford (including Age UK Salford and their local integrated care programme colleagues) have already done much of the thinking on this, having developed their own local scheme during the past 3 years. They are now continuing to pilot work in care homes and have developed an e-learning package which is designed to improve understanding of nutrition and hydration amongst practitioners and care staff working in the community and also relevant hospital staff.

The approach is relatively simple and likely to be replicable across other boroughs - delivered through effective project management at a GM level; supported by local buy-in to ensure that it fits and reflects existing local provision; and with the expertise and learning from colleagues at Salford.

New Economy has undertaken initial indicative analysis of the Salford Malnutrition Pilot to understand the financial case for the initiative. This analysis suggests that the gross fiscal return on investment over a five-year period is 3.20 and the net present budget impact is around £800,000. The long term cashable fiscal return on investment is estimated at 2.69.

The costs comprise staff input (predominantly GP capacity in screening elderly patients), resource and distribution of materials, and project management costs including initial outlay on programme design. The benefits are driven by the significant reactive cost savings from a reduction in falls associated with addressing malnutrition and dehydration – this includes savings from non-elective admissions, residential care admissions and a reduced need for intermediate care, reablement and home care. Considerable benefit is also anticipated from reduced GP appointments and a reduction in the use of enteral feeds and nutritional supplements.

Further work will need to be undertaken to test these emerging findings with partners and to replace national level assumptions with additional local evidence. As they stand, the CBA outputs should be considered as indicative and subject to change. To reflect plans for

scaling up more widely across GM, the CBA can be re-run on a multi-locality footprint. It is likely that this will increase the return on investment through cost efficiencies related to procurement and savings in the project design phase.

Plan

Objectives

The objectives of this programme of work are to help facilitate the roll out, testing and evaluation of an approach to tackle dehydration and malnutrition based on the nationally recognised work in Salford, in line with the other theme 1 proposals aimed at promoting an effective response to population ageing. The project is set up to achieve the following core objectives

- Objective 1: Using the Salford approach, develop and document a replicable and scalable model, which can be tested at scale in other parts of GM
- Objective 2: Support a number of localities in implementing the described model recognising the local variations that may be required
- Objective 3: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of GM based on the evidence.

Approach to delivering objectives

Objective 1: Using the Salford approach, develop a replicable and scalable model, which can be tested at scale in other parts of GM

The project will seek to:

- Describe a GM vision around tackling issues of malnutrition and dehydration
- Work with Salford to carry out an initial cost benefit analysis based on the finding to date and agree metrics for evaluation of future GM implementation sites
- Develop a costings model which includes staffing costs, plus all the materials / a working budget and funds to secure the services of an expert reference group.
- Develop and secure transformation funding to resource 2/3 localities to adopt and test the model

Objective 2: Support a number of localities in implementing the described model

The project will seek to:

- Secure and put in place agreements with a number of localities to implement the model and test locally.
- Provide programme management and delivery support to roll out the model across each of the boroughs (this could be shared across more than one borough)
- Provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of GM based on the evidence.

The project will seek to:

- Collate analysis from implementation sites from across GM
- Update and further develop cost benefit analysis developed for Salford model
- Collate local lessons learned to inform future development of the model for wider GM adoption
- Gain agreement from the system to fully roll the model out to the remaining GM boroughs
- Produce and agree a plan for GM wide roll out.
- Ultimately embed the use of the paperweight armband into routine contact with older people; improve awareness and vigilance of malnutrition and dehydration in the community; and reduce the impact of malnutrition and dehydration on the quality of life, health and care outcomes of older people.
- Implement a financially sustainable approach, using transition funding to mainstream good preventative practice which can then continue to be overseen and developed in the medium to longer-term by a local multi-disciplinary expert reference group.

Target outcomes for (16/17) and (17/18)

The programme will work towards achieving three key outcomes:

- Outcome 1: The partnership working with Salford and New Economy Manchester have developed a replicable and scalable model, which can be tested at scale in other parts of GM using Transformation Funding
- Outcome 2: A number of GM boroughs have implemented the model
- Outcome 3: A business case and plan for the GM wide rollout of the model produced and agreed

Programme of work - Scope

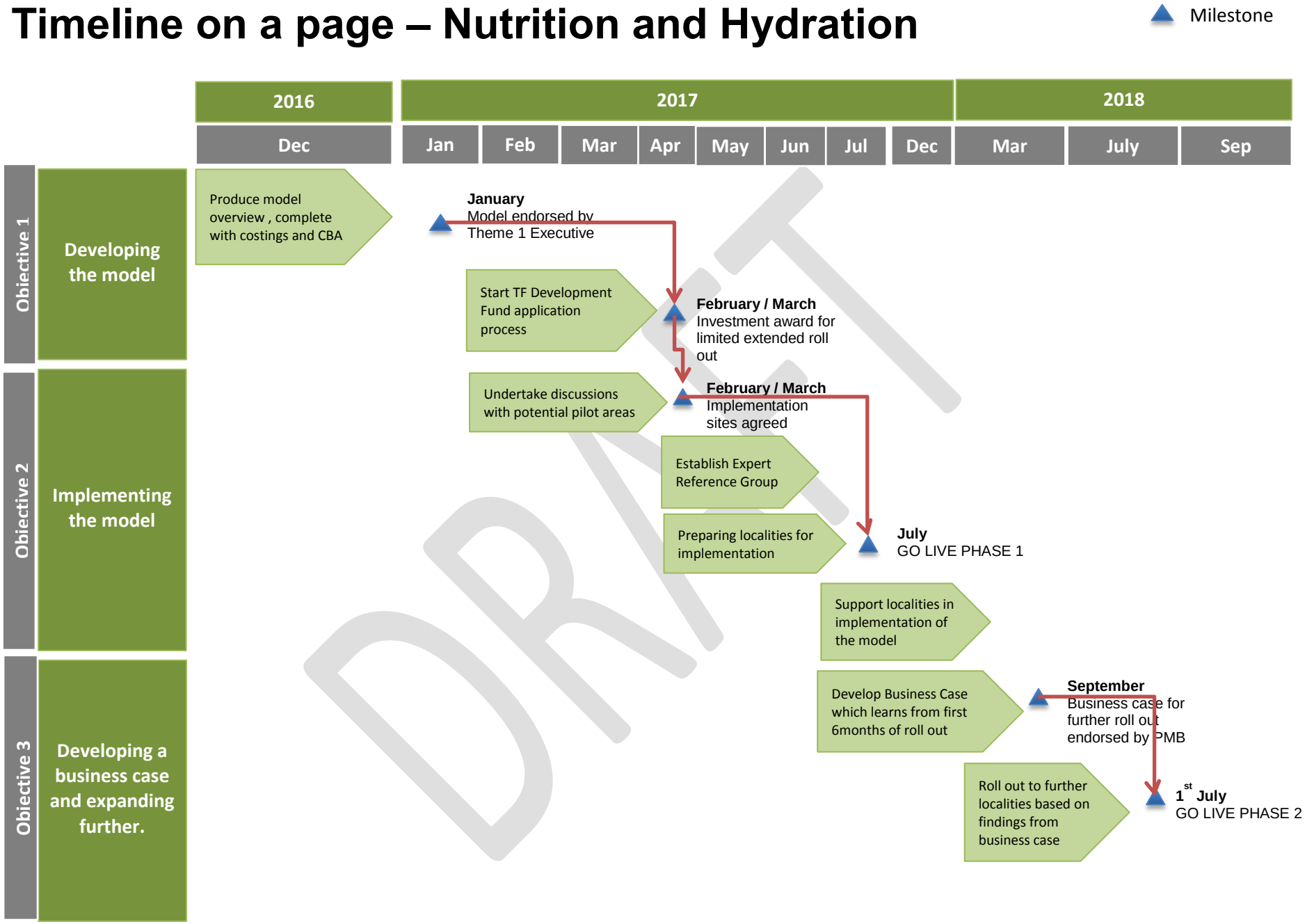
This proposal is intended to be implemented across community and allied healthcare, social care (public and independent sector) and voluntary sector services delivered within a locality, which are already in contact with older people in the normal course of delivering their services or support.

The proposal and model for delivery:

- The model is designed explicitly to be a community-level preventative approach which can be applied in a wide range of care and health scenarios with older people. It does not require clinical expertise to use the armband, so it has wide application across the social care and health workforce based in the community. Although the armband and its associated resources could be used in secondary care settings, that is not the focus of this proposal as it is expected that secondary care practitioners are likely to have more direct experience of malnutrition and dehydration and more tools at their fingertips to identify and assess it clinically.
- The target group to be identified, prompted and supported to benefit from the intervention will largely be an older old cohort of adults living in their own homes in the community, some of whom may be experiencing signs of mild frailty, and many are also likely to have co-morbidities which they are manging medically. A key sub-group will be older people living in a care home setting, where the emphasis of the intervention may be more tailored to that environment e.g. training for residential care staff.

- The chief purpose of the model is to embed better awareness and understanding of malnutrition and dehydration in older age and introduce a simple tool, which doesn't require any specialist or clinical knowledge to apply, (the paperweight armband) to prompt its identification. The Salford model was overseen and implemented by a cross-sector team who also collectively designed and produced the materials used. A multi-disciplinary team, who are jointly committed to the implementation of the project, creates shared ownership and disperses leadership, both of which strengthen the model.
- In practice, a local project co-ordinator takes lead responsibility for introducing the paperweight armband, and its associated support materials, to a wide range of practitioners who regularly come into contact with older people in the community, including family carers. It can also be used / promoted at one-off community events or alongside preventative interventions targeting older people e.g. 65+ flu clinics etc.

Timeline on a page – Nutrition and Hydration



Falls

Background

Falls, osteoporosis and fragility fractures are three sides of the same problem. Falls can happen to anyone at any time, but they are more common amongst older age groups and strongly associated with chronic conditions. Falls are a major cause of disability and the leading cause of mortality due to injury in people aged over 75 in the UK. Annually, around 35% of people aged 65 and over will experience one or more fall and this rate doubles for those living in care homes. Falls are implicated in the majority of fractures in older people. Most of these are fragility fractures affecting the pelvis, wrist, upper arm or hip. Around half of all women and one in six men will experience a fragility fracture in later life. Fragility fracture is often the first indicator of undiagnosed osteoporosis.

Falls-related injuries range from minimal to serious, including loss of confidence. Falls can increase isolation and reduce independence, with around 1 in 10 older people who fall becoming afraid to leave their homes in case they fall again. Falls trigger over 40% of admissions into nursing and residential care and are the commonest reason for referrals into intermediate care.

Hip fracture is the most serious consequence of a fall, the commonest reason for older people to need emergency surgery, and the most common cause of accident related death in older people. Around 30% of over 65s experiencing a hip fracture will die within a year, and a quarter will need long-term care. Hip fracture patients take up 1.5m hospital bed days each year and cost the NHS and social care £1bn. This one injury carries a total cost equivalent to about 1% of the whole NHS budget.

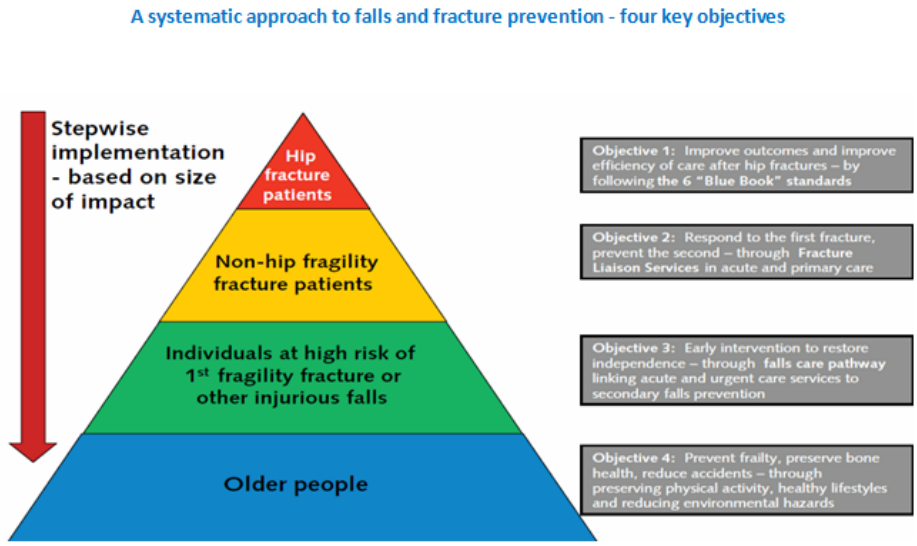
GM Context

'Taking Charge' sets out our ambition to reduce falls-related injurious falls admissions in older people to the England average, resulting in 2,750 fewer serious falls. All Locality Plans across GM have identified falls as a priority issue and/or an area for development. An understanding of key deliverables right across GM will be vital to ensure we are maximising all our potential to reduce injurious falls and we collaborate where possible. Ensuring falls pathways are in place that link acute and urgent care services to secondary falls prevention will be key to intervening early and restoring independence. Work with care homes, where falls prevalence is much higher than in the general 65+ population, will also be needed and exploring how we can scale up relevant physical activity interventions will also be key. There is much to learn and share from existing practices across GM and beyond, and we will seek to facilitate that and collaborative approaches where possible.

Opportunity

Given the ambition set out in ‘Taking Charge’ there is now an opportunity in GM to support the development of integrated systems geared to falls and fragility fracture prevention, informed by the available evidence. A GM Falls Programme could look to utilise the Department of Health's (DH) model for a systematic approach to falls and fracture prevention as set out in Figure 1. Falls and osteoporosis are essentially long term conditions and this needs to inform preventative approaches in parallel with other long term conditions.

Figure 1



Source: Falls and Fractures: Effective Interventions in Health and Social Care, 2009, DH,

A GM approach around falls could aim to:

- reduce the incidence of falls
- reduce the severity of injuries
- ensure effective treatment and rehabilitation for those who have fallen

Two high impact changes have been identified for years 1 and 2, in keeping with the stepwise implementation suggested in the model above. These centre around reducing variation in, and improving the quality of, hip fracture care outcomes (to be delivered through Theme 3) and testing the potential of fracture liaison services integrated with local falls prevention services across GM through the delivery of this Plan. These two areas are now described below:

<u>Hip Fracture Care</u>

Quality in Hip Fracture Care is incentivised through a Best Practice Tariff (BPT). The National Hip Fracture Database (NHFD) captures a range of clinical audit data in relation to hip fracture care by provider site. Comparative data for achievement of BPT shows some suboptimal care and variations across GM. This component of the programme will drive up improvements in hip fracture outcomes, implementing relevant recommendations from the NHFD Annual Report 2016, and seek to:

- Support quality improvement
- Implement relevant NICE Guidance and Quality Standards.
- Review and revise the whole hip fracture pathway beyond acute care, and bring in scope rehabilitation, intermediate care and community care.

This element of the GM Falls Programme will be taken forward by the GM MSK and Orthopaedics Programme within Theme 3.

Fracture Liaison Services (FLS)

Sustaining a fragility fracture at least doubles the risk of a future fracture6. A study of the Glasgow FLS established that 80% of re-fractures that occur over a 3 year follow up period, happen during the first year post-index fracture, with 50% of re-fractures having occurred during the first 6-8 months. A significant proportion of fragility fractures are recurring fractures which could have been prevented if steps had been taken to diagnose and treat osteoporosis after the initial or index fracture and to address any falls risk. This leads to a situation where “hip fracture is all too often the final destination of a 30 year journey fuelled by decreasing bone strength and increasing falls risk".

An FLS will systematically identify, treat and refer to appropriate services all eligible patients over 50 years within a local population who have suffered fragility fractures. An FLS is regarded as clinically and economically efficient. An FLS in an acute setting can intervene in 50% of future hip fracture cases and, in a primary care setting, increase compliance with NICE guidance on secondary prevention of osteoporotic fracture by up to 64%. These reductions are realised quickly and certainly within 3 years of the commencement of pharmacotherapy. It is generally recognised that, in the absence of follow up (which an FLS can provide), compliance with treatment is generally very poor.

Interventions to reduce future fracture risk in patients who have already broken a bone takes priority over primary fracture prevention due to:

- the 2-3 fold greater risk of fracture (any skeletal site) following index fracture)
- 50% of hip fractures occur in patients who have previously sustained a fracture
- To achieve the same reduction in fracture incidence through primary prevention would necessitate identification and assessment of 5–6 times more patients

A secondary fracture prevention strategy will achieve substantially greater fracture risk reduction for any investment of resources than can be achieved through primary fracture prevention.

FLSs originated in acute settings. However, more models are emerging within community-based settings which support the drive for care closer to home. A community model can be more easily facilitated with a 'reporting radiographer' approach rather than case finding in acute fracture care, which some earlier models adopted. This also maximises opportunities to identify vertebral fractures. Wigan, for example, currently has a community-based FLS+ which has an extended role into primary care. Wigan's FLS is also integrated with its Falls Prevention Service on the basis of the inter-relationship between falls, osteoporosis and fragility fractures.

High-level predictive CBA undertaken by New Economy suggests an overall gross fiscal return on investment of 2.26 with a net present budget impact of £11.2m over five years. While there is a significant increase in benefits as the target cohort increases over time, it is anticipated that the investment in FLS across GM will have been ‘paid back’ during the first year of activity.

The largest benefits created by the FLS are those pertaining to prevented hip fractures. These benefits include savings as a result of both a reduction in acute care presentations and the circumvented need for residential care. The most significant costs of the FLS are

those associated with staffing. However, there are also costs linked to the increased number of patients prescribed medication, and to a lesser extent, those likely to undergo bone scans.

Findings reflect indicative reactive savings which could be made through the provision of fracture liaison services (FLS) based in an acute setting within each of GM's hospital sites, and are subject to decision-making around service configuration. Findings are presented here in isolation from other strands of the 'Ageing Well' work stream, but in future will be considered as part of a wider portfolio of work.

Opportunities still to be scoped

Work is still needed to develop and agree further opportunities at GM to complement the work at a locality level to reduce injurious falls in older people. Work will take place over the next 12 months to further define these pieces of work in collaboration with localities. Initial areas for consideration are described in the sections below.

Falls care pathway

Ensuring falls pathways are in place that link acute and urgent care services to secondary falls prevention are key to intervening early and restoring independence.

All locality plans have identified 'falls' as an issue or area for development. An understanding of key deliverables right across GM will be vital to ensure we are maximising all our potential to reduce injurious falls and we collaborate where possible. There is much to learn and share from existing practice across GM and beyond in relation to multi-factoral risk assessments, falls pathways and falls prevention practice. For example, Stockport has developed a falls pathway that supports the implementation of relevant NICE Guidance.

The rate of falls in care homes is almost three times that of older people living in the community and 30% of hip fracture hospital admissions are from a care home. Scotland and Derbyshire have developed good practice toolkits.

Work could include steps to:

- Identify and share examples of practice from across GM
- Stimulate collaborative approaches to implementing relevant NICE Guidance on falls prevention.
- Work with localities to identify toolkits and best practice around falls prevention in care homes, and share for implementation

Evidence-based physical activity programme for falls prevention

Poor gait and balance is the most significant intrinsic risk factor for a fall. The most effective component of multi-factorial interventions is therapeutic exercise. Any therapeutic exercise should be individually prescribed, focus on building strength and balance, be progressive, and meet the right dosage criteria to sufficiently reduce falls risk. FaME, Otago, and LiFE are all evidence-based therapeutic exercise programmes which variously reduce falls risks by at least 35% and up to 54%. Compliance, however, is known to be problematic and, ideally, activity needs to be sustained beyond the initial therapeutic phase.

Delivery requires instructor training in one of the evidence-based programmes, with relevant pre-requisites. Instructors can come from a number of backgrounds including physiotherapists, occupational therapists, sports scientists, and registered exercise professionals. There are varied approaches to, and provision of, falls prevention physical activity programmes and we need to understand, learn and share from all GM districts. We will seek to:

Work could include steps to:

- Identify and share delivery models
- Facilitate an asset based approach to build capacity for physical activity interventions for falls prevention.
- Work with localities to identify options to scale up therapeutic physical activity programmes for falls prevention.

Plan

Objectives

The objectives of this programme of work are to help facilitate the roll out testing and evaluation of Fracture Liaison Services integrated with a range of locally designed falls prevention services in a number of GM boroughs. The programme is set up to achieve the following core objectives:

- Objective 1: Using national guidelines and learning from developments locally in Wigan, develop and document a replicable and scalable model, which can be tested at scale in other parts of GM
- Objective 2: Support a number of localities in implementing the described model recognising the local variations that may be required
- Objective 3: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the model across the whole of GM based on the evidence.

Approach to delivering objectives

Objective 1: Using national guidelines and learning from developments locally in Wigan, develop and document a replicable and scalable model, which can be tested at scale in other parts of GM

The project will seek to:

- Work with Wigan and the National Osteoporosis Society to carry out an initial cost benefit analysis based on the finding to date and agree metrics for evaluation of future GM implementation sites
- Develop a costings model which includes staffing costs, plus all the materials / a working budget and funds to secure the services of an expert reference group.
- Secure transformation funding to roll out FLSs in a number of localities, that align with new models of care locally

Objective 2: Support a number of localities in implementing the described model recognising the local variations that may be required

The project will seek to:

- Secure and put in place agreements with those 'early implementer' sites for provision of FLSs.
- Provide programme management and delivery support to the early implementer sites
- Provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.

Objective 3: Develop a business case which builds on the robust evaluation of implementing the model to support the future expansion of the project across the whole of GM based on the evidence.

The project will seek to:

- Support evaluation of FLS provision
- Collate analysis from implementation sites from across GM
- Update and further develop cost benefit analysis developed for original model
- Collate local lessons learned to inform future development of the model for wider GM adoption
- Gain agreement from the system to fully roll the model out to the remaining GM boroughs
- Produce and agree a plan for GM wide roll out.

<u>Target outcomes for (16/17) and (17/18)</u>

The programme will work towards achieving three key outcomes:

- Outcome 1: Transformation funding secured, via a robust business case, for roll out of FLSs in 'early implementer' sites
- Outcome 2: A number of GM boroughs will have developed and implemented an FLS
- Outcome 4: A business case and plan for the wider roll out of FLSs across GM will be developed

<u>Programme of work - Scope</u>

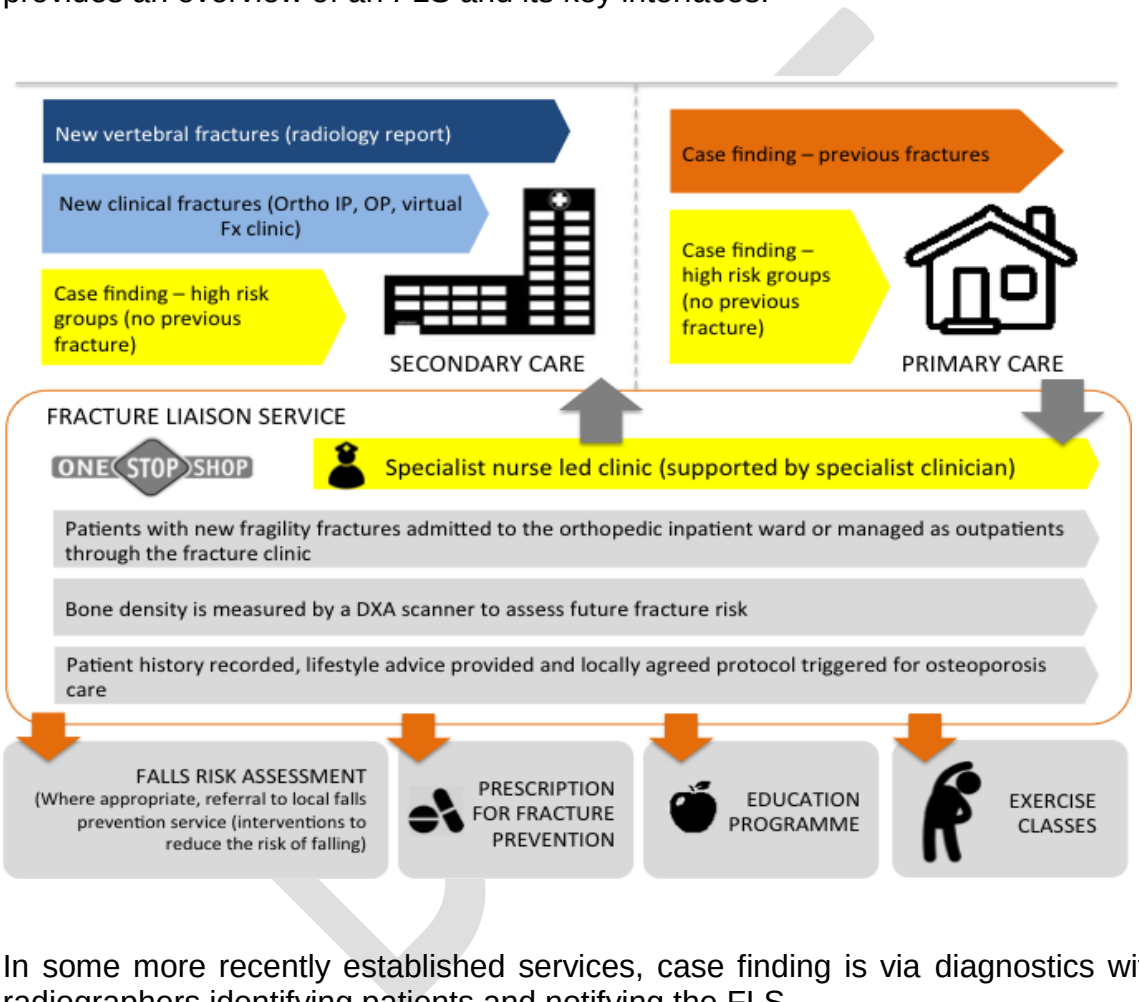
An FLS is typically developed around a fracture liaison coordinator, usually a nurse specialist, in collaboration with and supported by a metabolic bone disease specialist as named lead clinician.

The FLS and care pathway will provide specialist secondary fracture prevention assessment and management to all patients over 50 years. The service will promote coordination between acute, community and primary care to ensure that care is seamless and consistent. This integrated approach will include:

- Case finding in fracture clinic, emergency department, inpatient wards and outpatient clinics
- Triage and assessment of identified patients by coordinators/specialist nurses
- Diagnosis of osteoporosis using DXA
- Initiation of treatment for fracture risk reduction in line with agreed guidelines
- Appropriate pharmacological treatment
- Identification of the modifiable faller and referral to a falls prevention service

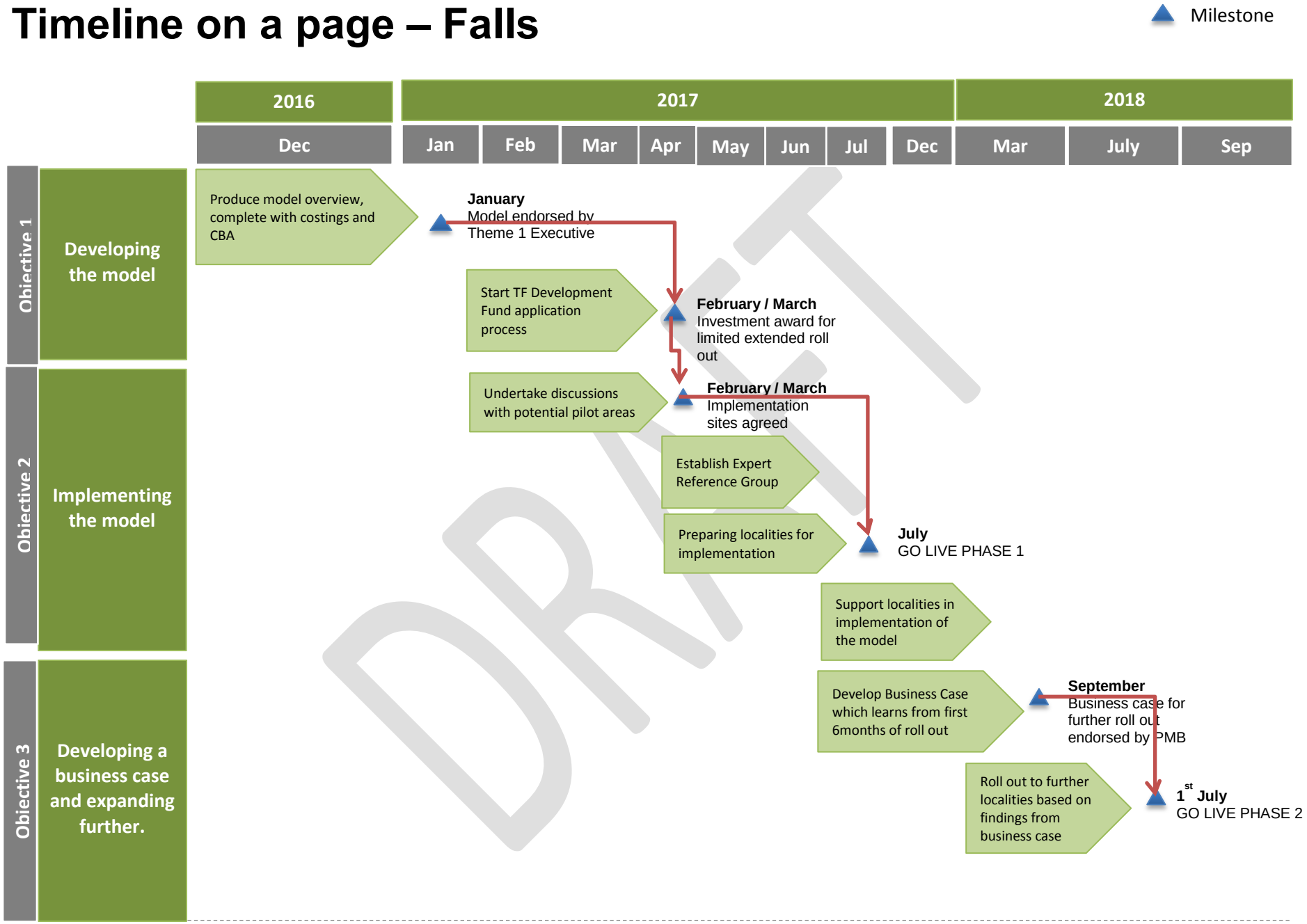
- Liaison with the patient's general practitioner with the aim of optimising long-term treatment
- Telephone follow up of patients to provide education and support in primary care
- Promotion of FLS to relevant hospital teams in order to maximise case finding
- Specialist clinic support for secondary care clinicians in managing complex and rare bone conditions
- A database of patients assessed through the service to support follow up and quality reporting.

The service will be available to all patients over the age of 50 years who have suffered a fragility fracture with the primary aim of preventing subsequent fracture. The figure below provides an overview of an FLS and its key interfaces.



In some more recently established services, case finding is via diagnostics with reporting radiographers identifying patients and notifying the FLS.

Timeline on a page – Falls



6. Person and Community Centred Approaches

Asset Based Approaches

Background

There is an emerging and growing evidence base that supports the notion that the more connected, empowered, resilient people and communities are then the greater is the likelihood they will live healthy and fulfilled lives. Together the evidence provides a compelling case for a shift to more person and community centred ways of working in public health and healthcare. The Wanless report concluded that high levels of public engagement are needed in order to keep people well and manage rising demand, further reasons why this shift needs to occur is identified in a recent PHE report:

- Wellbeing is a key concept for a functioning and flourishing society and community life, social connections, and active citizenship are all factors that enhance wellbeing.
- Social isolation and loneliness is a major public health issue, associated with higher risks of mortality and morbidity.
- Assets within communities, such as skills, knowledge and social networks, are the building blocks for good health.
- Health behaviours are determined by a complex web of factors including influences from those around us. Community engagement and outreach are often a vital component of behaviour change interventions.
- A flow of new ideas and intelligence from local communities is needed to give a full picture of what works and what is needed
- As the NHS Five Year Forward View (2014) makes clear, harnessing the 'renewable energy' of patients and communities is no longer a 'discretionary extra' but instead is key to the sustainability of health and care services.

Several influential publications have put forward a vision of positive health and wellbeing, as well as the case for enhancing assets, especially strong communities. The King's fund cites the evidence for strong communities, wellbeing and resilience and a report by NICE on behavior change recommends interventions that 'identify and build on the strengths of individuals and communities and the relationships within communities'.

A recent report by NESTA found that the NHS could realise savings of at least £4.4 billion a year if it adopted self-care innovations that involve patients their families and communities more directly in the management of their long term conditions. These savings are based on the most reliable evidence and represent a 7% reduction in terms of reduced A&E attendance, planned and unplanned admissions, and outpatient admissions

The NHS Five Year Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens. It identifies four key components to this, including getting serious about prevention; empowering patients; engaging communities; and the NHS as a social movement.

GM Context

A central focus of 'Taking Charge' is changing the relationship between people and public services, our aim is to boost independence, improve health and reduce demand on services, and this means more people managing their health, looking after themselves and each other.

The influence on people's behaviour on health outcomes can be seen in everything from preventing illness in the first place through to the management of long term conditions. Engaging people in their own health and care is key to delivering a sustainable health and care system for GM.

Our ambition is to develop a whole systems approach to person and community centred approaches and self-care, to enable high impact person centred care at scale. This will entail driving changes in commissioning; organisational and clinical processes; workforce development and the support provided to individuals and communities.

Putting people and communities genuinely in control of their health and health care requires a paradigm shift away from the medical model of illness towards a model of care which takes into account the expertise and resources of people and their communities. We will therefore also need to focus on the culture change needed to achieve wide scale transformation, along with consideration of the system barriers and levers that could be used to support change at GM and locality level.

GM has a rich history of working in these areas and has many examples of best practice which could be drawn on such as The Wigan Deal, Salford Promise and asset based approaches in Primary Care. This is further strengthened with a well-developed, varied and diverse voluntary sector in each area and various GM umbrella organisations.

Opportunity

A radical upgrade in population health brings with it a need for radical action and solutions - one of which is to shape a new relationship with an engaged citizenry empowered to develop and enrich their own communities within a framework of support and governance. The application of this across the city region has the potential to increase community cohesion, increase skills and promote economic development as well as help manage demand on health and social care.

We know:

- The number of people with complex long term needs is increasing as a result of longer lifespans.
- Currently too many people are going into residential and nursing care, particularly from hospital, in part because of a lack of clear and planned alternatives.
- Care staff solely focus on the needs, deficits and problems of the individual, rather than on their capabilities and resources
- Many people present with needs that could have been alleviated by earlier, community and family based support
- Around 15 million people in England have one or more long term conditions and they are frequent users of health services accounting for 50% of all GP appointments and 70% of all inpatient bed days
- Around 70-80% of all people, with long term conditions can be supported to manage their own condition.

There is strong evidence that people and communities who have certain “assets” also have better health and wellbeing outcomes. In the Health Foundation’s review of asset-based approaches they identified five assets which have strong links to health and wellbeing: **communities, social networks, connectedness, resilience and psychosocial health**. For example, a systematic review of 148 studies on the association of social relationships and health in 2010 found that the quality and quantity of relationships were linked to mortality and morbidity to the same degree as other accepted risk factors such as smoking.

Asset based approaches have a different starting point to traditional health and care services. Fundamentally they ask the question ‘what makes us healthy?’, rather than the deficit-based question ‘what makes us ill?’ The aim of asset based approaches is to promote and strengthen factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health. Asset based approaches are a way of working with and sustaining communities, individuals and services which require a fundamental shift in approach and control, especially for public services

In GM there are pockets of excellent work which are starting to demonstrate benefits to using this approach. For example in Stockport where there has been a partnership with NESTA in participating in their ‘Realising Value’ programme or in Wigan as part of the Wigan Deal initiative.

Here the council has been successful in dramatically reducing care support costs and improving outcomes for individuals in pilot work. This has also shown that up to 40% of GP appointments are not driven by a clinical need which is further supported by Citizens Advice who estimate that GPs spend nearly a fifth of their consultation time dealing with non-medical issues such as housing, unemployment and debt problems.

Such approaches are long established and the challenge is in making this form of engagement between the public and the public services the common and defining feature across GM.

Plan

There are challenges in developing a GM approach to what is fundamentally a localism agenda. The PHE report on community centered approaches emphasises that “community engagement is more likely to require a ‘fit for purpose’ rather than ‘one size fits all’ approach”. This latter point is crucial for any GM approach recognising that the form and function of any approach must allow the local flexibility which responds to the specific characteristics of any local community.

Objectives

A number of objectives have been identified at a GM level which would support the development of these approaches locally. These include:

- Objective 1: To help build capability and capacity within localities
- Objective 2: To have a consistency to approach and evaluation whilst allowing sufficient flexibility for localization
- Objective 3: To build an evidence base of work across GM, of different levels of maturity from emerging promises to demonstrating success.
- Objective 4: To ensure a strong system leadership commitment to the approach

Approach to delivering objectives

Objective 1: To help build capability and capacity within localities

The project will seek to:

- Identify of a group of 'explorers/enablers' who can help to seek out the practice and strengths – building capacity and sustainability from the start
- Development offer for explorer roles to skill them up to do this work
- Bringing together the OD community across health and social care in GM to act as a network of supporters
- Provide tools and resources to assist places to understand the conditions for success and assess readiness
- Menu of development programmes and tools for places to choose from e.g. Wigan approach, shared decision making, strength based conversations, quality improvement skills / tools , team coaching skills, consultancy support to support systems to understanding which approaches are likely to be most effective and in what circumstances.
- Building place based support teams - develop a team of skilled facilitators / enablers to support places.
- Developing a delivery team - training trainers approach on key skills - asset approach, large scale change and innovation skills etc.
- Develop system capacity through 'skills pools' 'time bank' approach.

Objective 2: To have a consistency to approach and evaluation whilst allowing sufficient flexibility for localization

The project will seek to:

- Define key principles to develop a GM framework for action that describes consistency of approach and recommendations for evaluation and CBA.
- Develop a platform to enable localities, local and national partners to connect with GM against an agreed framework which provides some consistency of approach
- Gain agreement from the system to adopt and implement the framework
- Launch the framework to cement support across the system for this way of working with people and communities.

Objective 3: To build an evidence base of work across GM, of different levels of maturity from emerging promises to demonstrating success.

This project will seek to:

- Map and capture existing practice on asset based approaches across a place and build on success of specific places and asset based approaches.
- Bring together the ten localities across GM to share best practice within a system wide learning event

- Develop a network of delivery leads with third sector partners to test and spread innovative solutions.

Objective 4: To ensure a strong system leadership commitment to the approach

This project will seek to:

  - Work with system leaders to sign up to a statement of commitment to demonstrate strong support to self-care/ person and community centred approaches'
- Work with system leaders to develop a road map to delivery that will feed into the framework for action.

Target outcomes for (16/17) and (17/18)

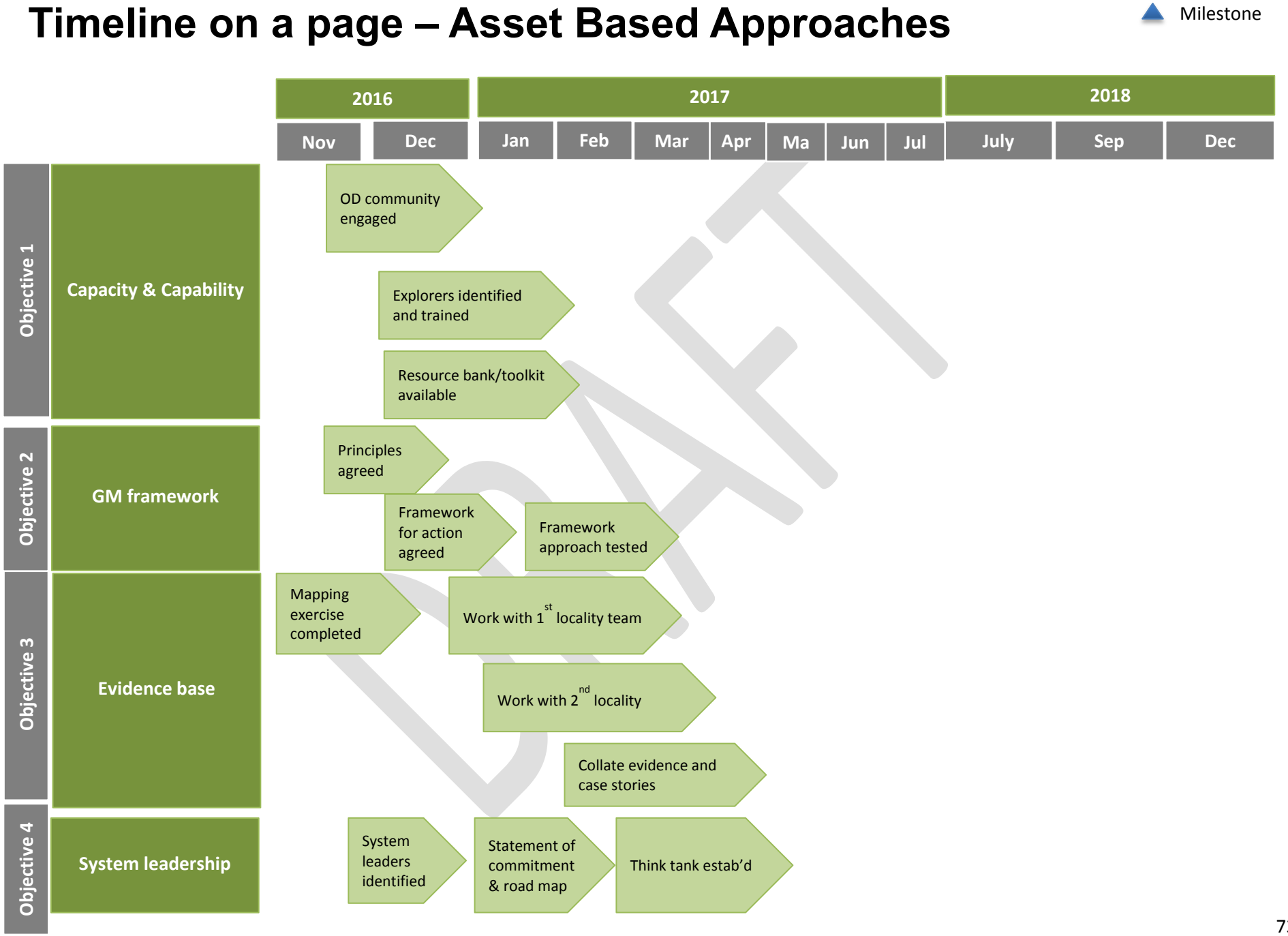
The programme will work towards achieving three key outcomes:

- Outcome 1: Localities will have a greater bank of local capability
- Outcome 2: GM will have a framework for action agreed by system leaders to support local implementation
- Outcome 3: baseline of work already underway and where opportunities for scale and spread exist.
- Outcome 4: An road map to delivery and strong leadership commitment agreed

Programme of work - Scope

This programme will work with system leaders from across GM and partner organisations including the third sector to influence and support ways of working at locality level. With an initial focus on asset based approaches it has the potential to develop and spread across the wider reform and at all levels of the system.

Timeline on a page – Asset Based Approaches



Health as a Social Movement

Background

Social movements are grounded in the lived experiences of people and communities. Their members are the people managing chronic health conditions or adhering to complex medication regimes, the people who have grievances with the status quo and can translate them into inspirational visions of a better life and society. The AIDS movement, the breast cancer movement and the disability rights movement aimed to transform people's experiences of their own health conditions and circumstances as well as create cultural shifts in how society responds to sexuality, gender and ableism.

There is no definitive definition of a social movement - they are messy, spontaneous and uncontrollable by nature. Nesta describe social movements in health as:

'A health social movement is a people-powered effort to promote or resist change in the experience of health or the systems that shape it.'

The NHS Five year Forward View made specific commitments to support individuals and communities to manage their own health, to provide better support to carers and to encourage health related volunteering. This included the commitment to work with voluntary sector partners to invest significantly in evidence based approaches such as self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge. Community life, social connections and having a voice in local decisions are known to be factors that underpin good health. Strong community engagement and investment in the voluntary sector can likewise support individual patients to be more empowered in relation to their health and care. In describing this approach the NHS 5YFV presents a vision for health as a social movement.

Responding to this NHS England launched a three year programme to support social movements in health and care.

GM Context

This proposal is linked to the Cancer Vanguard proposal described later in this plan. We know, In GM that the incidence of cancer is growing at a rate of about 2% per annum; in 2013 14,500 people were diagnosed with cancer in GM. This then means the burden of cancer on our health and social care system is also and ultimately becomes unsustainable.

Earlier diagnosis, prevention coupled with healthy lifestyle choices is essential if we are to have a significant shift in improving survival for our population.

Opportunity

In GM 'health as a social movement' is being undertaken in partnership with the national NHS England social movement programme and forms part of the National Cancer Vanguard.

Working in partnership with voluntary, community and social enterprise sector colleagues, this project intends to apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum which is ultimately self-sustaining.

The aim is to engage groups, networks and existing campaigns and support them to develop their own activity, build collective action and draw groups together to create (with support) their own social movement(s).

This project intends to harness the citizen and third sector energy and motivation that is currently centred on cancer, research, treatment and survivorship to understand what motivates people to make lifestyle choices and help tip the balance towards prevention.

Plan

Objectives

A central feature of this project in which the voluntary and third sector will play a revolutionary role, is to develop a 'more than medicine' approach to support the cancer prevention agenda.

- Objective 1: To develop a network of 20,000 individuals over the course of the three years.
- Objective 2: To explore the use of digital technologies including social media to support the development of a social movement and mass involvement across the entire cancer prevention spectrum which is ultimately self-sustaining.

Approach to delivering objectives

Objective 1: To develop a network of 20,000 cancer champions over the course of the three years.

- Work in partnership with the third sector to develop an exemplar social movement – focused on cancer prevention.
- Apply at scale a multi-faceted approach to nurture a citizen led social movement across the entire cancer prevention spectrum.
- Develop a network of 20k cancer champions and expert patients to provide a more than medicine approach
- Demonstrate 'what works' – using rigorous evaluation approaches
- Support spread – in year 3 identifying approaches that could be scaled or adapted and adopted in other communities

Objective 2: To explore the use of digital technologies including social media to support the development of a social movement and mass involvement across the entire cancer prevention spectrum this is ultimately self-sustaining.

- Test which digital opportunities that would support mass involvement such as social media approaches.

Target outcomes for (16/17) and (17/18)

- Outcome 1: The development of a mass social movement across the entire cancer prevention spectrum which is ultimately self-sustaining, to include an army of cancer champions networking across the conurbation driving the cancer prevention agenda.

- Outcome 2: Digital opportunities tested and evaluated.

Scope

The scope of this work includes all citizens of GM, community groups, charities and volunteers linked to cancer related activities.

The project will also need to connect to GM's broader communications work and the digital platform work linked to the proposed GM Lifestyle Hub.

Similarly it has the potential to link to the wider GM Cancer Vanguard prevention projects including the lifestyle based secondary prevention work; the large scale social marketing project and the enhanced screening offer for GM residents.

For a Timeline for this work please see Cancer Vanguard Objective 2 circa page 80.

7. System Reform

System Reform - Creating a Unified Public Health System for GM

Background

In July 2015, GM signed an Memorandum of Understanding (MoU) with Public Health England with an ambition to create a Unified Public Health System recognising that the last NHS reorganisation had resulted in significant fragmentation, breaking apart the commissioning, health protection and intelligence architecture creating duplication and overlap and limiting the capacity to effect significant change across GM.

The MoU proposed that Public Health Leadership in GM is considered as part of a single unified system to drive the necessary prevention and integration that will be central to improving outcomes in a landscape of diminishing resources.

The MoU provides an opportunity to support and add value to local working by reducing the fragmented nature of public health leadership in GM, since the Health and implementation of the NHS and Social Care Act in 2013, where capacity is to be found in local authorities, in the GM Public Health network, in the work of the Directors of Public Health group, in PHE and in NHS England.

GM Context

In GM, we have a shared commitment to the most ambitious approach yet in England to place Public Health at the heart of public service reform and economic growth. Rebalancing our economy also requires rebalancing our public services together with rebalancing of our health and care system towards prevention and early intervention

GM intends to secure the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million citizens of the conurbation by:

- ensuring all residents are connected to the current and future economic growth in the conurbation, including quality work, improved housing, and strengthened education and skills attainment;
- delivering effective integrated health and social care across GM, with a much stronger prioritisation of wellbeing, prevention and early intervention;
- closing the health inequalities gap faster, within GM and between GM and the rest of the UK;
- taking every opportunity across the life course to support residents to be in control of their lives and their care; and
- forging a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population.

As set out earlier in this plan, we have agreed four major transformational programmes that together demonstrate how a single unified public health leadership system can embed the linkage between health, jobs and better family outcomes:

- Person and community centred approaches - enabling people to make their own informed life-style choices and creating new platforms for full engagement of GM resident;
- starting well (early years) - the scaled implementation of the GM early years model to improve school readiness and addressing long term determinants of public service demand;
- living well (work and health) - aligning public health intervention to wider public service reform tackling multiple disadvantage and supporting residents to be in sustainable and good quality work; and
- ageing well - setting up a GM Ageing Hub to support age-friendly communities and environments, and scaling work on dementia friendly communities, supporting those with dementia to remain connected to their communities and in control of their lives for as long as possible.

Opportunity

It is clear that an ambition of this magnitude requires the support of a public health system which is organised to deliver at pace and scale.

GM has the chance to radically reframe the role of Public Health in the context of a devolved system, creating a unified system across ten localities and GM that is better able to achieve improved health outcomes for the citizens of GM.

This is an opportunity to prioritise the prevention agenda, and embed lasting and relevant changes to how GM organises itself for the best outcomes and wellbeing of GM's population. These benefits will be driven through the balance of integrating population health services at both GM and local levels. Reforming how public health functions are delivered within GM is now a critical part of the wider devolution transformation, and needs to be reformed in partnership across all public services in order to deliver GM's ambition of a well population and productive workforce. We are using a collaborative co-production approach to engage stakeholders across health and care in GM to address key challenges and improvement opportunities.

Plan

We now need to push ahead with the programme of reform to design the infrastructure and tools required to support the implementation of a system that can support GM, cluster, and local level delivery of population health priorities. Creating a unified system that delivers financial sustainability and is able to future proof against future funding changes.

We will create a leadership, governance and delivery model with clear lines of accountability and responsibility for achieving GM's population health ambitions.

We are mobilising the system to deliver the population health goals set out in the Taking Charge Plan and building health into the day to day business of public services and businesses in GM. By creating a GM Population Health system, we will provide a single interpretation of local data across the conurbation, and use data and intelligence to drive health policy, strategy and commissioning decisions at GM and locality level.

Objectives

The programme is set up to achieve the following core objectives:

- Objective 1: Develop a population health commissioning plan which brings together the NHS England Commissioning responsibilities set out in section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan.
- Objective 2: Develop and test a proposal for a new GM population health function serving localities, CCGs and GM structures.
- Objective 3: Develop a model for future resourcing of population health in GM

Approach to delivering objectives

Objective 1: Develop a population health commissioning plan which brings together the NHS England Commissioning responsibilities set out in section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan.

The programme will seek to:

- Baseline current contract spend
- Map commissioning plans and current contracts for PH grant spend
- Map planned cluster level commissioning and articulate how its contribution to transformation agenda
- Map of various commissioning approaches e.g. outcomes based; alliance; neighbourhood level
- Analyse the PH grant commissioning plans to date, including the collaborative commissioning arrangements and contributions to wider transformation
- Review alignment of locality commissioning plans with GM Theme One Transformation programmes
- Undertake agreed benchmarking of cost and quality for key PH commissions where benchmarking would be helpful
- Identifying further opportunities for collaborative commissioning

Objective 2: Develop and test a proposal for a new GM population health function serving localities, CCGs and GM structures.

The programme will seek to:

- Test stakeholder support for this approach
- Develop and test standard operating model
- Develop a workforce modernisation plan.
- Develop implementation plan

Objective 3: Develop a model for future resourcing of population health in GM

The programme will seek to:

- Share of CBA work and agree joint approaches and opportunities for pooling resources

- Complete an analysis of resources invested in PH across all authorities and GM structures
- Develop a system-wide approach to Transformation Fund asks for Population health programme

Target outcomes for (16/17) and (17/18)

The programme will work towards achieving three key outcomes:

- Outcome 1: A population health commissioning plan which brings together the NHS England Commissioning responsibilities set out in section 7a of the Health and Social Care Act 2012, together with local government-commissioned population health services and the new service models set out in this plan produced.
- Outcome 2: Agreed proposal and implementation plan for a new GM population health function produced.
- Outcome 3: Proposals for future resourcing of population health in GM produced and agreed.

Programme of work scope

Building on the approach to date, detailed proposals and reform options will be co-created with the system recognising that there are significant variations that currently exist across and within the 10 local authorities of GM. That the Public Health grant is subject to national reductions and that there has been a significant reduction in the public health workforce across the system compounded by fragmentation of public health functions.

Timeline

To be completed

Cancer Prevention and Early Detection

Background

Cancer survival rates are at their highest with more than half of those diagnosed living for at least ten years. However it is estimated that by 2020 more than one in two people will be affected by cancer which is particularly alarming given evidence suggesting that 42 percent of the country's most common cancer cases could be preventable. In the last 5 years, almost 600,000 cancer cases in the UK could have been prevented by modifications to lifestyle factors.

The Five Year Forward View signalled a continued focus on improving care, treatment and support for everyone diagnosed with cancer. It set an ambition to improve outcomes across the whole pathway, including:

- Better prevention;
- Swifter diagnosis; and
- Better treatment, care and aftercare.

In 2015 following the publication of the NHS Five Year Forward View, NHS England established the Independent Cancer Taskforce to look at how cancer services are currently provided and to set out a vision for what cancer patients should expect from the health service. The Taskforce produced a report, Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020, which included 96 recommendations to help transform the care that the NHS delivers for all those affected by cancer.

A plan has now been launched to deliver these changes. It is designed to increase cancer prevention, speed up diagnosis, invest in technology, improve patient experience and help people living with and beyond cancer.

As part of this plan, new models of care piloted by the National Cancer Vanguard will aim to radically improve patient outcomes and save thousands of lives every year by developing new models of care that are ambitious and transformational, and provide replicable models for cancer care nationally that will act as blueprints for the NHS. Its key objectives are to:

- Improve rates of earlier diagnosis and detection
- Improve patient outcomes
- Reduce variation
- Improve patient experience

The National Cancer Vanguard is led by The Christie, The Royal Marsden and University College London Hospitals. Locally, the three organisations will lead a local delivery system – Greater Manchester Cancer; Royal Marsden Partners and University College London Hospitals Cancer Collaborative – which comprises health organisations in their area, including clinical commissioning groups, NHS acute trusts, community services and hospices, that will develop and trial new models to improve cancer care along the patient pathway.

GM context

A key commitment in Taking Charge is to deliver improvements in our cancer services and outcomes, with a particular focus on reducing premature mortality from cancer by 1300

fewer deaths by 2021. This is predicated on the transformation of our health and social care system towards prevention and earlier intervention.

Half of people born since 1960 will be diagnosed with cancer in their lifetime and every 30 minutes someone in GM is told they have cancer. And the incidence of cancer is growing at a rate of about 2% per annum; in 2013 14,500 people were diagnosed with cancer in GM. This then means the burden of cancer on our health and social care system is also growing. There were 89,200 GP referrals for suspected cancer to GM hospitals in 2014/15 up from 77,800 the year before. The national audit office estimated that cancer related costs for the NHS in England, extrapolating from these costs for GM gives approximate costs of £335m in 2012/3, rising to £650m by 2020/21 (acknowledging that these do not capture all costs, such as those incurred by primary care).

Clearly we will not be able to sustain comprehensive health and social care coverage unless we take more concerted action on prevention. Rising numbers of cancer cases that could be prevented should be seen as unacceptable. It is within our control to prevent many cases pf cancer and we should seize this opportunity. More than 4 in 10 cases of cancer are caused by aspects of our lifestyles which we have the ability to change. Tobacco remains the main risk factor followed by obesity, alcohol consumption and physical inactivity.

Earlier diagnosis of the disease is also essential if we are to make meaningful steps in improving survival for our patients. The key here is a strong focus on improving the uptake of the 3 national cancer screening programmes. Screening contributes to reducing incidence and improving outcomes for those patients whose cancers can be treated at an earlier stage. England's existing cancer screening programmes already save thousands of lives each year. However there is potential to do better, to reduce the considerable variation in uptake of these programmes and further develop the programmes by introducing new tests.

With increasing numbers of people surviving their primary cancer, we also need a stronger focus on preventing secondary cancers.

Opportunity

In 2015 GM was designated as part of the national cancer vanguard. The two year vanguard programme will allow the testing of clinical innovations and a new approach to the commissioning of cancer and delivery for the GM population. It began delivery in April 2016. Central to the GM programme is a prevention workstream which incorporates primary and secondary prevention projects as well as a focus on screening.

In summer 2016 a new GM Cancer Board was established to oversee all cancer activity in the area, and it will develop over the next two months a five year cancer plan to transform services and reorientate the system towards prevention and early detection. This is an opportunity for GM to strengthen and build on the work of the Cancer Vanguard

As identified above we want to reduce premature mortality from cancer by 1300 fewer deaths by 2021. In xxx cancer was responsible for 7,571 deaths in GM and half of those were preventable. The main driver of premature mortality and health inequalities in GM is related to tobacco. Despite significant improvements made in recent years to reduce smoking, smoking rates in GM are significantly higher than in the rest of England 21% of our population still smoke (approx.. 450k adults). This equates to c70k more smokers than if GM was at England average. Smoking also significantly contributes to health inequalities

has rates amongst GMs poorest families are twice the GM average. Therefore a key focus of work for the Cancer Board will be tobacco control.

Plan

Objectives

The overall objectives of the programme are to effectively deliver the cancer prevention work stream of the national cancer vanguard by April 2018, testing and evaluating innovative approaches to awareness and behaviour change, social movement, cancer screening uptake and lifestyle based secondary prevention. This includes 4 key objectives:

- Objective 1: To develop new GM wide social marketing strategies for cancer to scale up prevention, and earlier detection
- Objective 2: To apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum which is ultimately self-sustaining, as part of the national pilot programme health as a social movement
- Objective 3: To improve access to and uptake of three national cancer screening programmes (bowel, breast, and cervical) among the eligible population of GM residents
- Objective 4: To develop a GM wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis)

NB This work will be strengthened by the work on the forthcoming GM 5 year Cancer Plan

Approach to delivering objectives

Approach to delivering objectives

Objective 1: To develop new GM wide social marketing strategies for cancer to scale up prevention, and earlier detection.

The project will seek to in year 1:

- Work in partnership with PHE/CRUK to test out, deliver and evaluate a major bowel screening campaign to improve uptake featuring mass media (TV, outdoor media etc.) and direct mail.
- Commission additional behavioural insights research into GM to gain a deeper understanding of the core behavioural attitudinal barriers and motivators for our population
- Use the insights gained to amplify the CRUK/PHE campaign activity to nudge further GM audiences into participation.
- Undertake evaluation to inform future national and local campaign activity

In year 2 the programme will:

- Commission primary and secondary qualitative and quantitative research to segment, profile and prioritise our smoking population
- Using the above audience profiling and behavioural insights design a social marketing programme
- Coordinate delivery and evaluation of GM social marketing programme
- Undertake evaluation to inform future campaign activity

Objective 2: To apply at scale a multi-faceted approach to nurture a social movement across the entire cancer prevention spectrum which is ultimately self-sustaining, as part of the national programme to pilot for health as a social movement.

The project will seek to:

- Work in partnership with the third sector to develop an exemplar social movement – focused on cancer prevention.
- Apply at scale a multi-faceted approach to nurture a citizen led social movement across the entire cancer prevention spectrum.
- Develop a network of 20k cancer champions and expert patients to provide a more than medicine approach
- Demonstrate 'what works' – using rigorous evaluation approaches
- Support spread – in year 3 identifying approaches that could be scaled or adapted and adopted in other communities
- Explore the digital opportunities that would support mass involvement such as social media approaches

Objective 3: To improve access to and uptake of three national cancer screening programmes (bowel, breast, and cervical) amongst GMs eligible population.

The project will seek to:

- To increase the effectiveness of the initial invites letters through the application of innovative behavioural insight techniques. This will involve running RCTs over a 6 month period to test out the different approaches.
- To commission HEAs for all providers of cancer screening services to identify inequities in service usage and test out service changes based on findings of HEAs
- To design and test out innovative patient engagement approaches to improve people's experience of screening and to increase uptake of screening and self-care.
- To evaluate different approaches to inform local and national roll out.

Objective 4: To develop a GM wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis)

The project will seek to:

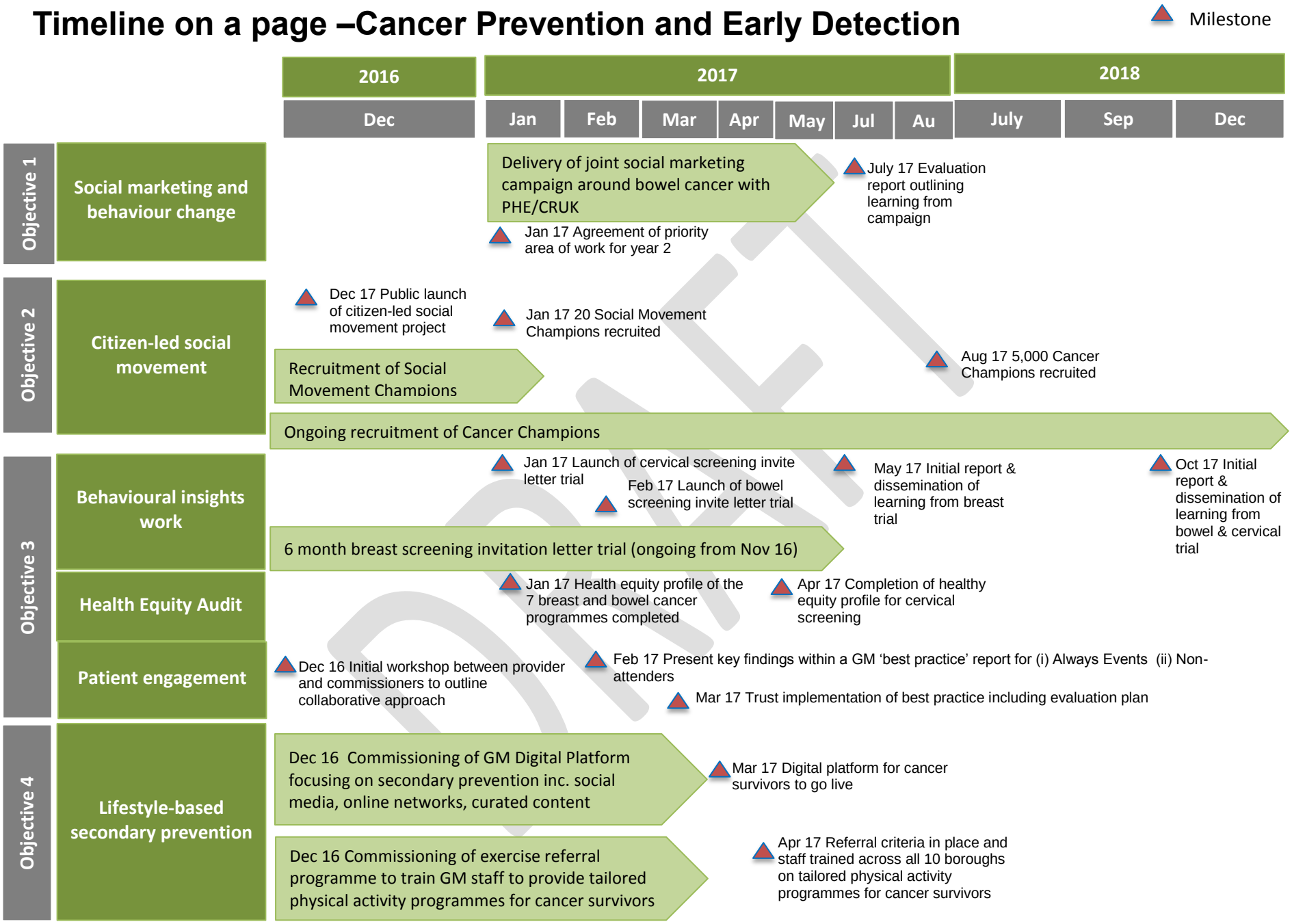
- Develop and test out an effective delivery model of lifestyle based secondary prevention as part of the vanguard's new after care pathways for breast, urology and colorectal.
- Development and rollout of a locality based lifestyle behaviour change support offer with a focus on GM wide access to exercise referral programmes for cancer survivors providing increased access to tailored physical activity programmes
- Development and testing of a digital platform (tech bundle) to enable cancer patients to access professionally approved secondary prevention self-management content, mobile applications, managed social support networks and links to locality based prevention services.
- Evaluation of different approaches to inform further roll out.

Outcomes

The overall objective is to make a significant contribution to reducing the number of premature deaths due to cancer by 1300 fewer deaths by 2021, through improved prevention and earlier diagnosis. More specific outcomes include:

- Outcome 1: Increased uptake of bowel screening (+10% in first timers and +3% in non-responders
- Outcome 2: Increase in smoking quitters- specific target TBC
- Outcome 2: The development of a mass social movement across the entire cancer prevention spectrum which is ultimately self-sustaining, and spread of effective approaches to other communities/areas
- Objective 3: Improved uptake to the three national cancer screening programmes (bowel, breast, and cervical) among the eligible population of GM residents
- Objective 4: The development of lifestyle support offer for cancer survivors in GM with a focus on secondary prevention of cancer

Timeline on a page –Cancer Prevention and Early Detection



Social Value

Background

Social value asks the question: "If £1 is spent on the delivery of services, can that same £1 be used to also produce a wider benefit to the community?". This involves looking beyond the price of each individual contract or activity, and considering the collective benefit to an area. A social value approach includes consideration of the social, environmental and economic wellbeing of a place and its citizens during the planning, commissioning and delivery of services, buying of goods or the procurement of works.

However, the same argument about gaining wider benefit can also be applied to business and non-commissioned VCSE activity, thereby increasing the whole economic footprint of GM.

Since January 2013, all public bodies have had to consider social value as part of their commissioning activities under the Public Services (Social Value) Act, both as part of contract specifications and as 'added value'. Under the Act, Social Value is an enabler that delivers additional benefits for suppliers and partners across all procurement and commissioning activity.

It is a legal obligation for local authorities and the NHS to consider the social good that could come from the procurement of services before they embark upon it. The Act allows authorities to choose a supplier under a tendering process who not only provides the most economically advantageous service, but one which goes beyond the basic contract terms and secures wider benefits for the community.

The themes of Social Value fall broadly into three categories; Economic (local jobs and growth), Social (resilience and strong voluntary and community sector) and Environmental (clean and protected environment). The spectrum of potential activities and measures within these categories is wide and varied, enabling individual authorities to match them to priorities and to some extent the resources they may have to support this work.

Furthermore, recent EU procurement regulations have increased emphasis on achieving wider societal goals through procurement and commissioning, and with these regulations embedded within public sector procurement, GM is now able to better commission social value.

GM Context

The GM Combined Authority (GMCA) Social Value Policy approved in November 2014 provides a consistent approach across each of the GM Councils. The GMCA Social Value Policy sets out how Social Value is used to underpin the core objectives of "GM Stronger Together" which are to stimulate growth in the economy and reform the way in which public services are delivered. Although the Social Value Act only applies to Services, the GMCA Policy is applied to procurement of Goods, Services and construction works. It does not however, currently extend to all public sector procurement activity in GM.

There are clear benefits of a consistent commissioning and procurement approach across GM – it provides a simpler landscape for suppliers who are expected to deliver Social Value under a contractual arrangement so the GMCA has a willingness to make sure that the principles included in the Policy are also applicable to non-Local Authority public sector bodies. A focus on a small number of priority areas would also help to target business and VCSE social value effort.

Social Value is an enabler that delivers additional benefits for suppliers and partners across all procurement and commissioning activity. Social Value should be used to underpin the core objectives of the GM Stronger Together and Taking Charge objectives by stimulating growth in the economy and reforming the way in which public services are delivered. It can be used to increase the spending power of every pound spent in GM.

The GM Police and Crime Commissioner (PCC) has also produced a Social Value Policy which echoes the principles of the GMCA Policy, and the AGMA Procurement Hub is currently in dialogue with the PCC and other partners to identify how a consistent approach can be taken to Social Value measurement.

Furthermore, Manchester Growth Company provides capacity building support to local businesses, particularly SMEs around the generation of added value and wellbeing outcomes through being a responsible employer, undertaking sound environmental practices and contributing towards local economic gain.

Opportunity

An opportunity exists to derive relevant **social, environmental and economic value** from everything that we do, in our business, in service delivery, commissioning and procurement; to use the huge purchasing power of the GM Devolution partners to obtain the greatest benefit for local people.

The proposed approach to Social Value across GM is to use this duty to increase the spending power of every pound spent in GM, therefore maximising the social value benefit to the people of GM from public sector commissioning and procurement, as well as increasing purposeful activities in the business sector and maximising the contribution made by voluntary, community and social enterprise.

Social Value can be created for the benefit of GM and its population by:

- Maximising Social Value from the expenditure of public funding
- Increasing purposeful business in GM
- Developing the ‘social market’ in GM
- Co-ordinating a programme of activity across GM to ensure that Social Value contributes towards the objectives of “Stronger Together” and “Taking Charge”

The longer term impacts of this approach will be to reduce dependency on and demand for public services, and contribute towards increased economic growth in GM.

The success of the proposal will depend upon this approach being embedded into normal practice for all parties involved at all levels.

It is intended that this proposal should build from good practice which is already happening in specific localities. Examples of this include:

- Creation of the GM Social Value Network and www.gmsvn.org.uk, Salford Social Value Alliance www.salfordsocialvalue.org.uk and policy work / commissioning arrangements at Salford City Council
- Oldham Council's Social Value Policy and Procurement arrangements
- Trafford Housing Trust work to broker neighbourhood level need with businesses looking to provide social value.
- Work with local SME's around social value, led by the Manchester Growth Hub.
- All GM authorities have established, but varying, social value procurement arrangements.
- Voluntary Sector 'For Good' initiatives which engage with businesses in Salford and Tameside, for example
- Social Value in Health and Care programme in Salford and Oldham, across local authorities, CCGs and VCSE. Also Building Health partnerships programme in Bolton and Manchester.
- A huge amount of work by GM registered housing providers around the measurement of social impact
- New Economy CBA tool, which includes social value calculations
- Work across the construction industry through the NW Construction Hub and major providers, including Laing O'Rourke, Waites and Keepmoat
- Interest in and early work towards measurement of social value by Foundation Trusts, including Salford Royal FT and Central Manchester FT

Evaluation of programmes in Salford and Oldham has shown the importance of leadership, values and working in partnership as being key determinants of successful social value. Furthermore, sharing of good practice and effective communication are essential for a successful intervention around social value

Plan

Our research shows that there is a great deal of work ongoing across GM to develop social value approaches in commissioning, procurement, business, voluntary and community activity and social enterprise – this programme will seek to ensure that health and wellbeing outcomes can be maximised from all this activity, and put effort and resources into gaps and opportunities which exist in the current picture to maximise the impact that could be achieved.

Objectives

The objectives of the work supported through the Theme One Population Health programme will be:

- Objective 1: To establish a clear baseline of existing activities and opportunities across GM, this will generate benefits for local people as ‘added social value’ to public services, business and VCSE action.
- Objective 2: To agree a single definition of social value which is applicable to all partners in Devolution
- Objective 3: To put in place a number of enabling activities which will maximise social value from the expenditure of public funds in GM, increase purposeful business, and develop the social marketplace.

Approach to delivering objectives

To be added

Scaling Up Our Response to HIV Eradication

Background

A 2015 report by Public Health England (PHE) estimated that 103,700 people were living with HIV in the UK in the year 2014. Once people are diagnosed they are able to receive very effective treatment. However, nationally 17% of people living with HIV are unaware of their status. Furthermore, 40% of adults newly diagnosed with HIV were diagnosed late, after they should have started treatment (PHE, 2014).

Late diagnosis reduces health outcomes for HIV positive people, as well as increases the likelihood of onward transmission of HIV. In addition to the negative effects of late HIV diagnosis on an individual's and population's health, it also makes an impact upon the public purse; the lifetime treatment cost of living with HIV is estimated to be around £360,000. Late diagnosis increases further the cost of HIV treatment by 50%.

It is well recognised that HIV symptoms are frequently missed. As a consequence, many people that have been diagnosed with HIV have previously presented at a healthcare setting but HIV diagnosis had been missed. Furthermore, whilst HIV is a condition which can affect all population groups, some communities are more disproportionately affected by HIV;

- Gay, Bisexual and other Men who have Sex with Men (MSM): Across the UK, one in 20 gay men is living with HIV. In large cities like Manchester, the figure is more likely to be 1 in 10. A total of 44,980 gay, bisexual and other men who have sex with men are living with HIV (prevalence of 4.8%).
- People from black and minority ethnic groups (BME) made up 40% of HIV positive individuals accessing treatment and care in GM in 2015, a substantial over representation compared to the proportion of BME groups in the GM population as a whole (16%).
- Trans Population: One worldwide meta-analysis of 39 studies from 15 countries found that transgender women had an HIV prevalence rate of 19% – 49 times higher than that of the general population. In high-income countries the prevalence was 22%, with the highest rate among trans women of colour. (AIDSMAP, 2016)

Late diagnosis of HIV is a key public health issue as identified within the Public Health Outcomes Framework. If someone has a late HIV diagnosis, they are 10 times more likely to die within the first year of diagnosis compared to people diagnosed promptly (PHE, 2014).

It has also been recognised that further progress needs to be made in improving early diagnosis of HIV; nationally, there is a need to increase and target HIV testing in order to improve early diagnosis and to reduce onward transmission by getting people onto treatment. Early diagnosis results in earlier treatment (National Institute for Health and Care Excellence, 2016).

We have an opportunity in GM to strengthen a City Region approach to eradicating HIV within a generation, by adopting a similar approach to the FAST-TRACK Cities initiative;

The FAST-Track Cities Initiative aims to build upon, strengthen and leverage existing HIV programs and resources in high HIV burden city regions to strengthen local AIDS responses; including attaining the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets:

- 90% of all People Living with HIV (PLHIV) will know their Status
- 90% of all PLHIV will receive sustained Antiretroviral Therapy (ART)
- 90% of all PLHIV on ART will have durable viral suppression

GM Context

There is clear synergy with a City Region approach to eradicating HIV within a generation and the Vision of transforming population health in GM; to deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8m people of GM.

In particular, a City Region approach fits with the GM objective to Transforming our health and social care system to help more people stay independent and well and take better care of those who are ill; it does this by preventing onwards transmission of HIV, both through earlier diagnosis and identification of undiagnosed people living with HIV, of whom across GM there is estimated to be 984 people living with undiagnosed HIV. These individuals are very much a part of the missing thousand's identified within GM priorities. An innovative, ambitious programme of upscaling of HIV testing and associated interventions, particularly targeted at and with those communities most at risk of acquiring HIV is an opportunity for GM.

The Fast-Track Cities initiative compliments and adds value to the GM focus of Social movement for health; through utilising the assets of communities, supporting people to talk about the importance of HIV testing, to share people's stories of how they maintain their wellbeing. This is focused upon communities taking charge of their own health.

Reducing late diagnosis of HIV is a key Public Health Outcomes indicator. Upscaling targeted HIV testing is a key mechanism to achieve this. A combination approach to prevention is a key part of FAST Track Cities, which includes not only testing but also Pre-Exposure Prophylaxis (PrEP), prompt access to treatment and support with adherence.

- 4,922 HIV positive GM residents accessed treatment and care (2014), a 5% increase on the number reported in 2013 (4,682 individuals).
- It is estimated that 1 in 6 people living with HIV in the UK is yet to be diagnosed.
- This means there could be approximately a further 984 people living undiagnosed with HIV in GM.
- Overall prevalence of HIV in GM is 2.78 per 1,000 population, (significantly higher than the England rate of to 2.1 per 1,000).
- Two local authorities in GM, Manchester (5.83 per 1,000 population aged 15-59) and Salford (4.8) have an adult prevalence of over 2 per 1,000 population; the threshold at

which the British HIV Association recommend routine testing for all medical admissions and new GP registrants.

- The dominant mode of HIV exposure is sex between men (MSM) at 57% of new cases, followed by heterosexual sex representing 37% of new cases.
- The predominant route of infection for new cases was MSM (57%) but this varied across local authorities with the majority of new cases in Stockport, Bury and Trafford being among MSM (71%, 62%, and 62% respectively) whilst in Wigan a higher proportion of new cases were acquired heterosexually (56%).
- People from black and minority ethnic groups (BME) made up 40% of HIV positive individuals accessing treatment and care in GM in 2015, a substantial over representation compared to the proportion of BME groups in the GM population as a whole (16%).
- Compared to other people living with HIV, people who died of an AIDS related cause in 2014 had the highest mean number of outpatient visits (5.8) and spent the greatest mean number of days as inpatients (19.6 days).

Opportunity

There is opportunity to develop a city region approach to eradicating HIV within a generation. GM Devolution and closer integration and collaborative approaches present opportunities for cross sector partnership working to eradicate HIV within a generation; public, voluntary and private sectors, developing an ambitious programme to identify the missing 984 people living with HIV.

Deeper exploration of the barriers and enablers of reducing late and undiagnosed HIV across GM will help formulate a GM Strategy to eradicate HIV within a generation to emerge. Shared GM system leadership will provide opportunities for analysis of how both more frequent and early HIV testing, at scale and targeted at those communities most at risk, could be implemented.

This GM wide City Region approach will also encompass transferable learning for addressing other health priorities and inequalities. This would include the similar challenges with early diagnosis of Hep B and Hep C which this GM approach can also help to tackle.

There are pockets of existing or recent best practice in individual GM boroughs, which could be more fully explored to identify areas which could be scaled up on via a GM approach. Regarding community based HIV testing, LGBT Foundation are working in partnership with BHA for Equalities, local PHE team and sexual health commissioners to provide Point of Care HIV Testing in community settings, Churches et.al. This approach is particularly targeting those most at risk of acquiring HIV infection; gay, bisexual and other MSM and black African communities. The project is currently in its delivery phase but it is providing to be successful and there are opportunities to explore scaling up provision and replicability in its community led and focused approaches.

A City Region approach and GM Strategy also provides opportunities to explore associated enablers for eradicating HIV within a generation. These could include evaluation of access

to Post-Exposure Prophylaxis (PEP) and exploration of how Partner Notification is currently working in GM.

Plan

Objectives

The objectives of this programme of work are to help develop a GM City Region approach to eradicating HIV within a generation. It would facilitate the roll out, testing and evaluation of an approach to tackling issues around undiagnosed and late diagnosis of HIV. The project would be informed by existing good local practice, including the current Public Health England community based POCT project, access to HIV testing within healthcare settings and PEP. The project is set up to achieve the following core objectives:

- Objective 1: Review and map out current HIV testing approaches and related interventions across GM, to inform the ambition of eradicating HIV within a generation.
- Objective 2: Develop a business case which builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a GM City Region approach to eradicating HIV with a generation. To then pilot and evaluate a GM City Region approach to eradicating HIV within a generation.

Approach to delivering objectives

Objective 1: Review and map out current HIV testing approaches across GM, to inform the ambition of eradicating HIV within a generation.

The project will seek to:

- Describe a GM vision around reducing undiagnosed and late HIV diagnosis.
- Work with the GM Sexual Health Network, mapping out current HIV testing methods and associated interventions.
- Utilise data within the public health domain to inform future HIV testing approaches.
- Develop a costings model for the possible expansion of HIV testing services, targeted at Black African Communities and Gay, Bisexual and other MSM, across GM.
- Develop and secure transformation funding to fund roll out to adopt and test the model.

Objective 2: Develop a business case which builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a GM City Region approach to eradicating HIV with a generation. To then pilot and evaluate a GM City Region approach to eradicating HIV within a generation.

The project will seek to:

- Provide a forum for sharing intelligence, analysis, perspectives and outputs related to the implementation of the model.
- Collate HIV data from a range of sources for analysis across GM.
- Develop cost benefit analysis for city region approach to eradicating HIV within a generation, particularly the upscaling of HIV testing.

- Collate lessons learned in targeting HIV testing for Black African Communities and Gay, Bisexual and MSM in order to inform future development of HIV testing models across GM.
- Explore different sustainability and investment models

Target outcomes for (16/17) and (17/18)

The programme will work towards achieving three key outcomes:

- Outcome 1: Through partnership working across GM and mapping of current practice, a GM wide HIV Strategy for eradicating HIV within a generation, has been developed.
- Outcome 2: A model to increase HIV testing and associated interventions has been developed.
- Outcome 3: A Business case and plan for the GM wide rollout of the model has been produced, agreed and a GM pilot implemented.

Programme of work - Scope

GM residents who are currently living with undiagnosed HIV are the primary target cohort who would benefit from this intervention. It is estimated that 984 people are currently living with undiagnosed HIV across GM. Thus, the programme would seek to target, reach and work alongside this key population group, through a community led assets based approach.

The specific sub groups within this proposal who are intended to benefit most from this programme are those communities who shoulder a disproportionate burden of HIV; Gay, bisexual and other MSM, black Africans and Trans communities.

The new delivery model would be a city region approach to eradicating HIV within a generation. It would be a cross sectoral collaboration, with the key driver being evidence led interventions. This city region approach would also capture wider benefits and learning to other health issues, and how these can be tackled GM wide.

Central to the new approach is an evidence led delivery model. System leadership and the development of a shared response to eradicating HIV within a generation will enable greater analysis and exploration of the barriers and enables to reducing late diagnosis.

Timeline

To be produced

References List

To be added