MEETING:	**Population Health Programme Board**
SUBJECT:	**Population Health Programme Plan: Progress Review and Forward Look**
RECOMMENDATION:	**To note the content of the report and support the continued implementation of the Population Health plan**
ACTION REQUIRED:	**Information Only**
AUTHOR:	**Sarah Price, Executive Director for Population Health and Commissioning**

1.0 INTRODUCTION

1.1. This report provides an overview of activities undertaken in 17/18 towards the priorities set out in the Greater Manchester (GM) Population Health Plan.

1.2. The report will cover the following areas:-

- Work to date to agree allocation of Population Health Transformation Fund monies against a number of strategic business cases and;
- Progress so far in terms of implementation of a number of early programmes of work as part of the plan.
- A forward look at future planned activities.

2.0 BACKGROUND

2.1. GM Population Health Plan

2.1.1. The GM devolution agreement and taking charge of GMs £6b health and social care budget has provided an unprecedented opportunity to address the deep rooted health inequalities and the chronic disease epidemic which we are facing. GMs strong track record of collaboration across NHS, local authority, business and VCSE sectors alongside the new devolved integrated system provides the right environment for breaking down organisational silos, garnering the assets of individuals and communities to take control of their own health, and harnessing the energy of all stakeholders across GM in the pursuit of health gain. Significantly it allows us to focus on the root causes of ill-health, for example strengthening the links between health, work and economic prosperity to take a truly whole systems approach to population health and wellbeing.

2.1.2. International and national policy identifies early intervention and prevention as the most cost effective, affordable and sustainable course of action to cope with the sharply rising burden of avoidable illness driven by our lifestyles, other demographic changes in particular population aging and by deprivation and social and economic influences. Evidence suggests most prevention and population health interventions are cost effective, meaning they generate a better outcome than the next best alternative use of resources and will save the public purse in the short and longer term as well as delivering improved and sustainable health outcomes and contributing to wider sustainability and economic, social and environmental benefits.

2.1.3. Within GM, Population Health is seen as a whole system issue requiring a whole system response. To address this, the GM HSC Partnership agreed a single GM wide Population Health Plan in January 2017. The Plan built on and reflected prior commitments made in the MoU with PHE (July 2015) and the GM Taking Charge Together Plan (December 2015) to prioritise the prevention agenda and the rebalancing of investment towards prevention to deliver the best outcomes for the health and wellbeing of GM's population.

2.1.4. The Population Health Plan set our collective ambition for delivering a radical upgrade in population health; it is focused on five priority themes: The first three (start well, live well, age well) sets out our approach to delivering population health consistently at scale across GM and taking the multiple opportunities across the life course to enhance quality of life. The Plan also sets out our ambition to create a unified population health system across the GM economy which is organised to deliver at pace and scale. Our Plan also embraces the concept of asset-based community development and actively involving our communities as a way of doing business.

2.1.5. The GM Population Health Plan is aligned with the Mayoral Manifesto, GM Strategy and includes key shared commitments including: early years and school readiness; work and health; healthy aging; physical activity and the promotion of active travel; air quality and social prescribing.

2.2. Strategic Investment Case

2.2.1. Following the sign off of the plan a Strategic Investment Case for Population Health was developed following an extensive process of engagement and socialisation over a 6 month period with localities, GM Mayor, wider system leaders supporting the delivery of the population health plan and strategic groups within GM Governance. The paper outlined a broad investment framework to underpin the implementation of the Plan over the remaining years of the devolution period and secured the allocation of up to £30m of GMHSCP transformation funding. A minimum ask of £25m was agreed with a further potential £5m subject to review.

2.2.2. The investment agreement also recognised that not all programmes of work within the Population Health Plan required investment. Key priorities for investment have been selected based on best available evidence of impact; areas which would benefit from scaling up practice across GM; are central to accelerating progress on population health at pace and scale or have been highlighted by citizens and the wider system as the right things to invest in.

2.3. Governance & Decision Making

2.3.1. In the build up to the development of an overarching Strategic Investment Case (SIC), a GM Population Health Programme Board was set up to guide the development of the SIC and to maintain oversight for delivery of the Programme. Alongside the programme board an Investment Oversight Panel was established to oversee the Transformation Fund process in relation to Population Health, review individual submissions and make recommendations to the Population Health Programme Board in respect of awarding monies from the Transformation Fund allocation.

2.3.2. Reporting to the Programme Board are then a subset of boards and groups which ensure oversight and drive delivery of each of the individual projects. These groups report progress into the board and escalate risks and issues where appropriate.

3.0 INVESTMENT CASE DEVELOPMENT AND AGREEMENT ON FUNDING ACTIVITIES

3.1. Over the last 12 months the PH Board have approved investment in population health initiatives totalling over £21.0m. In the coming few months further funding cases will be agreed totalling investment of £25m in delivering population health outcomes.

3.2. In line with the strategic investment case recommendations a further submission has been made to the transformation fund for an additional £5m funding allocation. This would be used to invest in the remaining priorities of the plan which are currently un-funded based on spending profiles described above.

4.0 POPULATION HEALTH – OVERVIEW OF KEY ACTIVITES IN 2017/18

4.1. In 2017/18 we have moved into the implementation phase of the Population Health Plan and the following section highlights the key progress that has been made over the last 12 months. Significant progress has been made in developing GM wide whole system approaches to tackle the main causes of ill health through the sign off and launch of the following strategies and action plans:

- The GM Making Smoking History strategy 2017-21, endorsed by the GM Strategic Partnership Board in July 2017, which will identify innovative and evidenced based approaches to reduce smoking rates by one third by 2021.
- The GM Moving Strategy 2017-21 refresh, endorsed by the GM Strategic Partnership Board in July, to increase levels of physical activity across GM.
- The prevention chapter of the GM Cancer Plan and the initiation and development of the prevention work stream of the GM Cancer Vanguard which identified innovative approaches to increasing cancer screening uptake, awareness and behaviour change.
- The new GM Integrated Substance Misuse Strategy, due to go through due governance in summer 2018.
- The GM Ageing Strategy approved in March 2018, which is also one of four GM Mayoral Reform priorities.

4.2. These strategies are pivotal as they set out a new level of ambition regarding population health, going further and faster than other city regions to deliver a radical upgrade in population health that ensures 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.

4.3. Alongside these strategies, and also key to the overall success of the Population Health Plan are our proposals to fundamentally reform the GM Public Health system which were progressed through AGMA Wider Leadership Team and approved by the GM Health and Social Care Strategic Partnership Board in Spring 2017.

These proposed the establishment of a unified Population Health system for GM that:

- Is united in its focus on the delivery of agreed priority population health outcomes and long term sustainability.
- Defines a set of population health goals that are recognised and embedded within all relevant GM programmes and services.
- Develops greater consistency of approach and common standards for delivering population health outcomes across GM, in terms of planning, monitoring, commissioning and service delivery for population health.
- Is consistent with the principle of subsidiarity (decisions are made at the most appropriate level) within GM, recognising the 'place' (Local Authority footprint) as the primary unit of planning whilst also being cognisant of the needs of communities of identity.
- Creates a strong and able cadre of population health leaders across GM, supported by clear governance and accountability and reporting systems, and a specialist public health workforce.
- Extends commissioning and delivery of some public health functions at GM level to achieve additional impact, complementary to that at locality level.
- Drives out inefficiencies and unnecessary variation in the system

4.4. Progress has been made in delivering these highly ambitious plans but, given the inherently transformational nature of system reform, and given the propensity for 'wicked issues', the rate of progress has been slower than for the issue-based Population Health Plan proposals.

Key achievements over the last 12 months include, but are not exclusive to:

- Development of a GM Population Health Outcomes Framework and accompanying online dashboard. This includes the establishment of trajectories as a means for identifying improvements of time.
- Co-production of a set of GM common standards for prescribed and core PH functions and other GM PH priorities.
- Agreement and implementation of a single integrated assurance process whereby population health outcomes, improvement trajectories and standards have been incorporated into the existing GM and locality assurance process.
- Development of proposals and an investment proposition in relation to a unified GM Population Health Intelligence system as part of a wider health intelligence system transformed through Taking Charge with a focus on
  - A unified Health Intelligence Function
  - A skilled and motivated workforce
  - An enabled population
- Commissioning of an independent review of the current Health Protection system to aid the development of detailed proposals for a unified GM Health Protection System.
- Devolution of responsibility for HIV treatment services (and associated funding) to GM under specialist commissioning transfer.
- Development of draft GM strategies for Drugs and Alcohol, and Sexual and Reproductive Health.
- Commissioning an independent review of the current GM Sexual and Reproductive Health system and the development of a set of detailed proposals for the form and function of a future integrated Sexual and Reproductive Health system.
- Establishment of the GM Commissioning Hub in order to identify areas for the development of GM service specifications and potential GM commissioning.
- Development of draft GM Population Health Workforce Transformation proposals and alignment with wider GM Workforce Strategy.
- Increased Population Health system reform investment from GM Directors of Public Health.
- Increased alignment with Mayoral work programme.

4.5. In addition, a number of other opportunities have emerged since the development of the PHP, which will be progressed during 2018/19 including the GMCA (Public Health Functions) Order 2017 and the development of System Architecture / New Models of Care.

4.6. Another area where we are taking a whole system and cross public sector approach is around our Health and Justice agenda. Following the recent commissioning of the GM integrated custody healthcare and liaison and diversion service, we are now seeking fresh insight to help inform the development of the first ever evidence-led GM Health and Justice Strategy. The strategy will be informed by a number of pieces of work including a commissioned independent strategic review , a thematic roundtable event and the development of a Health Needs Assessment guide & ROI tool with Public Health England.

5.0 THE DEVOLUTION DIFFERENCE – SO FAR

15 months after agreeing GMs first ever Population Health Plan devolution is making a difference to everyday lives in Great Manchester.

5.1. Making Smoking History

5.1.1. In July 2017 the Mayor of GM launched the GM Making Smoking History strategy aiming to at a pace and scale faster than any other major global city to reduce smoking by around a third to 13% by 2021, closing the gap with England, delivering 115,000 fewer smokers, saving thousands of lives. By 2027 we aim to deliver a tobacco- free generation by reducing adult prevalence to less than five per cent. An investable proposition and implementation plan for years 1 & 2 of the strategy was produced, with over £3million now secured from the Transformation Fund and matched funding being pursued through applications to Cancer Research UK and The Bloomberg Fund.

5.1.2. For the first time, GM smokers are able to access tailored help and advice to quit 7 days a week from the Stop Smoking GM Helpline launched 1st January 2018 on the MyCityHeath GM state of the art digital platform. 95% of GM smokers are not quitting with local services but more than 7 out of 10 do want further motivation, advice and support to quit successfully. MyCityHealth's smoking pages were refreshed and relaunched based on user insight, engagement and evaluation leading to a 425% increase in engagements.

5.1.3. Two further pieces of work also kicked off in January around e-cigarettes, including an innovative e-cigarette pilot in partnership with Salford City Council and local social housing providers. The pilot has enabled 1000 smokers, living in social housing where smoking rates are significantly higher, to access to a free e-cigarette starter kit, alongside local stop smoking support. Independent evaluation will include follow up at 6 and 12 months. Alongside, our partnership with CRUK resulted in the organisation's first mass media e-cigarette campaign being delivered in GM.

5.1.4. In February we launched our Don't Be the 1 integrated multi-media campaign centred on the smoking kills 'One in Two' message. Pre campaign research identified that 9 out of 10 GM smokers were unaware that smoking kills 1 in 2 with half believing the odds to be somewhere between 1in 10 and 1 in 20. Evaluation is underway, however previous campaign evaluation suggests 70% of our 393,000 smokers in GM will have engaged and around 90,000 would be expected to take some quit related action as a result of the campaign.

5.1.5. February also saw the launch of our History Makers Consultation, a radical public engagement conversation providing opportunities for members of the public to learn about and engage with the tobacco strategy including potential policy and regulatory changes. Over 200 advocates from across our 10 boroughs signed up to be History Makers, becoming the "face" of the campaign. To date there have been over 4500 responses. The consultation will run to April 30th.

5.1.6. The CURE secondary care programme is being trialled at Manchester FT Wythenshawe site for roll out across GM. Deaths from cardiovascular events are expected to start to fall immediately with deaths from all causes are expected to drop by 40% at 2 years in treated smokers. Expected pilot site outcomes include: 165 fewer admissions at 30 days, 310 fewer admissions at 1 year, 157 lives saved at 1 year and 929 successful quitters. The potential GM wide impact of this programme in targeting and supporting our sickest smokers and delivering a truly smokefree NHS is enormous.

> ***Case Study:*** *Leigh Webber is a 55-year-old teaching assistant from Timperley. A former heavy smoker, Leigh was diagnosed with lung cancer in 2017. She was successfully treated and is now in remission. Her consultant attributes that outcome partly to the fact that Leigh had given up smoking and got fit before her cancer diagnosis. An extremely keen runner, Leigh has gone from smoking 20 a day and eating junk to being one of the best runners in her age group.*
> *Leigh's enthusiasm for her new life is infectious. As an ambassador for choosing a healthier, happier, longer life she is determined to help us Make Smoking History. See Leigh's video for more of her story.*

5.2. Early Years

5.2.1. System leadership of this agenda is shared across the system with clear commitment to improving School Readiness made in the GM Taking Charge Strategy, GM Strategy, GM Population Health Plan, GM Start Well Strategy, GM Mental Health Strategy and the GM children and young people health and wellbeing strategy. Recently revised governance for this agenda has resulted in the development of a GM School Readiness Board co-chaired by Joanne Roney, Chief Executive of Manchester City Council and Jon Rouse, Chief Officer GMHSCP.

5.2.2. The Start Well programme within the GM Population Health Plan aims to support the delivery of integrated early intervention and prevention services across all localities in GM with the following specific objectives:

1. Fully implement the core elements of the GM Early Years delivery model (EYDM) which comprises 4 key elements:

   - High Quality Universal Services
   - 8-stage New Delivery Model assessment pathway
   - A range of multi-agency pathways
   - A suite of evidence based assessment tools and targeted interventions.

2. Develop a sustainable, resilient and consistent set of GM interventions to stopping smoking in pregnancy (investment committed).

3. Develop IMT proposition to improve data processes to track progress and allow earlier intervention (additional investment required via GM Connect work programme).

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 (investment committed).

Early Years: Reducing Smoking in Pregnancy

5.2.3. Quitting smoking is one of the best things a woman and her partner can do to protect their baby's health through pregnancy and into early childhood. Children born into households where both adults smoke are four times more likely to take up smoking themselves. GM currently has the smoking rate at time of delivery rate of 12.8%, the national average is 10.8%. Our ambition is to halve this rate to no more than 6% in any locality by 2021 and ultimately for every baby to be born smokefree. Reducing smoking rates in our most vulnerable families could also lift as many as 21,110 children above the poverty line in GM.

5.2.4. A GM level, universal approach to smoking cessation in pregnancy with a targeted element focussing on our most vulnerable will help deliver smoke free pregnancies and smoke free childhoods. It will reduce the social norm of smoking, its prevalence and increase the number of smokefree homes across GM; this will directly contribute to a reduction in the number of children starting to smoke.

5.2.5. The implementation of the programme began in December 2017. It will ensure 36,500 pregnant woman and their families will receive consistent support and advice regardless of where they give birth in GM. It will be implemented in all parts of GM during 2018 and is being rolled out on a cluster basis. All pregnant women who are smoking at booking (c4000 women) will be engaged. We expect to support an additional 3000 women through programme interventions during their pregnancies during 2018/19 and to deliver around 1,250 additional smokefree babies this year. Saving babies lives, delivering better births and securing a tobacco free generation.

5.2.6. Smoking cessation in pregnancy is delivered via the babyClear model and requires testing of all pregnant women for carbon monoxide exposure and referring those with a positive reading to smoking cessation services. This is being rolled out in three clusters with full implementation in Rochdale, Bury, Oldham and North Manchester from May 2018 with in all other areas by September 2018.

5.2.7. A smoke-free pregnancy incentive scheme was launched across GM in all areas except Wigan in February 2018 which targets a defined group of vulnerable women living in communities where smoking rates are highest, and who would find it hardest to maintain a quit without additional support. We expect to engage up to 1,200 women on the scheme this year. Previous scheme data suggests that we can expect around 600 of those vulnerable women will still be quit 3 months after they deliver their babies.

Early Years :Oral Health Improvement

5.2.8. The latest oral health survey of five year old children (DPHEP, May 2015) found that 36% of five year olds in GM (GM) had tooth decay compared with 25% in England. However, the GM prevalence of tooth decay in five year olds shows a marked inequality between Local Authority areas with the worst being: Oldham (51%), Salford (51%), Rochdale (44%) and Bolton (41%).

5.2.9. Oral health is an important part of general health and wellbeing. A healthy mouth enables children to communicate, eat and enjoy a variety of foods, socialise and attend school as well as contributing to their self-esteem, confidence and readiness to learn. Dental decay is highly prevalent in GM and the impact on both society and the individual is significant, causing pain, discomfort, sleeplessness, limitation in eating leading to poor nutrition and time off school or work as a result of dental problems. In 2015/6 treatment of preventable tooth decay in children cost GM circa £20 million, representing a significant proportion of the total annual spend for dentistry, of around £200 million.

5.2.10. Extraction of decayed teeth under general anaesthetic (GA) is the most common reason for a child aged between five and nine years of age to be admitted to hospital in England, with more than twice as many admissions as the next most common reason of tonsillitis

5.2.11. There is a strong evidence for interventions to improve the oral health of children. The following three having the strongest evidence base, feasibility of implementation and show the greatest financial return on investment:

- Daily supervised brushing programmes in all nursery and reception classes
- Distribution of free toothbrush and toothpaste packs and oral health advice Health Visitors.
- Fluoride varnish application at least twice yearly for every child

5.2.12. This large scale intervention programme which will is now in its delivery phase and i.e. embedding proven approaches consistently at scale across our 4 localities with the worst oral health in under 5s in a way that has never been achieved before

- Health Visitor teams in these localities have received refresher training on oral health to ensure consistent, evidence based advice to young families. Free toothbrush and paste is now being provided to all young families through the health visitor contacts, totally over 13,000 children per annum.
- Of the 106 NHS dental practices within these localities, 52 have committed to deliver enhanced provision. From 1st April these practices are commissioned to work with community partners and provide additional access capacity for c. 5,800 children. All NHS dental services are encouraged to promote children to attend for dental check up by the age of 1 year, and to provide fluoride varnish to children as part of Delivering Better Oral Health.
- Further building on the delivery above, the project team are beginning work with early years and reception classes to implement the consistent toothbrushing programmes for children, focused on the new intake arrangements for children.

5.3. <u>Focused Care in General Practice</u>

5.3.1. Focused care is a model to support patients and staff working in GP practices in areas of severe deprivation. These practices experience significant increases in volume of work and also complexity caused by the combination of physical and mental health combined with complex interplay with social circumstances and often addiction. This tri-morbidity and complex interplay puts significant strain on primary care personnel.

5.3.2. FC supports GPs and primary care teams and builds resilience. A GP that has had FC in their practice for 4 weeks reported that “FC is allowing me to be doctor I wanted to be when I entered medical school.”

5.3.3. Focused Care is engaged with 52 practices across GM, 31 of which are under the GM HSCP Population Health pilot funding. Oldham CCG and Rochdale CCG have directly commissioned additional local practice delivery.

5.3.4. The pilot is to be independently evaluated, including the development of an 'app' collecting activity data from across the practice workers' caseloads. As at January 2018, 705 assessments covering 622 households detailed on the App.

Case Study: *Alice* is a 49 year old lady, with complex medical and mental health needs, and significant social vulnerability. She was referred jointly to Focused Care by the Police and her own GP – both due to inappropriate and frequent contacts.*
Living alone in a flat, she was regularly contacting the police concerned about her neighbours, whether or not there was an actual problem found. Since engaging with the Focused Care Practitioner, she has found a safe point of contact and support, which has meant that she is now in touch with the Police less. She is supported to her medical appointments with the Focused Care Practitioner, and is more appropriately contacting health services. This is an ongoing case, for which there is no easy solution, but the help provided by a Focused Care Practitioner has enabled positive chanaes to be made.

5.4. Malnutrition and Dehydration in Older People

5.4.1. This programme is a classic early identification public health intervention targeting adults aged 65+ living in the community who may be at risk of malnutrition and dehydration. Both malnutrition and dehydration are often missed as risk factors in later life or they are misunderstood as a normal part of the ageing process.

5.4.2. The method of identification in this programme is the innovative paperweight armband, developed by Salford partners as a non-clinical and non-threatening way to identify malnutrition risk and start a conversation about weight loss, diet, appetite and food accessibility for example. This is accompanied by easy-to-use materials which support older adults and their families to follow good nutritional self-care and avoid further weight-loss. The 5 pilot localities of Bolton, Bury, Oldham, Rochdale and Stockport will also develop a range of awareness raising opportunities over the course of pilot.

5.4.3. The pilot begins frontline delivery this month (May 2018), with each locality aiming to target older adults who are likely to be more vulnerable to malnutrition risk, broadly in line with expected prevalence. The programme aims to achieve positive individual outcomes, including weight gain, weight maintenance and changes of dietary habits, for at least 3 in 10 adults who have been identified as at risk of malnutrition which is over 7,000 older people across the 5 pilot boroughs. In line with the Salford experience, stimulating increases in primary care recording of underweight BMI is a specific objective.

***Case study**: Jane, aged 91, lives alone had a history of heart disease (2 heart attacks), COPD, and skin cancer. She attended A&E at Salford Royal where as part of discharge it was established that she was having difficulties with eating meals. During the initial home visit, discussions with Jane identified that she had lost a lot of weight, and had no motivation to cook or eat well. The support worker discussed the aims of the 'paperweight armband' test, which identified that Jane was at risk of malnutrition. Jane had good family support networks but was also lacking motivation to cook at this time. The support worker provided Jane with the nutrition leaflet 'How to improve your food & drink intake if you have a poor appetite'. Over the following 8 eight weeks, the support worker visited Jane and on the visits encouraged and reminded her to increase her nutritional intake. Overall outcomes in this case included improved confidence, reduced attendance at GP and growing independence in the context of receiving reablement support. She also became interested in food and nutrition again, which led to:*

- *At the end of the 8 eight-week reablement period Jane had gained 4kg in weight*
- *Jane was making home cooked meals 2-3 times per week.*
- *Jane was out with friend 2- 3 times per week, including a lunch group*

5.5. Physical activity

5.5.1. The GM Moving Strategy refresh raised GMs level of ambition around reducing physical inactivity committing us to double the rate of past improvements reaching the target of 75% of people active or fairly active by 2025.

5.5.2. The MOU with SE has signalled a different way of working which has already led to £1m been secured from Sport England to address physical inactivity in older adults. GMs active aging programme was launched in March 2018, a transformational whole system approach to addressing inactivity and enabling active lives in Greater Manchester. This evidence based, insight led approach, which embeds physical activity at the heart of reform in GM, will lead to population scale change in physical activity behaviour.

5.5.3. In addition the announcement by Sport England in November that GM is one of the 12 local delivery pilots will bring significant investment in GM to address our high rates of physical inactivity (minimum investment c£20m). The LDP will focus on three target audiences: help children to be more active outside school; support the unemployed or those at risk of unemployment due to ill health ;those aged 40 -60 at risk of or with a long term condition. Work is underway to engage the audiences, those that work with them and local/national experts in the field to inform and shape the proposal and implementation phase which will begin in summer 2018.

5.5.4. GM has been announced as the world's first City Region committed to The Daily Mile by encouraging all its residents to get moving and adopt 15 minutes of physical activity every day. This sets a target for all nurseries, schools, universities and workplaces to adopt The Daily Mile. 43% of schools in GM are already on board with the initiative, contributing to the 2020 ambition of 75% of primary schools

across GM regularly taking part in The Daily Mile, this will see over 180,000 children a year by 2020 which will see over 180,000 children.

> ***Case Study:*** *Ladybarn Primary School implemented The Daily Mile programme two years ago and are in no doubt about the benefits it offers their students. "I've seen that children's body shapes have changed, their confidence has increased, their fitness levels have increased and they've started winning a lot more competitions," said Assistant Head and Year Four Teacher, Ms Cree. "They have improved their fitness levels and they really enjoy running, it's just had a really positive impact on their whole fitness life."*

5.5.5. The Walking and Cycling Report, 'Made to Move' from the GM Walking and cycling commissioner, Chris Boardman was approved by GM leaders in December 2017. It outlines how to deliver a step change in walking and cycling in GM and calls for £1.5bn investment. This work is aligned to GM Moving ambition and will accelerate the walking and cycling components of GM Moving.

6.0 THE DEVOLUTION DIFFERENCE – STILL TO COME

6.1. Our remaining Phase two programmes, have either just had funding approved and will go into delivery from August 2018 onwards or are going through the final business case approval process for delivery from 2019 onwards.

6.2. <u>Health and Employment</u>

6.2.1. The GM Working Well (Early Help) Programme will develop and test an effective early intervention system available to GM residents in work who become ill and risk falling out of the labour market, or are newly unemployed due to health issues. It will support up to 14,000 GM residents between March 2019 and 2022, targeting occupational health and condition management support alongside employment rights and impartial careers advice and guidance. The primary focus will be on people employed in small and medium sized enterprises (SME) across GM, with referrals sourced from General Practitioners (GPs), employers and individuals directly. Jobcentre Plus will be a sign posting partner for those who are newly unemployed.

6.2.2. The primary outcomes the programme will test are whether the support provided enables a rapid and sustainable return to work, although there will be significant further learning captured in the evaluation process to inform financial sustainability modelling. The aim is to support more people with health conditions and disability to remain in the labour market, to support productivity, reduce non-clinical demands on primary care and to reduce the flow of people who move onto long-term sickness and disability benefits.

6.2.3. The programme has successfully completed its phase one development phase, including programme design, business case approval and procurement imitation. During 18/19 the new service will be tendered and the contract mobilised to begin delivery in March 2019. Funding for the programme

totals £8million secured from Health & Social Care Transformation Fund, DWP/DH Work & Health Unit, Reform Investment Fund and European Social Fund.

6.3. HIV eradication

6.3.1. GM has set itself an ambition to eradicate HIV within a generation. Our plan is to address this through: optimizing prevention; scaling up testing and optimizing programmes of treatment for those who are HIV positive, with a particular focus on those at greatest risk. Thus early intervention programme is in its mobilisation phase with delivery commencing in August 2018.

6.3.2. In terms of expected reach and outcomes, the project is predicted to increase diagnosis rates (the proportion of the undiagnosed stock that is diagnosed each year) to 60% by March 2021, which under the modelled assumptions equates to 92% of people living with HIV in GM knowing their status, compared to the 2016 baseline estimate of 87%. This would ensure that the first of the Joint UN Programme on HIV/AIDS (UNAIDS) 90-90-90 target aspirations was met, for 90% of people living with HIV in GM to know their status by the end of the programme lifetime in March 2021.

6.3.3. A total of 145 diagnoses are estimated to be avoided over the nine years from 2018/19– 2026/27; this comprises a decrease in very late diagnoses of 104, and a decrease in late diagnoses of 110; overall, the number of early diagnoses over the period will increase by 69. The benefits comprise health and care savings associated with earlier and avoided diagnosis, and are anticipated to total some £24.5m.

6.4. Drugs and alcohol

6.4.1. A single GM Drug and Alcohol Strategy has been developed, which sets out GM's collective ambition to significantly reduce the risks and harms caused by drugs and alcohol. In comparison to the rest of the country, drug and alcohol use has a disproportionate impact on health outcomes and life expectancy in GM and we are starting from a challenging position, particularly in relation to alcohol. The financial cost of alcohol to GM is significant. It is estimated that expenditure on alcohol related crime, health, worklessness and social care costs amount to £1.3bn per annum.

6.4.2. As part of this jointly led strategy development, population health have recently approved two investment propositions relating to;

- A programme of activity aimed at engaging local people to engage in a wide-ranging engagement exercise aimed at tackling the harm associated with Drugs and Alcohol. This proposal focusses on the progression of a 'Big Alcohol Conversation' for GM aimed at engaging the wider population of GM and specific population cohorts and segments through a balance of social and digital media engagement, and direct 1 to 1 and group engagement at a locality and neighbourhood level. The Big Alcohol Conversation has a whole population reach, but with a specific focus on the "moderately unhealthy" cohort of the GM population

- A programme which contributes to an ambition within the Strategy to reduce the harm experienced by children and young people in GM as a result of parental substance misuse, and additionally contributes to GM ambitions relating to giving every child the best start in life. This specific investment proposition relates to a programme of activity aimed at reducing alcohol-exposed pregnancies and, as a consequence, eliminating new cases of Foetal Alcohol Spectrum Disorder (FASD) in GM.

6.5. Health Checks

6.5.1. The NHS Health Check is a national mandated programme that invites all adults in England aged 40-74 (who haven't already been diagnosed with one of the specified long term conditions) once every five years aims to review their risk of cardiovascular disease (CVD) and other non-communicable diseases such as stroke, diabetes, chronic kidney disease and dementia. Across GM there is significant variation in the level of investment, offer and uptake of NHS Health Checks, leading to approximately 594,000 eligible GM adults who have not yet had a Health Check.

6.5.2. The growing evidence base on prevention of CVD and the NHS Health Checks programme suggests targeting those at most risk is cost effective. PHE have now agreed that they will work with GM to trail a targeted offer which invites those most at risk for a face-to-face check utilising a neighbourhood model approach to support those at lower risk with advice and signposting through a digital approach.

6.5.3. The targeted model will provide face to face Health Checks to a smaller proportion of the population. This will free capacity in the Health Check system to target checks to those at higher risk for CVD and associated conditions. A targeted Health Check alongside other complementary programmes, such as a GM Healthy Hearts Programme could result in 600 fewer deaths (by 2021).

6.5.4. The face to face model will be tested in one or two localities in 2018. Initial priority areas would include Manchester (given that it has the highest number of CVD deaths to prevent) and Salford (due to its organisational maturity with regards to data sharing, high need and identified priority to improve Health Check uptake).

6.6. Food, Nutrition & Healthy Weight

6.6.1. A focus on food and nutrition is a natural sister programme to GM Moving and the population health physical activity programme, which together address the two most influential individual and social factors in obesity and overweight at a population level.

6.6.2. This programme which is the final stages of scoping proposes to develop a GM strategic leadership approach to food and nutrition which is like that adopted by many urban cities across the UK and internationally with the aim of developing sustainable food systems and promoting healthy diets.

6.6.3. The essence of this proposal is to enable the development of food system change leadership through a multi-agency food leadership body for GM, harnessing the existing expertise in the VCSE and social housing sectors and engaging wider leaders and sectors. The proposed 2-year programme capacity development resource will include a fund earmarked specifically to enable a feasibility study to be commissioned which will identify opportunities within the remit of public sector authorities and organisations to apply positive influence on the food environment. The business case will be brought forward for approval in May 2018.

6.7. Falls prevention

6.7.1. The collaborative work under development through the falls programme aims to stimulate best practice across the health and social care system and environment which will reduce the incidence and impact of falls in the community and reduce hospital admissions due to falls. The programme is primarily designed to support and influence commissioning decisions and will therefore work with the GM commissioning hub to ensure that the outputs support effective commissioning in the arena of falls prevention and management.

6.7.2. There are currently 4 themes under consideration which are: falls in the context of frailty and care home provision; case finding and managing rising falls risk; case finding and managing high falls risk, and fracture liaison services (FLS). The outputs from the programme are likely to include an outline business case for investment, quality and care standards for relevant aspects of the pathway e.g. fracture liaison services, standards and practice in care homes, and a monitoring / evaluation framework.

6.7.3. Alongside these outputs, wider learning from the programme is expected to include a shared understanding of falls risk factors and markers, the opportunities to case-find and reduce falls risk at an earlier stage, and best value investment of limited resources, all in the context of an optimal approach to falls prevention.

7.0 RECOMMENDATION

7.1. The Population Health Programme Board are asked to:

- To note the content of the report and support the continued implementation of the Population Health plan