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HEALTH AND WELL BEING BOARD
Regulatory Committee
Agenda

Date	Tuesday 26 June 2018
Time	2.00 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Sian Walter-Browne at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Sian Walter-Browne Tel. 0161 770 5151 or email Fabiola.fuschi@oldham.gov.uk

3. PUBLIC QUESTIONS - Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon, Thursday, 21 June 2018.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held.

Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD
Councillors M Bashforth, Chadderton, Chauhan, Harrison (Chair), Jacques and Sykes
Dr Zubair Ahmad, Dr Zuber Ahmed, Jon Aspinall, Jill Beaumont, Julie Daines, Noreen Dowd, Neil Evans, Julie Farley, Nicola Firth, Majid Hussain, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Donna McLaughlin, Raj Patel, Dr. John Patterson, David Smith, Katrina Stephens, Charlotte Stevenson, Mark Warren, Carolyn Wilkins OBE and Liz Windsor-Welsh

Item No

1	Apologies For Absence
2	Urgent Business
	Urgent business, if any, introduced by the Chair
3	Declarations of Interest
	To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.
4	Election of Vice-Chairs
	To nominate two Vice-Chairs for Municipal Year 2018/19
5	Public Question Time
	To receive Questions from the Public, in accordance with the Council's Constitution.
6	Minutes of Previous Meeting (Pages 1 - 10)
	The Minutes of the Health and Wellbeing Board meeting held on 27th March 2018 are attached for approval.
7	Action log (Pages 11 - 16)
8	Meeting Overview (Pages 17 - 18)
9	Data Sharing & Information Governance (Pages 19 - 20)
10	Urgent Primary Care Strategy
	Report to follow
11	GM Population Health Programme (Pages 21 - 36)
12	Update on Greater Manchester Population Health Outcomes Framework and Common Standards and the Oldham Care Outcomes Framework (Pages 37 - 68)
13	Children's Health and Wellbeing
	Report to follow
14	SEND Update (Pages 69 - 70)
15	Healthwatch Oldham Work Programme (Pages 71 - 76)

16 Date of Next Meeting

The next meeting of the Health and Wellbeing Board will be a development session and it will take place at Harry Burns Suite – First Choice Homes Oldham on 24th July 2018 at 2 p.m.

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HEALTH AND WELL BEING BOARD
27/03/2018 at 2.00 pm

Present: Councillors Harrison, Heffernan and Moores

Independent Members: Dr Zuber Ahmed, Jill Beaumont, Noreen Dowd, Siobhan Ebden, Jax Effiong, Julie Farley, DCI Jim Faulkner, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Donna McLaughlin, David Smith, Katrina Stephens, Mark Warren, Carolyn Wilkins OBE and Liz Windsor-Welsh

Also in Attendance:

Oliver Collins	Principal Policy Officer
Lori Hughes	Constitutional Services
Barbara Mulvihill	Project Manager - Information Management
Rebekah Sutcliffe	Strategic Director of Reform
Stephen Woods	GM Shared Services (NHS)

1 **ELECTION OF CHAIR**

RESOLVED that Councillor Moores be elected Chair for the duration of the meeting.

2 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Chauhan, Councillor Price, Dr. Patterson, Chief Supt Evans, Dan Lythgoe and Jon Aspinall.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **DECLARATIONS OF INTEREST**

Dr. Zuber Ahmed declared a pecuniary interest at Item 16, Pharmaceutical Needs Assessment by virtue of his ownership of a pharmacy. Dr. Ahmed left the room and took no part in the discussion or voting thereon on this item.

5 **PUBLIC QUESTION TIME**

There were no public questions received.

6 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the Health and Wellbeing Board held on 23rd January 2018 be approved as a correct record.

7 **MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE**

RESOLVED that the minutes of the Health Scrutiny Sub-Committee meeting held on 30th January 2018 be noted.

8 **ACTION & RESOLUTION LOG**

RESOLVED that the Action Log from the meeting held on 23rd January 2018 be noted.

9 **MEETING OVERVIEW**

RESOLVED that the overview for the meeting be noted.

10 **OLDHAM CARES OUTCOMES FRAMEWORK**

Consideration was given to a report of the Director of Public Health which outlined the development of a set of supporting indicators for the Oldham Cares Outcomes Framework. The high-level outcomes for Oldham Cares, as outlined in Appendix 1 of the report, and the proposed approach to develop a set of supporting indicators had been agreed at the January meeting. Further work had been undertaken and a proposed list of supporting indicators for Oldham care was set out in the report.

Each outcome required supporting indicators which were a range of specific measures which demonstrated the achievement (or otherwise) of the outcome. Each outcome framework would be supported by a maximum of 30 indicators.

An initial long list of indicators had been compiled from the three national outcomes frameworks and Oldham's investment agreement with the Greater Manchester Health and Social Care Partnership. This consisted of over 300 indicators. Using the principles as outlined in Section 2.1 of the report the list was reduced to a medium list of approximately 65 indicators. Following a discussion with a group of stakeholders a refined list of 28 key indicators was produced as outlined at Appendix 2 of the report.

The Board were informed of work that was ongoing for consideration of other collected data. High level outcomes set the framework for commissioning. There were significant challenges in the health and wellbeing of the borough, there were recognised areas where more development was needed. The number of areas and the attempt to group some topics was discussed. There was differential effort in parts of the borough and in some areas of the borough to get to the national average would have an impact on the overall picture. It was recognised that organisations had their own performance frameworks which would contributed to the aggregate.

The Board raised concern on the mental health areas and GP health checks.

The Board would be updated when the list had been refined and brought back to the June meeting.

The Board sought clarification on the vaccination target which was 72.9% and it was clarified that the national target was 75%.

The Board raised that in terms of supporting indicators that vulnerable children was absent. What could be commissioned would be discussed under JSNA.

RESOLVED that:

1. The proposed supporting indicators for the Oldham Care outcomes framework be agreed.
2. A further report be received at the next Health and Wellbeing Board meeting which described the proposed targets and reporting arrangements for the outcomes framework.

11 **PENNINE ACUTE CQC INSPECTION UPDATE**

Consideration was given to a report which provided an update on the Care Quality Commission's (CQC) follow up inspection of the Pennine Acute Trust in October 2017 following the initial inspection held in February and March 2016.

The CQC had based their inspection and subsequent report on five domains, i.e. was the service:

- Safe;
- Effective;
- Caring;
- Responsive to people's needs; and
- Well led.

An overview of the findings of the two inspections where improvements had been identified at the Trust was outlined at Appendix 1 of the report.

The Board were informed of the achievements of the Trust. There would be a further review across all services in the next 12 months. The focus was now on those areas which were inadequate.

The Board queried about outpatient imaging and why this had not been assessed. The Board were informed that this was not part of the review.

The Board expressed their congratulations on the work undertaken to achieve the improvements made and expressed their thanks to Pennine Acute and, especially, the Royal Oldham Hospital. The Board agreed to write to Sir David Dalton offering their congratulations.

RESOLVED that:

1. The progress and improvement made by the Trust and the continued ways to identify ways in which support could be given to the Trust and the Royal Oldham Hospital site to continue the journey of improvement be noted.
2. A letter of congratulation be written to Sir David Dalton on behalf of the Health and Wellbeing Board on the improvements made.

12 **SPECIAL EDUCATIONAL NEEDS AND DISABILITY**

Consideration was given to a report which provided a brief overview of the findings and an update on progress since the

SEND inspection and specifically around the five areas of weakness which had been identified.

The focus of the joint inspection carried out by Ofsted and the Care Quality Commission (CQC) was:

- Assessing the effectiveness of Oldham identifying children and young people's special educational needs and/or disabilities;
- The effectiveness of Oldham in meeting the needs of children and young people with SEND; and
- The effectiveness of Oldham in improving outcomes for children or young people who have SEND.

The areas of strength which were identified during the inspection were outlined in the report. As a result of the inspection, Oldham was required to produce a written statement of action to Ofsted and the CQC which outlined how five areas of significant weakness would be tackled. The areas were:

1. Potential non-statutory compliance
2. Effective Leadership
3. The EHC Process and Quality of EHCP's
4. Oldham's Home to School Transport Policy
5. Underachievement, Fixed Term Exclusions and Persistent Absent Levels

A draft written statement of action (WSOA) had been submitted to Ofsted. The Council was still waiting for confirmation of sign off from Ofsted.

The Board were informed of revised governance arrangements and the measures that had been put into place. The transport policy had been revised and was going through a consultation process. A data modeller had been engaged for the provision of more analytical data. Since the inspection a number of workshops with a large number of stakeholders had taken place. There had been true partnership working and the commitment was recognised.

The Board asked about the new arrangements and broader accountability and were advised that revised membership would be more inclusive, also greater scrutiny around working groups under the partnership board and the management committee would be chaired by a senior officer. Co-production with families on governance and assurance would be embedded. There had been key learning in terms of building reassurance between the CCG and the Council.

RESOLVED that:

1. The strengths and weaknesses highlighted within the SEND Action Plan be noted.
2. The actions outlined in the report and a recommendation to have a standing item on the Health and Wellbeing Board agenda related to SEND be noted.

3. The relationship between the Health and Wellbeing Board and the SEND Governance Structure be noted.

13 **OLDHAM'S AUTISM STRATEGY**

Consideration was given to a report which provided an overview of the Oldham Autism Strategy (2017-2020), the Autism Way Forward & and the Autism Strategy sub-groups, an update on what had been achieved in the first year of the Autism Strategy and recommendations for area of focus in the second year of the strategy.

The Autism Strategy had been published in January 2017 and was a three year strategy for all ages and joint between Oldham Council and the NHS Oldham Clinical Commissioning Group. A key objective was to increase awareness and understanding of autism across the borough with the ambition for Oldham to be acknowledged as an Autism Friendly Town.

The link between the SEND Inspection and the Autism Strategy was outlined in the report. There were areas of work that the Autism Strategy and SEND action plan would be done in conjunction which included Preparation for Adulthood and Joint Commissioning.

The Autism Partnership Board met every two months and four sub-groups which also met every two months. Each group had a defined action plan and included Joined Up Commissioning; Diagnosis and Post-Diagnosis Support; Getting the Right Support at the Right Time; and Better Information and Awareness.

An update on the achievements of the first year of the Autism Strategy was outlined in the report.

The Board were informed of the statutory requirements under the Act, the development of the self-assessment framework, the development of the local strategy and how this had been produced. The GM Mayor had set out the strategy for Greater Manchester. All ten CCGs and Local Authorities funded the GM Autism Consortium which Oldham hosted. The group reported to the Greater Manchester Health and Social Care Partnership Board. The consortium held local authorities accountable.

The Board were informed that the replacement lead would be a named individual and not just an organisation. The Board were informed this would be Suzannah Meakin, Had of Service Mental Health and Learning Disability, who had also been linked to the recent SEND inspection.

The Board raised the 14 recommendations and asked for the top 3 and being more succinct. The Board requested that the Autism Strategy be raised at the next Joint Strategic Needs Assessment meeting. The strategy would also be linked to the SEND wider work which was ongoing.

Employment of those with a learning disability was raised.

RESOLVED that:

1. The membership of the AWF and strategy groups be refreshed with support and backing with the implementation.
2. The appropriate time of the meetings to take place for all partners be understood with a focus on how to engage schools in the actions of the strategy which was crucial for success.
3. The review of services provided by the Co-located Learning Disability Teams be continued.
4. Due to the actions having been completed, the Diagnosis and Post Diagnosis sub-group be suspended until further notice in order to review the data against the diagnosis pathway.
5. The focus required on the Getting the Right Support at the Right Time strategy Group be acknowledged.
6. The relevant areas undertake a joint strategy needs analysis for people in Oldham with Autism to support integrated commissioning action across education, health and social care be supported.
7. The dissemination of the diagnosis flow chart which enabled the public and be aware and understand the process of autism diagnosis when published be supported.
8. The identification of schools across Oldham who could contribute to the development of the autism strategy and its ambitions be supported.
9. The identification of representatives from housing providers and partners to further develop the support that is available to people living in rented accommodation be supported.
10. The establishment of a formal working arrangement between the Autism Strategy Joined-Up Commissioning and the SEND Joint Commissioning work streams to prevent duplication and the promotion of working together be supported.
11. The continuation of providing autism awareness training to partners across Oldham with the aim of making Oldham more Autism Friendly be supported.
12. The development of more advanced autism training that focused on practitioners working with people at the complex end of autism be supported.
13. The engagement with businesses and organisations and provision of support to them on the way they could make reasonable adjustments and become autism friendly be supported.
14. The consideration of options for infrastructure investment required for ensuring Oldham was more Autism Friendly by 2020 thus fulfilling the ambition of Oldham's Autism Strategy which included the identification of a replacement lead to drive the strategy be supported.

STRATEGY

Consideration was given to the proposed outline of First Choice Homes' new health and wellbeing strategy.

The Strategic Framework for the strategy included the Vision, Mission and Values. The Strategic Objectives included Start Well, Live Well and Age Well and included the continuation of innovative work that was already in place, elements to be built upon and a range of activity that First Choice Homes wanted to initiate.

First Choice Homes, working in partnership with colleagues in Oldham and Greater Manchester, would demonstrate the potential of a housing provider adopting a population health approach for its residents, staff and wider communities in Oldham. Key actions were outlined in the report.

The Greater Manchester Housing Partnership key pledges and initial investible propositions were outlined and Oldham was the first to deliver. Investments were being made in various living services such has housing support and independent living services and with the CCG a new range of services under aid and adaptations, hospital discharge service, housing options, healthy homes and warm homes Oldham was being delivered.

The new Health and Wellbeing Strategy was outlined with the move from immediate urgent care issues towards population health improvement. One of the main areas for FCHO was to be a key partner and part of the decision making bodies. FCHO sought lead delivery of the GM Home Improvement Agency and supported delivery of the GM Population Health Plan. Specific new projects included fall preventions, domestic violence and school readiness. Data sharing was raised as a concern. FCHO was also developing their workforce development staff wellbeing programme.

FCHO had been shortlisted for an excellence award in its approach to health and wellbeing.

The Board sought clarification on the point of reduction in hospital appointments and were informed that this would be addressed under preventable hospital treatment. The Board also raised the issue of the clusters and FCHO were prepared for that discussion on integrating delivery into localities. The Board also welcomed further discussions around Looked After Children, making every contact count to address integrated teams in a non-clinical opportunity, the Mental Health Strategy Partnership, domestic violence, further exploration of children currently placed outside the borough as well as adults and further work with the voluntary sector around the Thriving Communities Hub.

The Board welcomed the report and feedback. The Council would be rolling out the Fit for Oldham Programme to more

challenging territory. Domestic violence was being addressed collectively.

RESOLVED that the proposed outline for the First Choice Homes new Health and Wellbeing Strategy be noted.

15 **GENERAL DATA PROTECTION REGULATION (GDPR) DATA PROTECTION REFORMS**

Consideration was given to a report which outlined the reforms under the new General Data Protection Regulation (GDPR) and the implementation through the draft UK Data Protection Bill (UKDP). The GDPR comes into effect on 25 May 2018.

The key features were outlined in Appendix 1 of the report. The key elements were organisational commitment, understanding the personal data used, implementation of appropriate measures, e.g. appointment of the Data Protection Officer (DPO), reviewing private notices, security policies and breach reporting, revised contractual terms and staff training.

The Council in conjunction with its partners needed to ensure that all partners were data protection compliant in the handling of personal data, and in particular when related to health and social care, sensitive personal data was also subject to law of confidentiality.

The Board were informed of groups who were addressing various work-streams and requirements in legislation. The changes would affect everyone and provided individuals with new and enhanced rights. All contractors would need to ensure they were addressing the new legislation.

The Board raised the issue of the requirement to demonstrate outcomes as a result of interventions taken across several organisations and asked if there was a forum with an urgency route to commission in an integrated way with confidence to get the data evaluated effectively which needed to be shared. There had been an investment agreement with Greater Manchester to transform services but there was a need to demonstrate how the funding was making an impact. The Board were informed that this was linked to work ongoing at GMCA and an equivalent was needed locally to gather data across boundaries. Data protection could be used as an enabler. The Board understood the significance but also raised that data protection was used as a barrier. The Board agreed to discuss this item further as part of the next scheduled Development Session.

RESOLVED that:

1. The engagement and participation of stakeholders and business areas required to contribute/implement the data protection framework be mandated.
2. The review and implementation of changes by the Information Management Team (IMT) be supported.

3. Assurances be sought that partner organisations were taking the appropriate steps to compliance.
4. IMT being involved as a stakeholder in any integration or joint working initiatives that involved personal data handling be ensured.
5. The issue of GDPR be discussed at the next Development Session.

16 **PHARMACEUTICAL NEEDS ASSESSMENT**

Dr. Ahmed declared a pecuniary interest at this item by virtue of his ownership of a pharmacy. Dr. Ahmed left the room and took no part in the discussion or voting thereon on this item.

Consideration was given to an update on the Pharmacy Needs Assessment. The Health and Wellbeing Board had a statutory responsibility to publish and to keep updated a statement of the needs for pharmaceutical services for the population in its area which was referred to as the Pharmaceutical Needs Assessment (PNA). The PNA aimed to identify whether current service provision met the needs of the population and to considered whether there were any service delivery gaps.

The PNA may inform of the current provision of pharmaceutical services and any gaps related local health priorities. Where gaps were not met by NHS England, they could be considered by the Clinical Commissioning Group (CCG) or local authorities (LA). The PNA would be used by NHS England in the determination as to whether to approve applications to join the pharmaceutical list under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The relevant area team would review the application and decide if the application met the criteria for approval.

The Health and Wellbeing Boards duties in respect of the PNA were outlined in the report as well as the purpose of the PNA and the Scope of the PNA. The report also outlined how the assessment was undertaken for the population of Oldham. The Health and Wellbeing Board had established a steering group to lead a comprehensive engagement process which informed the development of the PNA.

Taking into account the totality of the information available, the Health and Wellbeing Board considered the location, number, distribution and choice of pharmacies for each district. Based on the information available:

- No current gaps in the need for provision of essential services during normal working hours had been identified.
- No current gaps in the provision of essential services outside normal working hours had been identified.
- No current gaps in the need for pharmaceutical services specified in future circumstances had been identified.

- No gaps had been identified in essential services that, if provided either now or in the future, would secure improvements, or better access, to essential services.
- No gaps had been identified in the need for advanced services that, if provided either now or in the future, would secure improvements or better access to advanced services.
- No gaps, in respect of securing improvements, or better access, to other NHS services, either now or in specified future circumstances, had been identified.

Healthwatch asked to be involved in the review of pharmacies. The issue of taking medication into hospitals was raised. Communication between the acute and primary services was key.

RESOLVED that the Oldham Health and Wellbeing Board Pharmaceutical Needs Assessment 2018 to 2021 be agreed.

17 **DATE AND TIME OF NEXT MEETING**

RESOLVED that the date and time of the next Health and Wellbeing Board to be held on Tuesday, 26th June 2018 at 2.00 p.m be noted.

The meeting started at 2.00 pm and ended at 3.48 pm

Actions from the March meeting of the Health and Wellbeing Board

Board Meeting	Agenda Item	Resolution / Action	Update
March	**Oldham Cares Outcomes Framework**	A further report be received at the next Health and Wellbeing Board meeting which described the proposed targets and reporting arrangements for the outcomes framework.	Item included on Agenda and linked to GM Outcome Frameworks
	Pennine Acute CQC Inspection update	A letter of congratulation be written to Sir David Dalton on behalf of the Health and Wellbeing Board on the improvements made.	Letter written and sent on behalf of Cllr Eddie Moores on 3rd April 2018 See appendix 1 for a copy of the letter
	SEND	The actions outlined in the report and a recommendation to have a standing item on the Health and Wellbeing Board agenda related to SEND be noted.	SEND is to be a standing item on the Board's agenda
	General Data Protection Regulation (GDPR)	The issue of GDPR be discussed at the next Development Session	April Development session was dedicated to the issue of GDPR and Data Sharing. An update is to be provided as an agenda item

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Health & Wellbeing Board Notes 17tH April 2018

Data and Information Sharing

Presentations from:

Mike Turner – Northern Care Alliance - The Salford ICO journey and lessons learnt from data sharing

slides to be included when received

Jym Bates – Northern Care Alliance - Understanding the GDPR regulations and what this will enable

Gerard Gudgion – Early Help Operational Manager - Sharing health data to improve outcomes for families and children.

Key discussion notes

- Data and information sharing should be an enabler to delivering quality and appropriate care and a better system response to an individual's circumstances
- **It should not be the ultimate end goal**

- Early Help / Fitton Hill example from 2014
    - Both sides identified their markers for identifying those in, or close to crises
    - Shared the qualifying individuals with each other for cross referencing
    - Easy to identify who had been in contact with both services, but the services were not always aware that the other had had contact with the individual
    - If had known, could have developed a very different solution
    - Small data points may seem insignificant but when pieced together across the health / care and wellbeing system then they can paint a very clear picture of a individuals circumstances and how best to approach

    - Consent gained through opt-out process via individualised letters
    - Consent, whilst does enable data sharing, is a very weak footing upon which to build data and information sharing upon as it can be removed at any time by the individual. **The individual also has the "Right to be forgotten"**
    - Exercise, whilst extremely informative, was a highly labour intensive process.

- Risk stratification
    - General consensus that the ability to identify those that are orange (i.e. medium-risk) before they move to red (high-risk) would improve outcomes across the system
    - Capacity – what is the ability and commitment of the system to respond to what the data tells us once we have risk stratified i.e. do we have sufficient early intervention/key worker/MDT/ place based teams type capacity to work with those identified at risk.
    - Not only need data crunchers but we also need the people who can turn the data into intelligence and increase the data's effectiveness

    - The more data points and agencies involved, the higher quality and detailed the picture of the individual becomes, but also more difficult it is to categorise
        - How would a stratification matrix to support and deliver this?
    - Concerns were raised around how much is “too much data” and could we be at risk at profiling individuals rather than dealing with them as humans, given that health and care is a process of human interaction
        - Data sharing and profiling should only be used as a way of prioritising resource and service interventions to achieve the best outcomes for the individual

- Risk
    - Data and information sharing does involve a level of risk
    - Have to agree as a services, organisations and a system what level of ‘risk’ is acceptable
    - How also use other (Health and Care) statute such as the Care Act and the Health and Social Care Act to share data in a *legally defendable manner* i.e. for the provision of services to support people
        - Do Crime and Disorder statutes allow similar?
    - Historical process have driven people to a point of being risk adverse with sharing data and information
    - GPs have personal responsibility for data (not ‘covered’ by an organisation) and the notes and inputs into their systems are their own work, hence a possible added reluctance to share
    - Need to create a shared, and emotive narrative about why we want to share. Built around the individual and their outcomes
    - Challenge posed about who the data actually belongs to?
        - Is it the GPs / Health Organisations or is it the individuals?
        - Public engagement and co-design how we share data

- GDPR
    - Designed to make sharing easier and is designed to make the individual at the centre of the data sharing process
    - Doesn’t allow for data sharing at population levels
    - GDPR is new and therefore have been few legal precedents set around what can and can’t be done

Summary

Key focus should be on

1. Establish exactly what is wanted
2. Get good, proactive IG people involved early - This is emphasised within the GDPR guidance
3. Work through how to do what want to achieve

Learn from others

- Salford / Northern Care Alliance
- Local – Maternity notes kept by the individuals themselves

- GMCA Digital Strategy
- GMHSCP

Suggestion was that given we already have the ICO work streams and supporting Investment Agreement, should we look to take one theme / condition / service within one of the workstreams and look at in particular:

- The legal framework and the degree to which it enables information sharing to risk stratify, through consent or otherwise. This will help us to properly understand what we can and can't do
- What the implications of GDPR are
- The need to and manner of engaging stakeholders, especially GPs, and develop a new way of doing things together.

This to be discussed and progressed through Joint Leadership

The notes to be shared with the Board and a progress report to be taken to the next HWB meeting on the 26th June.

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Health & Wellbeing Board – Agenda

Oldham Health and Wellbeing Board

26th June 2018
Crompton Suite
2pm – 4pm

No	Item	Timings
1 - 8	Appointment of Vice Chairs, Apologies, Urgent business, Declarations of interest, Public question time, Minutes from last meeting**,** Action log, Meeting Overview	2.00pm
9	**Data Sharing & Information Governance** *Donna McLaughlin & Rebekah Sutcliffe* For the Board to receive an update on the actions from the April Development session	2.05pm 5 mins
10	**Urgent Primary Care Proposals** *Dr Shelley Grumbridge and Hilary Baker* For the Board to receive an update on the decision taken by the CCG regarding the provision of Urgent Primary Care in the borough and the implementation of the plans	2.10pm 25 mins
11	**GM Population Health Programme** *Carolyn Wilkins* For the Board to receive an overview of activities undertaken in 17/18 towards the priorities set out in the Greater Manchester Population Health Plan.	2.35pm 15 mins
12	**Oldham Cares Outcomes Framework** *Katrina Stephens* For the Board to receive an update on the Oldham Cares and GM Population Health Outcomes Frameworks and for the Board to discuss the interdependencies between the two	2.50pm 20 mins

13	**Children's Health & Wellbeing** *Merlin Joseph* For the Board to receive an update on the development of a Children's framework and how this is addressing the outcomes and implications of the Children's Society report and child poverty local indicators published in Autumn 2017	3.10pm 20 mins
14	**SEND Update** *Merlin Joseph / Jill Beaumont* For the Board to receive a progress report on the implementation of the SEND Written Statement of Action	3.30pm 10 mins
15	**Healthwatch 2018/19 workplan** *Julie Farley* For the Board to discuss Healthwatch's work priorities for 18/19 in Oldham, the process that we will use in setting the work priorities for 19/20 and where the Board can support in the planning and delivery against these priorities.	3.40pm 20 mins
	Next Meeting: 24th July Development Session Harry Burns Suite First Choice Homes	

BRIEFING TO OLDHAM HEALTH AND WELLBEING BOARD

Report Title: Data Sharing & Information Governance

Report Author: Donna McLaughlin

Date: 18th June 2018

Requirement from the Health and Wellbeing Board:

The H&WB are asked to note progress and agree how they would like to be kept informed in future.

Background:

Data and information sharing remains a critical enabler in delivering high quality joined up care for the citizens of Oldham. Historically there has been difficulties between organisations in Oldham which through the Oldham Cares Alliance are being worked through. The workshop in April was a catalyst to confirm commitment from system leaders at the highest level to the importance of data and information sharing. A number of key actions have taken place since the workshop which can be summarised into three areas; data sharing, risk stratification/ population health and Digital Strategy.

Data Sharing
The Memorandum of understanding and Alliance Agreement have been signed by all parties by end of May. The parties are;

- Oldham Council
- Oldham Clinical Commissioning Group
- Northern Care Alliance (Inc. Oldham Care Organisation)
- Pennine Care Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Miocare Group
- Action Together
- Oldham General Practice (made up of the 5 GP clusters)
- IGP Care LTD
- GTD (GotoDoc) Healthcare
- First Choice Homes

This includes a commitment to have appropriate detailed agreements in place and to move to a population approach to health. Data sharing agreement for Oldham Cares is in development and will be signed off by all partners by September 18, this balances the individual institutions legislative requirements with our system needs. This is in addition to the data sharing arrangements which are in place for individual

work programmes e.g. Graph Net (sharing of patient level data between hospital and primary care).

Population Health
There were internal conversations with key stakeholders within Oldham following on from the H&WB workshop regarding our current position in *risk stratification and population health*. The conclusion of which were taken to Oldham Cares Board (May) and agreement was reached;

- To continue with the existing risk stratification EMIS tool
- To use our BI combined resource and clinical leadership to work with Salford to accelerate the roll out of (Global Digital Excellence Status) GDES tools into Oldham.
- To review this approach in six months' time (November 2018) and in between provides feedback through the Project Highlights Report to the Alliance Board.
- We have made a bid to the Health Foundation for a BI integrated platform to support service development and data sharing at a neighbourhood level. The outcome of which will be known in late summer. There was an event at Salford which a team from Oldham attended.

Digital Strategy
Oldham Digital Strategy is in development and will be presented to Greater Manchester Health and Social Care Partnership in July. This includes the development of digital solutions to support integration and data sharing.

Recommendations:
The H&WB are asked to note progress and agree how they would like to be kept informed in future.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

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**
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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. Health and Employment

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

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BRIEFING TO OLDHAM HEALTH AND WELLBEING BOARD

Report Title: Update on Greater Manchester Population Health Outcomes Framework and Common Standards and the Oldham Care Outcomes Framework

Report author: Katrina Stephens, Joint Acting Director of Public Health

Date: 26th June 2018

Introduction

This report provides an update on the development of the Greater Manchester Population Health Outcomes Framework and Common Standards and the Oldham Cares Outcomes Framework.

Background

Greater Manchester Population Health Outcomes Framework and Common Standards

In March 2017, the GM Health & Social Care Partnership agreed to a set of proposals to facilitate the creation of a unified population health system, to support the delivery of the GM Population Health Plan at pace and scale. This included a commitment to the reduction of unwanted and unwarranted variation in standards, improvement in population health outcomes, more consistent adoption of evidence based practice, and the enhanced use of benchmarking data.

Over time, this programme has developed to incorporate 3 core elements:

- A GM Population Health Outcomes Framework (as part of a single integrated assurance process)
- GM Population Health Common Standards
- Excellence in GM Sector Led Improvement Programme

On 29th March 2018 the GM Population Health Board agreed that the Framework and accompanying online dashboard would be used in future Locality Quarterly Assurance processes and would be tested during the 2017/18 Q4 Assurance Cycle. The dashboard is available online at:
https://public.tableau.com/profile/dashboard6270#!/
Work is ongoing to further develop the Framework and to identify alternative means of measuring desirable outcomes (Phase 2 of framework development).

The GM Population Health Board also reviewed drafts of the first phase of the Population Health Common Standards covering prescribed and non-prescribed core public health functions, tobacco, sexual and reproductive health and oral health, and requested that localities note the development of standards and continue engage

with this work to further develop a suite of standards to help improve outcomes, reduce inequalities locally and across GM.

Oldham Cares Outcomes Framework

The Oldham Cares outcomes framework sets out a range of high level outcomes based on the key changes we want to see in Oldham over the next decade. These are the headline outcomes for Oldham Cares, which the whole system will work together to deliver, in order to improve the health of the population and the way the local health and social care system operates.

The outcomes framework and supporting indicators were agreed at the Health and Wellbeing Board in March 2018. Work to develop targets and ambitions for these indicators is now being progressed.

Requirement from the Health and Wellbeing Board:

The Health & Wellbeing Board is asked to:

- Note the GM Population Health Outcomes Framework and the intention for this to be used in Locality Quarterly Assurance processes.
- Note the development of GM common standards and continue engage with this work to further develop a suite of standards to help improve outcomes, reduce inequalities locally and across GM.
- Note the progress to date in developing the Oldham Cares outcomes framework and the proposed engagement of commissioners, alliance providers and health and wellbeing board members, to develop ambitions and targets for each indicator, for approval at the next meeting of the Board.

Supporting papers:

a) Population Health Outcomes and Common Standards, Report to GM Health and Social Care Partnership Population Health Board, 29th March 2018
b) Greater Manchester Population Health Outcomes Framework (including Oldham performance relative to other Greater Manchester authorities.
c) Greater Manchester Population Health Common Standards
d) Update on Oldham Cares Outcomes Framework

Common Standards for prescribed public health functions

The standards listed below have been developed to detail headline standards for the prescribed functions outlined in the Public Health Ring fenced Grant Guidance for 2018/19 to Local Authorities. These are intended to provide guidance on action to be taken by localities in each prescribed and priority non prescribed areas.
In addition to the prescribed functions we have included standards relating to Drugs and Alcohol services, tobacco, mental health and wellbeing as these are also key functions related to the Public Health Grant and are of significance to improvement of GM population outcomes.
These headline standards have been chosen based on a judgement on how we can best meet the prescribed function and also achieve population health improvement for residents within Localities and across GM. For some areas there is a more detailed suite of standards available. These are currently in the areas of Sexual Health, Oral Health and tobacco. Further suites of standards for other areas are in production and will be added over time.

Prescribed Public Health functions	Common Standard	Guidance Measures or Metrics	Outcome Area	GM Outcomes Framework measure
Statutory Post	Each locality has an agreed arrangement for the statutory post of Director of Public Health	Each locality has a named Director of Public Health	All	n/a
Sexual health services - STI testing and treatment	To provide timely open access to STI advice and treatment services (in each locality)	To offer an appointment within 48 hours for 98% of people	Reduction of Sexually Transmitted Infections	New HIV diagnosis rate / 100,000 people aged 15+
	Provision of personalised risk reduction support and information for all who attend sexual health services and their partners	Advice and treatment pathway in place forpatients and partners in place for all sexual health providers and localclities	Reduction of Sexually Transmitted Infections	
	Routine offer of an HIV test in high prevalence areas and a regular, targeted offer to those in high risk groups	Appropriate testing offer publicised	New HIV diagnosis rate / 100,000 people aged 15+, Eradication of HIV	
Sexual health services - Contraception	All under 18s within a locality are encouraged to access a sexual & reproductive health service or GP before engaging in sexual activity	Young Peoples Education and Promotion programme in place in each locality	Conception Rate per 1,000 (15-17 year olds)	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)
	Open access to specialised services for young people up to the age of 19	Specialist clinic session offered each week for young people in each locality	Reduction in Teenage Pregnancy and Reduction in Abortion rates under 25s	
			Drop-in sessions available in every secondary school	
	All women (15-44 years old) are fully informed about and, if clinically appropriate, encouraged to use LARC as their form of contraception	LARC Rate per 1,000 (15-44 year olds)	Reduction in unwanted pregnancy	
	For all women having a LARC removed and requiring contraception to have immediate access to an alternative, reliable method of contraception	Service audit in place	Reduction in unwated pregnancy	
NHS Health Check programme	All eligible individuals aged 40-74 to be offered an NHS Health Check once in every 5 years, with pilot areas prioritising people at greater risk, and for each individual to be recalled every 5 years if they remain eligible	% Offer and Uptake of eligible population of NHS Health Checks	Reduction in CVD premature mortality rates	Under 75 mortality rate from CVD considered preventable
	All identified at high risk to receive the advice and support to manage that risk	Local data collection or description of service offer	Reduction in CVD premature mortality rates	
Health Protection	Locality provision of community infection prevention and control service for proactive management, advice and response across social care, education and other community settings	Evidence of infection prevention and control service - audits completed , campaigns and initiatives, outbreak response, AMR plans	Reduction in communicable and infectious diseases	MMR vaccination rate
	Local arrangements and plans to achieve good uptake of NHS immunisation programmes	Local seasonal flu plan, including approaches to achieve targets of flu vaccine in over 65s, clinical risk groups and children	75% Flu Vaccination Uptake [NOTE suggest focus on clinical risk groups or children]	
		Local plans to achieve high immunisation rates including regular review of coverage	MMR uptake rates of 95% (2 doses) at 5 years across GM and all localities	
	Across GM and in each Locality there will be a robust Outbreak Plan and response for health protection incidents and emergencies	Agreed and exercised outbreak plan in place in each locality with arrangements to identify, implement and share lessons learnt	Reduction in communicable and infectious diseases	
Public Health advice to NHS Commissioners	Public Health specialist advice and support is available to NHS Commissioners, integrated commissioners and care organisations in all Localities and at a GM level	Memorandum of Understanding or programme of work agreed	All	n/a
National Child Measurement Programme	Completion of the National Child Measurement Programme in every Locality with above average uptake	Good uptake of the prorgamme in every Locality	Prevalence of overweight and obese as measured by NCMP part of GM and Local	Prevalence of overweight children (including obese) as measured by NCMP
	Each Locality has a documented service offer for children and families identified as being overweight, obese or underweight identified through the NCMP	Service offer for children and families publicised in each area	Reductions in levels of obesity and overweight children in reception and Year 6	
Prescibed Children's 0-5 services	Commissioning and delivery of the national 0-5 Healthy Child Programme in line with agreed targets	Number of mothers who receive an antenatal contact with the service at 28 weeks or above	Eary years outcomes	Breastfeeding Initiation; Proportion of 5 year old children free from dental decay; % of children achieving a good level of development at the end of reception
		95% of births that receive a face to face New Birth Visit within 14 days by a health visitor	Eary years outcomes	
		95% of babies who receive a 6-8 week review.	Eary years outcomes	
		95% of children who receive a 8- 12 month review by the time they turned 12 months old	Eary years outcomes	
		95% of children who received a 2-2.5 year review (stage 5).	Eary years outcomes	
Headline services (non-prescribed functions)	**Common Standard**	**Guidance Measures or Metrics**	**Outcome Area**	**GM Outcomes Framework measure**
*Drugs and Alcohol	All localities to demonstrate how they are meeting the local needs for the take up and the outcomes of its drug and alcohol treatment services	% of opiate / non-opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months	Reduced drug related harm and deaths	Alcohol-related hospital admissions (narrow definition)
		% of alcohol users that left drug treatment successfully who do not re-present to treatment within 6 months	Reduction in harm caused by alcohol including alcohol related hopsital admissions	
*Tobacco	All pregnant women who smoke are referred to services which can help them to stop smoking during their pregnancy	Number of mothers who quit smoking during pregnancy	Smoking at time of delivery rates (SATOD) reduce (N.B. target 6% by 2021 for GM).	% of women who smoke at time of delivery
	Publicised arrangements are in place for smokers to access pharmacotherapy and motivational support in all areas (Including advice about nicotine inhaling products)	Numbers accessing smokng cessation services in each locality	Adult Smoking prevalence rates reduce (N.B. target 13% by 2021 for GM).	Smoking prevalence in adults - current smokers (APS)
			% of smokers helped to quit through local stop smoking services.	
*Oral Health	LA's commission oral health preventive programmes in line with Commissioning Better Oral Health guidance and ensure oral health is embedded with children's services.	Local oral health plan and services in place in each locality	Proportion of 5 year old children free from dental decay	Proportion of 5 year old children free from dental decay
*Mental Health	All Localities will support the GM Suicide Prevention Strategy and we will have a GM and Locality suicide prevention action plans in place.	Local suicide action plan in place that is in line with the GM plan	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Suicide Prevalence
*Physical Activity	Every community will offer a range of high quality spaces and opportunities for people to live active lives, supported by welcoming leaders and suited to different motivations, attitudes and interests.	Local plan in place that aligns with #GMMOving	% of physically active adults (<150 minutes per week)	% of GM population who are Active or Fairly Active
			% of physically inactive adults (>30 minutes per week)	% of physically inactive adults (>30 minutes per week)

* Non-precribed functions

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GM Outcome Based Common Standard: Sexual and Reproductive Health

GM Shared Vision:

Poor sexual and reproductive health, including the ongoing transmission of HIV, has major impacts on Greater Manchester residents, and despite the progress made, there are still high rates of HIV and STIs in the conurbation. Continuing challenges include the rising rates of some sexually transmitted infections, the continuing transmiss
outcomes. Almost half all HIV diagnoses in GM are late, which lead to poorer outcomes for the individual and increased risk of onward transmission. Further demands on services are anticipated with the potential introduction of pre-exposure prophylaxis (PrEP) and immediate initiation of anti-retroviral therapy (ART). The vision for G
• all residents have the knowledge, skills and confidence to make informed choices about their sexual health, reproduction and relationships;
• sexual and reproductive health services are accessible, sensitive and appropriate for all;
• improved outcomes in sexual and reproductive health, bringing Greater Manchester to among the best in the country;
• working together to eradicate HIV in a generation
Our ambition is for a holistic system to ensure good sexual and reproductive health for all Greater Manchester residents with clear pathways, common standards and expectations set within it enabling people to access what they need, at a consistently high quality, when and where they need it. In addition, the aim to help people be mo
health and reduce the stigma associated with poor sexual health outcomes. These reforms of the system aim to have the following impacts on the region:
• GM population will be able to exercise personal choice and self-management regarding sexuality, sexual health and contraception.
• Significantly reduced prevalence of STIs & HIV in GM, particularly amongst targeted, higher risk communities.
• Ensure that we are prepared for emerging challenges in sexual health including multidrug resistant gonorrhoea.
• Improved health and life expectancy for people living with HIV within GM, thus improving the quality of life for people living with HIV and reducing the cost to the sub-region's health and social care system.
• Maintain open access to sexual and reproductive health services, giving people the choice of where to attend.
• Agreed standards across the system to ensure that no matter where people gain access to the system, they are able to obtain the right, high quality care.
• Deliver a more consistent primary care offer, especially for reproductive health.

GM Common Standards:

Strategic Outcome: Improving the Health of the GM Population and Reducing Health Inequalities across GM

"I" Statement: *"I will live a long and healthy life in Greater Manchester"*

Outcome	Standard	Method of Measuring Impact
Sexual & Reproductive Health is embedded within Health & Social Care	Sexual & Reproductive Health is a strategic consideration within overarching plans for health and social care transformation and is embedded within service provision.	Presence of Sexual & Reproductive Health in plans for Health and Social Care transformation.

Strategic Outcome: Start Well - Give every GM child the best start in life

"I" Statement: *"I will make sure that every GM child will has the best start in life and will develop well"*

Outcome	Standard	Method of Measuring Impact
Maintain the uptake of syphilis, HIV and Hepatitis B testing in pregnancy	All pregnant women are screened for infectious diseases in line with NHS screening guidelines	% of uptake

Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential

"I" Statement: *"I will receive an appropriate, non-judgemental service by suitable trained staff"*

Outcome	Standard	Method of Measuring Impact
Positive patient experience	Inclusion of questions around sexual & reproductive health in all annual patient surveys (surveys, focus groups)	Patient survey
Patient supported following an HIV diagnosis		
Delivering a responsive service		

"I" Statement: *"I will have swift access to the service(s) I need"*

Outcome	Standard	Method of Measuring Impact
48 hour access to STI treatment and advice for symptomatic patients	100% offer within 48 hours	Clinic data
Improve cervical cancer screening uptake	80% of women uptake cervial screening	NHS England uptake data

"I" Statement: *"I will be offered choice and support to make an informed decision regarding contraception"*

Outcome	Standard	Method of Measuring Impact
Reduction in unwanted pregnancies	All under 18s within a locality are encouraged to visit a sexual & reproductive health service or GP before engaging in sexual activity and are having appropriate levels of contact with these services during adolescence.	Rate per 1,000 (15-17 year olds)
	All schools to provide an up-to-date and appropriate age-related RSE programme	tbc
	Open access to specialised services for young people up to the age of 19	No. of specialist clinic sessions per week for young people available across Greater Manchester
	All young people to have access to school based drop-in sessions	School nurse drop-in sessions available in every secondary school
Increase in uptake of long acting reversible contraception (LARC)	All women (15-44 years old) are fully informed about and, if clinically appropriate, encouraged to use LARC as their form of contraception	Rate per 1,000 (15-44 year olds)
	For all women having a LARC removed and requiring contraception to have immediate access to an alternative, reliable method of contraception	Audit (tbc)

"I" Statement: *"I will have access to the testing and treatment I need"*

Outcome	Standard	Method of Measuring Impact
Reduction in new and late diagnosis of HIV	Routine offer of an HIV test in high prevalence areas and a regular, targeted offer to those in high risk groups	Number of new diagnoses and % of which are late
	Evidence of training re Blood Born Viruss for Primary Care every 3 years	Training to GPs/Pharmacies for advice and onward referral
Improve Chlamydia detection rate	Achieve the agreed population level Chlamydia detection rate and meet PN standards	Rate per 100,000 (15-24 year olds) and maintain PN rate of 0.6
Reduction in the prevalence of STIs and onward transmission	Improved digital offer including self-assessment of risk, campaigns	Number of new diagnoses and rate per 100,000 residents

"I" Statement: *"I will be given information and advice about reducing my personal risk of sexual health issues"*

Outcome	Standard	Method of Measuring Impact
Reduction in abortions and repeat abortions	LARC offered post-abortion	Rate per 1,000 (15-44 year old women) and % of who are under 25
Reduction in repeat STIs	Provision of personalise risk reduction support and information	% reinfected within 12 months

Additional relevant guidance for commissioners and providers (i.e NICE Guidance; National Strategy; GM Strategy; Associated GM Common Standards)

Name	*Link*
NICE Guidance - Sexually transmitted infections and under-18 conceptions: prevention [PH3]	https://www.nice.org.uk/guidance/ph3
NICE Guidance - HIV testing: increasing uptake among people who may have undiagnosed HIV [NG60]	HIV testing: increasing uptake among people who may have undiagnosed HIV
NICE Guidance - Sexually transmitted infections: condom distribution schemes [NG68]	https://www.nice.org.uk/guidance/ng68
NICE Guidance - Harmful sexual behaviour among children and young people [NG55]	https://www.nice.org.uk/guidance/ng55
NICE Guidance - Contraceptive services for under 25s [PH51]	https://pathways.nice.org.uk/pathways/contraceptive-services-for-under-25s
NICE Quality Standards - HIV testing: encouraging uptake Quality standard [QS157]	https://www.nice.org.uk/guidance/qs157
NICE Quality Standards - Contraception Quality standard [QS129]	https://www.nice.org.uk/guidance/qs129
NICE Pathways - Preventing sexually transmitted infections and under-18 conceptions overview	https://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions
NICE Pathways - HIV testing and prevention overview	https://pathways.nice.org.uk/pathways/hiv-testing-and-prevention
NICE Guidance - Long Acting Reversible Contraception [CG30]	https://www.nice.org.uk/guidance/cg30
BHIVA guidelines for the routine investigation and monitoring of adult HIV-1-positive individuals (2016)	http://www.bhiva.org/guidelines.aspx
BHIVA guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2015 (2016 interim update)	http://www.bhiva.org/HIV-1-treatment-guidelines.aspx
BHIVA guidelines for the management of HIV infection in pregnant women 2012 (2014 interim review)	http://www.bhiva.org/pregnancy-guidelines.aspx
UK National Guideline for the Use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE) 2015	http://www.bhiva.org/PEPSE-guidelines.aspx
Greater Manchester Sexual & Reprodutive Health Strategy	tbc
RCGP - Sexually Transmitted Infections in Primary Care	http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/sexually-transmitted-infections-in-primary-care.aspx
Faculty of Sexual & Reproductive Health - Contraception Guidelines	https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/
Faculty of Sexual & Reproductive Health - Management of SRH Issues Guidelines	https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/management-of-srh-issues/
NHS Cervical Screening Programme (CSP)	https://www.gov.uk/topic/population-screening-programmes/cervical
NICE Guidance - Antenatal care for uncomplicated pregnancies [CG62]	https://www.nice.org.uk/guidance/cg62/ifp/chapter/screening-and-tests

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GM Outcome Based Common Standard: ORAL HEALTH

GM Shared Vision:

As poor oral health is almost always preventable, these standards seek to set a level of self and professionally led care to establish good oral health. These standards are derived from well-established, nationally published guidelines with a strong evidence base including Commissioning Better Oral Health (PHE, 2014) and NICE. The document forms part of the common standards suite of population health measures. It links fits within the population health and prevention Theme 1 of the Greater Manchester Health and Social care plan but also contributes to the themes of enabling better care, transforming care in localities and standardising acute hospital care. Standards for dental services have been outlined within the GM plan for dentistry "Putting the mouth back in the body, 2017-2021 and complement the dental health standards below:

- Improving access to general dental services
- Improving cancer survival rates and earlier diagnosis
- Ensuring a proactive approach to health improvement and early detection
- Improving outcomes for people with long-term conditions
- Improving outcomes in childhood oral health
- Proactive disease management to improve outcomes

Our strategic priorities are as follows:

1. Everyone can eat speak and socialise without the pain or discomfort of dental disease.
2. People can access dental care when needed.
3. Differences in oral health between individuals and groups across GM are reduced.

This is document provides a list of standards and measures, and a core outcome linked to the GM Population Health Outcomes Framework.

Commissioners, providers, and clinicians are asked to:

• Review current practice against these standards
• Identify gaps in the evidence and the implementation of these standards
• Develop actions to address these gaps and provide evidence and feed this into the development of local plans and the GM oral health strategy.
• Agree a small number of KPIs to feed into the performance framework for Local Care Organisations.

GM Common Standards:

Strategic Outcome: Improving the Health of the GM Population and Reducing Health Inequalities across GM
"I" Statement: *"I will live a long and healthy life in Greater Manchester"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Oral Health is embedded within Health and Social Care	Oral Health is a strategic consideration within overarching plans for health and social care transformation and is embedded within service provision.	Presence of Oral Health in plans for Health and Social Care transformation.	

Strategic Outcome: Start Well - Give every GM child the best start in life
"I" Statement: *"I will make sure that every GM child can grow up able to eat speak and smile free from pain and distress of dental disease. "*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Children are protected from dental disease by the use of fluoride and protection from excess sugar	LA's commission oral health preventive programmes in line with Commissioning Better Oral Health guidance and ensure oral health is embedded with children's services.	% children under the age of 11 taking part in evidence based preventive programmes in locality	
	All health and social care practitioners promote use of fluoride & good diet and uptake of dental care	% 5 year old children in each borough with experience of	

	Parents, Carers & individuals take good oral hygiene & diet and access dental care when needed	dental decay	Proportion of 5 year old children free from dental decay
Children have access to good preventive programmes in dental practices & other settings	Dental teams deliver quality prevention & access to treatment & promote health & wellbeing	% children aged 0-15 receiving fluoride varnish in previous 12 months at a dental practice	
All children receive the dental care they need.	All Children within a locality are encouraged to visit a dentist before the age of 2 and are having appropriate levels of contact with a dentist during childhood	% children under the age of 2 who have visited a dentist	
		% children visiting a dentist in previous 24 months	
		waiting time for hospital admissions for dental General Anaesthetic	

Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential

"I" Statement: ***"I will maintain good oral health and access dental care"***

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Services improve health and wellbeing	Healthy Living Dental practices are delivering a health and wellbeing offer	Number of healthy living dental practices	n/a
All people can access dental care	All Adults , including those with additional needs have access to holistic dental health care.	% people who report difficulty in finding a dentist (GP patient survey)	
		Reduced differences in % people visiting a dentist in the previous 12 months between geographical areas & vulnerable groups	
Good Oral Health amongst the adult population with a long term condition	Oral health is included within relevant care pathways to ensure that people with long term conditions get the care that they need.	% newly diagnosed patients with diabetes signposted for a dental check.	

Strategic Outcome: Age Well - Every adult will be enabled to remain at home, safe and independent for as long as possible

"I" Statement: ***"As my needs change I will continue to maintain good mouth care and access appropriate dental care with appropriate support to be able to eat, speak and socialise and remain independent for as long as possible"***

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Older people have the proactive prevention and support that they need to maintain good oral health and wellbeing as they age. Any increased health needs are proactively managed to prevent pain, difficulty eating, malnutrition and maintain dignity	All services incorporate oral health into the assessment, treatment planning and care for all older adults to improve wellbeing and reduce need for treatment.	% adult care plans that include mouth care plan	n/a
		% people diagnosed with dementia with mouth care plan	
		% care home providers with meeting commissioning oral health for vulnerable older people guidance (policy, training, plans in place)	
	Dental services ensure that people aged 50+ and with long term conditions receive robust assessment, treatment planning, prevention and treatment to minimise the risk of future treatment need.	Number of practices that have achieved dementia friendly status.	

Strategic Outcome: Enabling resilient and thriving communities and neighbourhoods

"I" Statement: ***"I will live, work and play in a strong and thriving community and neighbourhood"***

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Dental services seek to improve health and oral health	Healthy Living Dental practices are delivering a health and wellbeing offer	Number of healthy living dental practices	

Programmes are in place to address poverty & wider determinants of health	Localities have considered oral health within plans to tackle Child Poverty	% children living in poverty	n/a
		Presence of oral health in local plans to tackle child poverty	
Risk factors for oral cancer are reduced	Healthcare professionals identify potential risk factors for cancer and chronic conditions and all people offered guidance and support to reduce that risk.	Smoking prevalence in routine and manual workers	
		Incidence of oral cancer diagnosis.	
		Alcohol attributed mortality rate	

Additional relevant guidance for commissioners and providers (i.e NICE Guidance; National Strategy; GM Strategy; Associated GM Common Standards)

Name	*Link*
PHE Guidance: Commissioning Better Oral Health	https://www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities
PHE Guidance: Delivering Better Oral Health	https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention
Healthy Child programme	https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life
PHE guidance Commissioning better oral health for vulnerable older people	To be published 2018
NICE guidance NG48: Oral health in Care home residents	https://www.nice.org.uk/guidance/ng48
NICE guidance NG 30: Oral health Promotion: General Dental Practice.	https://www.nice.org.uk/guidance/ng30
NICE guidance PH 55: Oral Health: Local authorities and partners	https://www.nice.org.uk/guidance/ph55
Mouth Care Matters	www.mouthcarematters.hee.nhs.uk
GM Toolkit: Healthy Living Dentistry toolkit	[Link to be inserted]
GM Toolkit: Medical Histories do Matter	[Link to be inserted]
GM Toolkit: Baby Teeth do Matter	[Link to be inserted]

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GM Outcome Based Common Standard: Tobacco Control

GM Shared Vision:

2017 saw the launch of the government's new tobacco control strategy for England, "Towards a Smokefree Generation" which expresses a desire to reduce adult smoking prevalence levels to 5% or less by 2030. Challenging interim targets are set.
Smoking is still by far the biggest single cause of early death and ill health in Greater Manchester, with huge economic impact. Although our starting point, in terms of achieving the government's targets, is much more challenging than in more affluent areas, we are no less ambitious or aspirational. We have developed a model, callec harm. This model is based on the World Health Organisation Tobacco Control Framework.
Smoking rates have reduced across Greater Manchester in recent years, but we now need to make change at scale and pace if we are to meet meet national and GM targets. We must ensure that good practice is applied consistently in all areas of GM and try new programmes, particularly in NHS settings, such as secondary care. By aim to cut smoking rates across Greater Manchester by one third by 2021.
The common standards for tobacco control are challenging, will require change and make the agenda the responsibility of GM Health and Social Care, local authorities, Clinical Commissioning Groups, Acute Trusts, NHS providers and partners.

GM Common Standards:

Strategic Outcome: Improving the Health of the GM Population and Reducing Health Inequalities across GM
"I" Statement: "*I will live a long and healthy life in Greater Manchester*"

Outcome	Standard	Method of Measuring Impact
Whole system Tobacco Control is embedded in Health and Social Care and the Environment	The GM Power model for Tobacco Control will be translated into local plans for each area of GM.	Each area of GM will have a Tobacco Control Plan based on GM Powe

Strategic Outcome: Start Well - Give every GM child the best start in life
"I" Statement: "*I will make sure that every GM child will has the best start in life and will develop well*"

Outcome	Standard	Method of Measuring Impact
Children are protected from tobacco related harm from conception onwards	All pregnant women will have a Carbon Monoxide breath test	% of pregnant women who have a Carbon Monoxide Breath test
	All pregnant women who smoke are referred to services which can help them to stop smoking during their pregnancy	Smoking at time of delivery rates (SATOD) reduce (N.B. target 6% by 2021 f
Children and young people will be protected from Environmental Tobacco Smoke	All families are supported to achieve a smoke free home	Smoking prevalence rates aged 15 years
		Adult Smoking prevalence rates reduce (N.B. target 13% by 2021 for G
		Numbers of smoking related accidental dwelling fires, injuries and deaths record

Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential
"I" Statement: *"I will maintain good health and wellbeing and will have good and equitable access to information, support and services"*

Outcome	Standard	Method of Measuring Impact
All smokers in GM understand the risks of smoking and tobacco related harm	Each area in GM will adopt a Making Every Contact Count approach: all front line staff are able to talk about the risks associated with smoking. (NB. suggest front line NHS staff, Housing Officers, Social Care Professionals)	Numbers of staff trained per year to talk about smoking (type of training to be dete
		% of designated frontline staff trained
All smokers should be able to access all available frontline pharmacotherapies. Combination Nicotine Replacement Therapies should always be an option. Any pharmacotherapy supplied should be alongside motivational support	Publicised arrangements are in place for smokers to access pharmacotherapy and motivational support in all areas (Including advice about nicotine inhaling products)	Adult smoking prevalence rates
		% of smokers helped to quit through local stop smoking services.
Tobacco Control measures (including smoking cessation support) will focus on groups known to have higher smoking prevalence rates in order to reduce smoking related health inequalities	All areas will have plans to focus resource on the areas and groups with the highest prevalence of smoking (routine and manual occupation; mental health problems; LGBT community; groups with complex long term conditions caused or exacerbated by smoking; locally identified priority groups; offenders).	Routine and manual smoking rates
		Adult smoking prevalence rates
		Smoking at time of delivery (SATOD)
		• NB. No measures routinely available for measuring in other groups which is something tha at in due course.
All smokers admitted to hospital will be assessed and treated for nicotine addiction irrespective of the cause of admission . (There will be zero tolerance to smoking for staff, patients and visitors).	All smokers admitted to hospital will receive appropriate pharmacotherapy and motivational support as inpatients and on-going support on discharge. The "CURE" programme is an example of an appropriate model .	Adult smoking prevalence
		Smoking related hospital admissions

Strategic Outcome: Age Well - Every adult will be enabled to remain at home, safe and independent for as long as possible
"I" Statement: *"I will be able to be safe and independent for as long as possible"*

Outcome	Standard	Method of Measuring Impact
People who have conditions caused by or exacerbated by smoking will be supported to stop smoking	All people aged 50 and over who have a smoking related or smoking exacerbated chronic condition will be offered evidence based support to stop smoking.	Smoking related conditions for people aged 50 and over.
All smokers aged 50 and over admitted to hospital will be assessed and treated for nicotine addiction, irrespective of the cause of admission. (There will be zero tolerance to smoking for staff, patients and visitors).	All smokers, irrespective of age, who are admitted to hospital, will receive appropriate pharmacotherapy and motivational support as inpatients and on-going support on discharge. (the "CURE" programme is an example of an appropriate model .	Smoking related hospital admissions for people aged 50 and over

Strategic Outcome: Enabling resilient and thriving communities and neighbourhoods
"I" Statement: *"I will live, work and play in a strong and thriving community and neighbourhood"*

Outcome	Standard	Method of Measuring Impact
Tobacco Legislation is enforced and illicit tobacco is countered.	Publicised arrangements are in place for members of the public to report concerns about illicit tobacco and breaches of legislation e.g. underage sales.	Numbers of reports to local Trading Standards teams
		Numbers of intelligence lead inspections and test purchases
Fewer smoking related accidental dwelling fires means that GM homes and residents are safer	All areas will work towards making all GM homes smoke free	Numbers of smoking related accidental dwelling fires, injuries and deaths record
Smoke free hospitals : there is zero tolerance to smoking for staff, patients and visitors in all hospitals across GM	All acute and mental health trusts to develop and implement a Smokefree policy	Nice guidance PH48 will be implemented in full
There will be more smoke free public spaces in GM	All areas will increase the number of voluntary schemes promoting smoke free family spaces	Numbers of new voluntary smoke free family spaces per GM area
A smoke free Public Sector	All public organisations' sites and grounds are supported to be smoke free	% compliance rates

Additional relevant guidance for commissioners and providers (i.e NICE Guidance; National Strategy; GM Strategy; Associated GM Common Standards)	
Name	***Link***
Towards a smoke free generation: tobacco control plan for england	https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
Making Smoking History: A Tobacco Free Greater Manchester	www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf
Smoking:stopping in pregnancy and after childbirth/NICE guidance, ph26	https://www.nice.org.uk/guidance/ph26
Smoking:supporting people to stop (new guidance pending).	https://www.nice.org.uk/qs43
Smoking: acute, maternity and mental health services	https://www.nice.org.uk/guidance/ph48
Greater Manchester Fire and Rescue Service - Fire Safety at Home	http://www.manchesterfire.gov.uk/media/4554/working-in-partnership-preventing-fires-and-improving-health-and-wellbeing.docx
NCSCT-National Centre for Smoking Cessation and Training	www.ncsct.co.uk

What is the desired outcome?	What will success look like?	How will we measure success?	What outputs will we measure?	Phase 1	Phase 2	Desired direction of travel	GM Rank	Improvement Rank	Direction of travel	CIPFA / 16
LIFE EXPECTANCY, WELLNESS & INEQUALITIES							1=best performing	1= greatest improvement in last year		
In Greater Manchester we will live longer and healthier lives, with the greatest improvement in the areas and groups which have the worst outcomes.	By 2026, people in Greater Manchester will have a Life Expectancy and Healthy Life Expectancy that is at least the same as the national average (and will have matched the Northwest average by 2021)	Fewer people will die early in Greater Manchester from causes considered preventable	Mortality rate from causes considered preventable	x		↓	7	5	↑	15
			Under 75 mortality rate from CVD considered preventable	x		↓	9	8	↑	15
			Under 75 mortality rate from cancer considered preventable	x		↓	8	3	↓	
			Under 75 mortality rate for Respiratory disease considered preventable	x		↓	6	4	↓	
		Overall Life Expectancy will increase for men and women	Gap in life expectancy at birth between each local authority, GM and England as a whole (Male)	x		↓	8	10	↓	
			Gap in life expectancy at birth between each local authority and England as a whole (Female)	x		↓	8	7	↓	
		Overall Healthy Life Expectancy will increase for men and women.	Healthy life expectancy at birth (Male)	x		↑	5	5	↓	9
			Healthy life expectancy at birth (Female)	x		↑	5	1	↑	
		There will be a reduction in Infant Mortality	Infant Mortality	x		↓	9	10	↑	14
		More people with long term conditions will be receiving optimal treatment and there will be a reduction in the "missing thousands"	Gap between estimated and diagnosed prevalence for CvD (* Rightcare as placeholder)	x		↓				
			Gap between estimated and diagnosed prevalence for Diabetes (* Rightcare as placeholder)	x		↓				
			Gap between estimated and diagnosed prevalence for Hypertension (* Rightcare as placeholder)	x		↓				
			Gap between estimated and diagnosed prevalence for Atrial Fibrillation (* Rightcare as placeholder)	x		↓				
	By 2021, the gap between those with the worst Health Outcomes and those with the best will have reduced, due to significant improvements amongst those with the worst	We will see a reduction in Health Inequalities due to significant improvements in the areas that currently have the poorest health outcomes	Health inequalities using Slope Index	x		↓	M: 9, F:10	M:7, F:10	↑	M:15, F:16
			New GM inequality metric		x					
START WELL										
In Greater Manchester we will have the best possible start in life.	More Greater Manchester Children will reach a good level of physical, cognitive, social and emotional development to prepare them for school and life.	We will meet or exceed the national average for the proportion of children reaching a 'good level of development' by the end of reception	% of children achieving a good level of development at the end of reception.	x		↑	10	1	↑	16
			% of children with free school meal status achieving a good level of development at the end of reception.	x		↑	4	4	↑	
		GM babies will have a healthy birth weight.	% of all live births at term with very low birth weight	x		↓	2	1	↓	
		More children will be breast fed at the start of their life	Breastfeeding at 6-8 weeks	x		↑	6	6	↓	5 (of 8)
		Fewer GM children experience dental decay	Proportion of 5 year old children free from dental decay	x		↑	9			15
		More GM children will be physically active	Temporary placeholder: % of children aged 5-15 meeting national physical activity guidelines (At least 60 minutes (1 hour) of moderate to vigorous intensity physical activity (MVPA) on all	x		↑	6			
			% of GM children aged 2-15 who are active or fairly active.		x					
		More GM children will be at a healthy weight at the end of reception.	Prevalence of overweight children (including obese) as measured by NCMP	x		↓	Reception: 3, Year 6: 4	Reception: 7; Year 6: 2	Reception ↑, Year 6↓	
		Fewer GM babies will be affected by maternal smoking during pregnancy and at point of delivery.	% of women who smoke at time of delivery	x		↓	7	7	↑	6
		Children will receive vaccinations and immunisations that prevent avoidable harmful health conditions	MMR vaccination rate	x		↑	7	8	↓	
LIVE WELL										
In Greater Manchester we will all have the opportunity to live well and fulfil our potential.	More Greater Manchester residents will be employed.	More people in GM will be employed	% of people aged 16-64 in employment	x		↑	8	1	↑	
			New GM employment and health measure to be developed		x					
	People who live in Greater Manchester will choose to live healthier lifestyles.	Fewer GM residents will be affected by the harmful impact of smoking	Smoking prevalence in adults - current smokers (APS)	x		↓	5	2	↓	
			Smoking prevalence in adults in routine and manual occupations - current smokers	x		↓	4	1	↓	
		More GM residents will by physically active, and fewer GM residents will be physically inactive.	% of GM population who are Active or Fairly Active	x		↑	3			
			% of physically inactive adults (>30 minutes per week)	x		↓	4			
		Fewer GM residents will experience alcohol-related harm	Alcohol-related hospital admissions (narrow definition)	x		↓	3	4	↓	
		More GM adults will be at a healthy weight	% of adults (18+) who are overweight or obese	x		↓	8			6 (of 11)
		More GM adults will have access to appropriate contraception	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)	x		↑	8	4	↓	10 (of 11)
		Fewer new cases of Sexually Transmitted Infections	New GM measure		x					
		New cases of HIV will be eradicated in Greater Manchester	New HIV diagnosis rate / 100,000 people aged 15+	x		↓	6	3	↓	
	People in GM will be in good mental health	People in GM will be emotionally well.	New GM Wellbeing Measure - GM Survey		x					
		People IN GM will be social connected	New GM Social Isolation / Loneliness Measure - GM Survey		x					
		Fewer people in GM will die as a result of suicide	Suicide Prevalence	x		↓	2	3	↓	
AGE WELL										
In Greater Manchester we will have every opportunity to age well and to remain at home, safe and independent for as long as possible.	Older GM residents will be supported to live a productive, healthy, safe and independent life in healthy communities.	Adults will remain in employment as they get older	50-64 Employment Rate	x		↑	4	1	↑	
		Fewer GM residents aged over 65 will be admitted to hospitals due to fall, accidents and injury.	Emergency hospital admissions due to falls in people aged 65 and over	x		↓	6	9	↑	14
		More GM older adults will be screened for cancer	Cancer Screening Coverage - Bowel Cancer	x		↑	6	1	↑	
		Older GM residents will be socially connected	% of GM residents aged 65+ who report being socially isolated (GM Survey)		x					
			% of GM residents aged 65+ who report being lonely (GM Survey)		x					

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Greater Manchester Health and Social Care Population Health Programme Board

Date: 29 March 2018

Subject: Population Health Outcomes and Common Standards

Report of: David Boulger (Head of Population Health Transformation, GMHSCP) and Wendy Meston (Consultant in Public Health, Rochdale Council)

SUMMARY:

This report provides proposals in relation to:

- Establishing a GM Population Health Outcomes Framework, as part of a Single Integrated Assurance process.
- The development of GM Common Standards
- Proposals for an 'Excellence in GM' Population Health sector led improvement programme

RECOMMENDATIONS:

GM Population Health Programme Board are asked to:

- Review and approve:
  - GM Population Health Outcomes Framework and the Tableau Based dashboard.
  - GM Population Health Common Standards for Core Public Health Functions
  - GM Population Health Common Standards for Tobacco
  - GM Population Health Common Standards for Oral Health
  - GM Population Health Common Standards for Sexual & Reproductive Health
- If approval is not possible, Population Health Programme Board are asked to specific actions that are required to progress to approval
- Note the intention to develop an 'Excellence in GM' Population Health sector led improvement programme

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1.0 INTRODUCTION

1.1 This report provides proposals in relation to:

- Establishing a GM Population Health Outcomes Framework, as part of a Single Integrated Assurance and improvement process.
- The development of GM Population Health Common Standards
- The development of a GM Population Health Sector Led Improvement programme

1.2 The report will cover the following areas:

- Use of interim arrangements, as agreed at Performance and Delivery Board in October 2017, within the Q2 and Q3 Single Integrated Assurance Process
- Development of a GM Population Health Outcomes Framework for use by GM and Localities as part of a single integrated assurance process
- Development of GM Common Standards for a range of priority areas
- Establishment of an Excellence in GM Sector Led Improvement Programme

2.0 OVERVIEW & BACKGROUND

2.1 In March 2017, the GM Health & Social Care Partnership agreed to a set of proposals to facilitate the creation of a unified population health system, to support the delivery of the GM Population Health Plan at pace and scale.

2.2 This included a commitment to the reduction of unwanted and unwarranted variation in standards, improvement in population health outcomes, more consistent adoption of evidence based practice, and the enhanced use of benchmarking data.

2.3 This confirmed a vision to drive improvements in population health across and within GM and through the 10 GM localities, reducing inequalities and setting outcomes and priorities that are aligned to place based priorities and delivery.

2.4 Over time, this programme has developed to incorporate 3 core elements:

- A GM Population Health Outcomes Framework (as part of a single integrated assurance process)
- GM Population Health Common Standards
- Excellence in GM Sector Led Improvement Programme

3.0 POPULATION HEALTH SINGLE INTEGRATED ASSURANCE PROCESS – INTERIM ARRANGEMENTS

3.1 At GMHSCP Performance and Delivery Board in October 2017, it was agreed that an interim Population Health assurance process would be incorporated into quarterly locality assurance meetings from Q2 2017/18, and would be underpinned by benchmarking data provided through the PHE Locality Dashboard (https://healthierlives.phe.org.uk/topic/public-health-dashboard).

3.2 This approach was implemented as planned and formed the basis for the development of key lines of inquiry during Q2 and Q3 (by exception) 2017/18.

4.0 A GM POPULATION HEALTH OUTCOME FRAMEWORK

4.1 Activity to establish the Population Health contribution to a Single Integrated Assurance Process through the development of a GM Population Health Outcome Framework has progressed at pace.

4.2 A GM Population Health Outcomes Framework has been developed in partnership, and through a process of engagement and co-design, with key stakeholders from across the Health and Social Care system and the wider Public Service.

4.3 A task and finish group was established to progress this task to completion, consisting of key partners from:

- GMHSCP
- GMCA
- Localities
- Public Health England
- Academia (University of Manchester)

4.4 The Framework focusses upon the key Population Health outcomes which adversely impact upon the health and wellbeing of the Greater Manchester population and seeks to place focus and emphasis on a reduced number of key indicators, from within the multiple thousands of measures that currently exist within the wider system.

4.5 The Framework seeks to reconcile the ambitions of:

- Taking Charge
- GM Population Health Plan
- GM Strategy

4.6 The Framework, and accompanying dashboard, establishes headline data, trends, benchmarking and locality outcome trajectories.

4.7 It is recognised that there is no 'perfect' version of this framework and that there are many complementary and competing variables within the system. However, following a wide-ranging process of co-design, review and rationalisation, the final proposed framework is attached as Appendix 1. The suite of outcomes presented at this stage is a sub set of many possible outcomes and the product can be adapted moving forward as required by GM or Localities.

4.8 This framework was reviewed and endorsed by GMHSCP Performance and Delivery Board on 14th March 2018, and GMHSCP Senior Management Team on 20th March 2018.

4.9 It is acknowledged that the full initial ambitions for the framework cannot all immediately be realised due to unavailable, incomplete or flawed data sets. As such, the framework will be mobilised in two phases. Phase 1 will incorporate the outcome and output measures as set out within Appendix 1. Phase 2 (due for completion by September 2018 but with iterative development up to that date), will seek to identify alternative means of measuring additional desirable outcomes and will also include further work around trend and trajectory modelling, simulation and visual representation.

4.10 The framework and associated datasets have been built into an interactive, tableau based dashboard which will be tested during the 2017/18 Q4 Assurance Cycle in April and May 2018. A link to the dashboard will be circulated in advance of GM Population Health Programme Board.

5.0 GM COMMON STANDARDS

5.1 In order to reduce variance, enhance consistency and improve outcomes across GM, a programme of work has been undertaken to develop GM Population Common Standards. Existing and new GM task groups have completed this task drawing upon existing standards such as those produced by NICE and Primary Care and the development of new standards that would drive improvement in outcomes and quality. The attached set are now ready for testing in the field. This process will result in further amendment and refinement.

5.2 Attached as Appendix 2 to 5 of this report are proposed GM Common Standards for:

- Prescribed and Core Public Health Functions
- Oral Health
- Tobacco
- Sexual and Reproductive Health

The headline standards for prescribed and non-prescribed public health functions has been produced for guidance and assurance for the implementation of Local Authority Circular Number LAC (DH) (2017) – Public Health Ring-Fenced Grant 2018/19

5.3 These standards have been designed by subject matter experts and stakeholder groups from within the Greater Manchester system and have been endorsed by GM Directors of Public Health. There has not been additional public engagement.

5.4 Further GM Common Standards are current under design and will be progressed through Population Health Programme Board governance in June 2018. These relate to:

- Physical Activity
- Integrated Wellness Services
- Drugs and Alcohol
- Mental Health and Wellbeing
- Health Protection
- Population Health Intelligence

6.0 EXCELLENCE IN GM

6.1 This programme also proposes a revitalised Sector Led Improvement programme, provisionally named 'Excellence in GM'.

6.2 This project is aimed at ensuring that a GM Population Health Outcomes Framework (as part of a single integrated assurance process) and a suit of GM Common Standards lead to actual improved outcomes, reduced inequalities and reduced variance.

6.3 This project has not commenced to date, but has been endorsed in principle by key stakeholders, including GM Directors of Public Health and will be progressed during Q1 2018/19 with a view to detailed proposals being brought to Population Health Programme Board in July 2018.

6.4 To enable this, GM Directors of Public Health have collectively approved investment in some dedicated Project Management capacity.

6.5 This programme will also seek to make best use of the resources available through the refreshed Local Government Association (LGA) / Association of Directors of Public Health (ADPH) national SLI programme (https://www.local.gov.uk/sector-led-improvement-public-health-prevention-and-early-intervention), but through a bespoke and coherent GM approach.

7.0 RECOMMENDATIONS

7.1 Population Health Programme Board are asked to:

- Review and approve:
  - GM Population Health Outcomes Framework and the Tableau Based dashboard.
  - GM Population Health Common Standards for Core / Prescribed Public Health Functions

- GM Population Health Common Standards for Tobacco
- GM Population Health Common Standards for Oral Health
- GM Population Health Common Standards for Sexual & Reproductive Health

- If approval is not possible, Population Health Programme Board are asked to specify actions that are required to progress to approval
- Note the development of an Excellence in GM programme for sector led improvement

END

Appendix 1 – GM Population Health Outcomes Framework

What is the desired outcome?	What will success look like?	How will we measure success?	What outputs will we measure?	Phase 1	Phase 2
LIFE EXPECTANCY, WELLNESS & INEQUALITIES					
In Greater Manchester we will live longer and healthier lives, with the greatest improvement in the areas and groups which have the worst outcomes.	By 2026, people in Greater Manchester will have a Life Expectancy and Healthy Life Expectancy that is at least the same as the national average (and will have matched the Northwest average by 2021)	Fewer people will die early in Greater Manchester from causes considered preventable	Mortality rate from causes considered preventable	x	
			Under 75 mortality rate from CVD considered preventable	x	
			Under 75 mortality rate from cancer considered preventable	x	
			Under 75 mortality rate for Respiratory disease considered preventable	x	
		Overall Life Expectancy will increase for men and women	Gap in life expectancy at birth between each local authority, GM and England as a whole (Male)	x	
			Gap in life expectancy at birth between each local authority and England as a whole (Female)	x	
		Overall Healthy Life Expectancy will increase for men and women.	Healthy life expectancy at birth (Male)	x	
			Healthy life expectancy at birth (Female)	x	
		There will be a reduction in Infant Mortality	Infant Mortality	x	
		More people will long term conditions will be receiving optimal treatment and there will be a reduction in the "missing thousands"	Gap between estimated and diagnosed prevalence for CvD (* Rightcare as placeholder)	x	
			Gap between estimated and diagnosed prevalence for Diabetes (* Rightcare as placeholder)	x	
			Gap between estimated and diagnosed prevalence for Hypertension (* Rightcare as placeholder)	x	
			Gap between estimated and diagnosed prevalence for Atrial Fibrillation (* Rightcare as placeholder)	x	
	By 2021, the gap between those with the worst Health Outcomes and those with the best will have reduced, due to significant improvements amongst those with the worst	We will see a reduction in Health Inequalities due to significant improvements in the areas that currently have the poorest health outcomes	Health inequalities using Slope Index	x	
			New GM inequality metric		x
START WELL					
In Greater Manchester we will have the best possible start in life.	More Greater Manchester Children will reach a good level of physical, cognitive, social and emotional development to prepare them for school and life.	We will meet or exceed the national average for the proportion of children reaching a 'good level of development' by the end of reception	% of children achieving a good level of development at the end of reception.	x	
			% of children with free school meal status achieving a good level of development at the end of reception.	x	
		GM babies will have a healthy birth weight.	% of all live births at term with very low birth weight	x	
		More children will be breast fed at the start of their life	Breastfeeding at 6-8 weeks	x	
		Fewer GM children experience dental decay	Proportion of 5 year old children free from dental decay	x	
		More GM children will be physically active	Temporary placeholder: % of children aged 5-15 meeting national physical activity guidelines (At least 60 minutes (1 hour) of moderate to vigorous intensity physical activity (MVPA) on all seven	x	
			% of GM children aged 2-15 who are active or fairly active.		x
		More GM children will be at a healthy weight at the end of reception.	Prevalence of overweight children (including obese) as measured by NCMP	x	
		Fewer GM babies will be affected by maternal smoking during pregnancy and at point of delivery.	% of women who smoke at time of delivery	x	
		Children will receive vaccinations and immunisations that prevent avoidable harmful health conditions	MMR vaccination rate	x	
LIVE WELL					
In Greater Manchester we will all have the opportunity to live well and fulfil our potential.	More Greater Manchester residents will be employed.	More people in GM will be employed	% of people aged 16-64 in employment	x	
			New GM employment and health measure to be developed		x
	People who live in Greater Manchester will choose to live healthier lifestyles.	Fewer GM residents will be affected by the harmful impact of smoking	Smoking prevalence in adults - current smokers (APS)	x	
			Smoking prevalence in adults in routine and manual occupations - current smokers	x	
		More GM residents will by physically active, and fewer GM residents will be physically inactive.	% of GM population who are Active or Fairly Active	x	
			% of physically inactive adults (>30 minutes per week)	x	
		Fewer GM residents will experience alcohol-related harm	Alcohol-related hospital admissions (narrow definition)	x	
		More GM adults will be at a healthy weight	% of adults (18+) who are overweight or obese	x	
		More GM adults will have access to appropriate contraception	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)	x	
		Fewer new cases of Sexually Transmitted Infections	New GM measure		x
		New cases of HIV will be eradicated in Greater Manchester	New HIV diagnosis rate / 100,000 people aged 15+	x	
	People in GM will be in good mental health	People in GM will be emotionally well.	New GM Wellbeing Measure - GM Survey		x
		People IN GM will be social connected	New GM Social Isolation / Loneliness Measure - GM Survey		x
		Fewer people in GM will die as a result of suicide	Suicide Prevalence	x	
AGE WELL					
In Greater Manchester we will have every opportunity to age well and to remain at home, safe and independent for as long as possible.	Older GM residents will be supported to live a productive, healthy, safe and independent life in healthy communities.	Adults will remain in employment as they get older	50-64 Employment Rate	x	
		Fewer GM residents aged over 65 will be admitted to hospitals due to fall, accidents and injury.	Emergency hospital admissions due to falls in people aged 65 and over	x	
		More GM older adults will be screened for cancer	Cancer Screening Coverage - Bowel Cancer	x	
		Older GM residents will be socially connected	% of GM residents aged 65+ who report being socially isolated (GM Survey)		x
			% of GM residents aged 65+ who report being lonely (GM Survey)		x

Appendix 2 – GM Common Standards: Core Public Health Functions:

Common Standards for prescribed public health functions
The standards listed below have been developed to detail headline standards for the prescribed functions outlined in the Public Health Ring fenced Grant Guidance for 2018/19 to Local Authorities. These are intended to provide guidance on action to be taken by localities in each prescribed and priority non prescribed areas.
In addition to the prescribed functions we have included standards relating to Drugs and Alcohol services, tobacco, mental health and wellbeing as these are also key functions related to the Public Health Grant and are of significance to improvement of GM population outcomes.
These headline standards have been chosen based on a judgement on how we can best meet the prescribed function and also achieve population health improvement for residents within Localities and across GM. For some areas there is a more detailed suite of standards available. These are currently in the areas of Sexual Health, Oral Health and tobacco. Further suites of standards for other areas are in production and will be added over time.

Prescribed Public Health functions	Common Standard	Guidance Measures or Metrics	Outcome Area	GM Outcomes Framework measure
Statutory Post	Each locality has an agreed arrangement for the statutory post of Director of Public Health	Each locality has a named Director of Public Health	All	n/a
Sexual health services - STI testing and treatment	To provide timely open access to STI advice and treatment services (in each locality)	To offer an appointment within 48 hours for 98% of people	Reduction of Sexually Transmitted Infections	New HIV diagnosis rate / 100,000 people aged 15+
	Provision of personalised risk reduction support and information for all who attend sexual health services and their partners	Advice and treatment pathway in place forpatients and partners in place for all sexual health providers and locaclities	Reduction of Sexually Transmitted Infections	
	Routine offer of an HIV test in high prevalence areas and a regular, targeted offer to those in high risk groups	Appropriate testing offer publicised	New HIV diagnosis rate / 100,000 people aged 15+, Eradication of HIV	
Sexual health services - Contraception	All under 18s within a locality are encouraged to access a sexual & reproductive health service or GP before engaging in sexual activity	Young Peoples Education and Promotion programme in place in each locality	Conception Rate per 1,000 (15-17 year olds)	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)
	Open access to specialised services for young people up to the age of 19	Specialist clinic session offered each week for young people in each locality	Reduction in Teenage Pregnancy and Reduction in Abortion rates under 25s	
			Drop-in sessions available in every secondary school	
	All women (15-44 years old) are fully informed about and, if clinically appropriate, encouraged to use LARC as their form of contraception	LARC Rate per 1,000 (15-44 year olds)	Reduction in unwanted pregnancy	
	For all women having a LARC removed and requiring contraception to have immediate access to an alternative, reliable method of contraception	Service audit in place	Reduction in unwated pregnancy	
NHS Health Check programme	All eligible individuals aged 40-74 to be offered an NHS Health Check once in every 5 years, with pilot areas prioritising people at greater risk, and for each individual to be recalled every 5 years if they remain eligible	% Offer and Uptake of eligible population of NHS Health Checks	Reduction in CVD premature mortality rates	Under 75 mortality rate from CVD considered preventable
	All identified at high risk to receive the advice and support to manage that risk	Local data collection or description of service offer	Reduction in CVD premature mortality rates	
Health Protection	Locality provision of community infection prevention and control service for proactive management, advice and response across social care, education and other community settings	Evidence of infection prevention and control service - audits completed , campaigns and initiatives, outbreak response, AMR plans	Reduction in communicable and infectious diseases	MMR vaccination rate
	Local arrangements and plans to achieve good uptake of NHS immunisation programmes	Local seasonal flu plan, including approaches to achieve targets of flu vaccine in over 65s, clinical risk groups and children	75% Flu Vaccination Uptake [NOTE suggest focus on clinical risk groups or children]	
		Local plans to achieve high immunisation rates including regular review of coverage	MMR uptake rates of 95% (2 doses) at 5 years across GM and all localities	
	Across GM and in each Locality there will be a robust Outbreak Plan and response for health protection incidents and emergencies	Agreed and exercised outbreak plan in place in each locality with arrangements to identify, implement and share lessons learnt	Reduction in communicable and infectious diseases	
Public Health advice to NHS Commissioners	Public Health specialist advice and support is available to NHS Commissioners, integrated commissioners and care organisations in all Localities and at a GM level	Memorandum of Understanding or programme of work agreed	All	n/a
National Child Measurement Programme	Completion of the National Child Measurement Programme in every Locality with above average uptake	Good uptake of the prorgamme in every Locality	Prevalence of overweight and obese as measured by NCMP part of GM and Local	Prevalence of overweight children (including obese) as measured by NCMP
	Each Locality has a documented service offer for children and families identified as being overweight, obese or underweight identified through the NCMP	Service offer for children and families publicised in each area	Reductions in levels of obesity and overweight children in reception and Year 6	
Prescibed Children's 0-5 services	Commissioning and delivery of the national 0-5 Healthy Child Programme in line with agreed targets	Number of mothers who receive an antenatal contact with the service at 28 weeks or above	Eary years outcomes	Breastfeeding Initiation; Proportion of 5 year old children free from dental decay; % of children achieving a good level of development at the end of reception
		95% of births that receive a face to face New Birth Visit within 14 days by a health visitor	Eary years outcomes	
		95% of babies who receive a 6-8 week review.	Eary years outcomes	
		95% of children who receive a 8- 12 month review by the time they turned 12 months old	Eary years outcomes	
		95% of children who received a 2-2.5 year review (stage 5).	Eary years outcomes	
Headline services (non-prescribed functions)	**Common Standard**	**Guidance Measures or Metrics**	**Outcome Area**	**GM Outcomes Framework measure**
*Drugs and Alcohol	All localities to demonstrate how they are meeting the local needs for the take up and the outcomes of its drug and alcohol treatment services	% of opiate / non-opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months	Reduced drug related harm and deaths	Alcohol-related hospital admissions (narrow definition)
		% of alcohol users that left drug treatment successfully who do not re-present to treatment within 6 months	Reduction in harm caused by alcohol including alcohol related hopsital admissions	
*Tobacco	All pregnant women who smoke are referred to services which can help them to stop smoking during their pregnancy	Number of mothers who quit smoking during pregnancy	Smoking at time of delivery rates (SATOD) reduce (N.B. target 6% by 2021 for GM).	% of women who smoke at time of delivery
	Publicised arrangements are in place for smokers to access pharmacotherapy and motivational support in all areas (Including advice about nicotine inhaling products)	Numbers accessing smokng cessation services in each locality	Adult Smoking prevalence rates reduce (N.B. target 13% by 2021 for GM).	Smoking prevalence in adults - current smokers (APS)
			% of smokers helped to quit through local stop smoking services.	
*Oral Health	LA's commission oral health preventive programmes in line with Commissioning Better Oral Health guidance and ensure oral health is embedded with children's services.	Local oral health plan and services in place in each locality	Proportion of 5 year old children free from dental decay	Proportion of 5 year old children free from dental decay
*Mental Health	All Localities will support the GM Suicide Prevention Strategy and we will have a GM and Locality suicide prevention action plans in place.	Local suicide action plan in place that is in line with the GM plan	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Suicide Prevalence
*Physical Activity	Every community will offer a range of high quality spaces and opportunities for people to live active lives, supported by welcoming leaders and suited to different motivations, attitudes and interests.	Local plan in place that aligns with #GMMoving	% of physically active adults (<150 minutes per week)	% of GM population who are Active or Fairly Active
			% of physically inactive adults (>30 minutes per week)	% of physically inactive adults (>30 minutes per week)
* Non-precribed functions				

Appendix 3 – GM Common Standards: Tobacco

GM Outcome Based Common Standard: Tobacco Control

GM Shared Vision:

2017 saw the launch of the government's new tobacco control strategy for England, "Towards a Smokefree Generation" which expresses a desire to reduce adult smoking prevalence levels to 5% or less by 2030. Challenging interim targets are set.
Smoking is still by far the biggest single cause of early death and ill health in Greater Manchester, with huge economic impact. Although our starting point, in terms of achieving the government's targets, is much more challenging than in more affluent areas, we are no less ambitious or aspirational. We have developed a model, called GM Power, which will allow us to tackle all of the causes of smoking and tobacco related harm. This model is based on the World Health Organisation Tobacco Control Framework.
Smoking rates have reduced across Greater Manchester in recent years, but we now need to make change at scale and pace if we are to meet meet national and GM targets. We must ensure that good practice is applied consistently in all areas of GM and try new programmes, particularly in NHS settings, such as secondary care. By applying GM Power across the conurbation in evidence based, but innovative ways, we aim to cut smoking rates across Greater Manchester by one third by 2021.
The common standards for tobacco control are challenging, will require change and make the agenda the responsibility of GM Health and Social Care, local authorities, Clinical Commissioning Groups, Acute Trusts, NHS providers and partners.

GM Common Standards:

Strategic Outcome: Improving the Health of the GM Population and Reducing Health Inequalities across GM
"I" Statement: "*I will live a long and healthy life in Greater Manchester*"

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Whole system Tobacco Control is embedded in Health and Social Care and the Environment	The GM Power model for Tobacco Control will be translated into local plans for each area of GM.	Each area of GM will have a Tobacco Control Plan based on GM Power.	n/a

Strategic Outcome: Start Well - Give every GM child the best start in life
"I" Statement: "*I will make sure that every GM child will has the best start in life and will develop well*"

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Children are protected from tobacco related harm from conception onwards	All pregnant women will have a Carbon Monoxide breath test	% of pregnant women who have a Carbon Monoxide Breath test	% of women who smoke at time of delivery
	All pregnant women who smoke are referred to services which can help them to stop smoking during their pregnancy	Smoking at time of delivery rates (SATOD) reduce (N.B. target 6% by 2021 for GM).	
Children and young people will be protected from Environmental Tobacco Smoke	All families are supported to achieve a smoke free home	Smoking prevalence rates aged 15 years	Smoking prevalence in adults - current smokers (APS)
		Adult Smoking prevalence rates reduce (N.B. target 13% by 2021 for GM).	
		Numbers of smoking related accidental dwelling fires, injuries and deaths recorded by GMFRS	

Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential
"I" Statement: "*I will maintain good health and wellbeing and will have good and equitable access to information, support and services*"

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
All smokers in GM understand the risks of smoking and tobacco related harm	Each area in GM will adopt a Making Every Contact Count approach: all front line staff are able to talk about the risks associated with smoking. (NB. suggest front line NHS staff, Housing Officers, Social Care Professionals)	Numbers of staff trained per year to talk about smoking (type of training to be determined locally)	Smoking prevalence in adults - current smokers (APS)
		% of designated frontline staff trained	
All smokers should be able to access all available frontline pharmacotherapies. Combination Nicotine Replacement Therapies should always be an option. Any pharmacotherapy supplied should be alongside motivational support	Publicised arrangements are in place for smokers to access pharmacotherapy and motivational support in all areas (Including advice about nicotine inhaling products)	Adult smoking prevalence rates	
		% of smokers helped to quit through local stop smoking services.	
Tobacco Control measures (including smoking cessation support) will focus on groups known to have higher smoking prevalence rates in order to reduce smoking related health inequalities	All areas will have plans to focus resource on the areas and groups with the highest prevalence of smoking (routine and manual occupation; mental health problems; LGBT community; groups with complex long term conditions caused or exacerbated by smoking; locally identified priority groups; offenders).	Routine and manual smoking rates	Smoking prevalence in adults in routine and manual occupations - current smokers
		Adult smoking prevalence rates	Smoking prevalence in adults - current smokers (APS)
		Smoking at time of delivery (SATOD)	% of women who smoke at time of delivery
		• NB. No measures routinely available for measuring in other groups which is something that may need to be looked at in due course.	n/a
All smokers admitted to hospital will be assessed and treated for nicotine addiction irrespective of the cause of admission . (There will be zero tolerance to smoking for staff, patients and visitors).	All smokers admitted to hospital will receive appropriate pharmacotherapy and motivational support as inpatients and on- going support on discharge. The "CURE" programme is an example of an appropriate model .	Adult smoking prevalence	Mortality rate from causes consider preventable
		Smoking related hospital admissions	

Strategic Outcome: Age Well - Every adult will be enabled to remain at home, safe and independent for as long as possible
"I" Statement: *"I will be able to be safe and independent for as long as possible"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
People who have conditions caused by or exacerbated by smoking will be supported to stop smoking	All people aged 50 and over who have a smoking related or smoking exacerbated chronic condition will be offered evidence based support to stop smoking.	Smoking related conditions for people aged 50 and over.	Smoking prevalence in adults - current smokers (APS)
All smokers aged 50 and over admitted to hospital will be assessed and treated for nicotine addiction, irrespective of the cause of admission. (There will be zero tolerance to smoking for staff, patients and visitors).	All smokers, irrespective of age, who are admitted to hospital, will receive appropriate pharmacotherapy and motivational support as inpatients and on-going support on discharge. (the "CURE" programme is an example of an appropriate model .	Smoking related hospital admissions for people aged 50 and over	

Strategic Outcome: Enabling resilient and thriving communities and neighbourhoods
"I" Statement: *"I will live, work and play in a strong and thriving community and neighbourhood"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Tobacco Legislation is enforced and illicit tobacco is countered.	Publicised arrangements are in place for members of the public to report concerns about illicit tobacco and breaches of legislation e.g. underage sales.	Numbers of reports to local Trading Standards teams	n/a
		Numbers of intelligence lead inspections and test purchases	
Fewer smoking related accidental dwelling fires means that GM homes and residents are safer	All areas will work towards making all GM homes smoke free	Numbers of smoking related accidental dwelling fires, injuries and deaths recorded by GMFRS	n/a
Smoke free hospitals : there is zero tolerance to smoking for staff, patients and visitors in all hospitals across GM	All acute and mental health trusts to develop and implement a Smokefree policy	Nice guidance PH48 will be implemented in full	n/a
There will be more smoke free public spaces in GM	All areas will increase the number of voluntary schemes promoting smoke free family spaces	Numbers of new voluntary smoke free family spaces per GM area	n/a
A smoke free Public Sector	All public organisations' sites and grounds are supported to be smoke free	% compliance rates	n/a

Additional relevant guidance for commissioners and providers (i.e NICE Guidance; National Strategy; GM Strategy; Associated GM Common Standards)

Name	*Link*
Towards a smoke free generation: tobacco control plan for england	https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
Making Smoking History: A Tobacco Free Greater Manchester	www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf
Smoking:stopping in pregnancy and after childbirth/NICE guidance, ph26	https://www.nice.org.uk/guidance/ph26
Smoking:supporting people to stop (new guidance pending).	https://www.nice.org.uk/qs43
Smoking: acute, maternity and mental health services	https://www.nice.org.uk/guidance/ph48
Greater Manchester Fire and Rescue Service - Fire Safety at Home	http://www.manchesterfire.gov.uk/media/4554/working-in-partnership-preventing-fires-and-improving-health-and-wellbeing.docx
NCSCT-National Centre for Smoking Cessation and Training	www.ncsct.co.uk

Appendix 4 – GM Common Standards: Oral Health

GM Outcome Based Common Standard: ORAL HEALTH

GM Shared Vision:

As poor oral health is almost always preventable, these standards seek to set a level of self and professionally led care to establish good oral health. These standards are derived from well-established, nationally published guidelines with a strong evidence base including Commissioning Better Oral Health (PHE, 2014) and NICE. The document forms part of the common standards suite of population health measures. It links fits within the population health and prevention Theme 1 of the Greater Manchester Health and Social care plan but also contributes to the themes of enabling better care, transforming care in localities and standardising acute hospital care. Standards for dental services have been outlined within the GM plan for dentistry "Putting the mouth back in the body, 2017-2021 and complement the dental health standards below:

- Improving access to general dental services
- Improving cancer survival rates and earlier diagnosis
- Ensuring a proactive approach to health improvement and early detection
- Improving outcomes for people with long-term conditions
- Improving outcomes in childhood oral health
- Proactive disease management to improve outcomes

Our strategic priorities are as follows:

1. Everyone can eat speak and socialise without the pain or discomfort of dental disease.
2. People can access dental care when needed.
3. Differences in oral health between individuals and groups across GM are reduced.

This is document provides a list of standards and measures, and a core outcome linked to the GM Population Health Outcomes Framework. Commissioners, providers, and clinicians are asked to:

- Review current practice against these standards
- Identify gaps in the evidence and the implementation of these standards
- Develop actions to address these gaps and provide evidence and feed this into the development of local plans and the GM oral health strategy.
- Agree a small number of KPIs to feed into the performance framework for Local Care Organisations.

GM Common Standards:

Strategic Outcome: Improving the Health of the GM Population and Reducing Health Inequalities across GM
"I" Statement: *"I will live a long and healthy life in Greater Manchester"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Oral Health is embedded within Health and Social Care	Oral Health is a strategic consideration within overarching plans for health and social care transformation and is embedded within service provision.	Presence of Oral Health in plans for Health and Social Care transformation.	n/a

Strategic Outcome: Start Well - Give every GM child the best start in life
"I" Statement: *"I will make sure that every GM child can grow up able to eat speak and smile free from pain and distress of dental disease. "*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Children are protected from dental disease by the use of fluoride and protection from excess sugar	LA's commission oral health preventive programmes in line with Commissioning Better Oral Health guidance and ensure oral health is embedded with children's services.	% children under the age of 11 taking part in evidence based preventive programmes in locality	Proportion of 5 year old children free from dental decay
	All health and social care practitioners promote use of fluoride & good diet and uptake of dental care	% 5 year old children in each borough with experience of dental decay	
	Parents, Carers & individuals take good oral hygiene & diet and access dental care when needed		
Children have access to good preventive programmes in dental practices & other settings	Dental teams deliver quality prevention & access to treatment & promote health & wellbeing	% children aged 0-15 receiving fluoride varnish in previous 12 months at a dental practice	
All children receive the dental care they need.	All Children within a locality are encouraged to visit a dentist before the age of 2 and are having appropriate levels of contact with a dentist during childhood	% children under the age of 2 who have visited a dentist	
		% children visiting a dentist in previous 24 months	
		waiting time for hospital admissions for dental General Anaesthetic	

Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential
"I" Statement: *"I will maintain good oral health and access dental care"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Services improve health and wellbeing	Healthy Living Dental practices are delivering a health and wellbeing offer	Number of healthy living dental practices	n/a
All people can access dental care	All Adults , including those with additional needs have access to holistic dental health care.	% people who report difficulty in finding a dentist (GP patient survey)	
		Reduced differences in % people visiting a dentist in the previous 12 months between geographical areas & vulnerable groups	
Good Oral Health amongst the adult population with a long term condition	Oral health is included within relevant care pathways to ensure that people with long term conditions get the care that they need.	% newly diagnosed patients with diabetes signposted for a dental check.	

Strategic Outcome: Age Well - Every adult will be enabled to remain at home, safe and independent for as long as possible
"I" Statement: *"As my needs change I will continue to maintain good mouth care and access appropriate dental care with appropriate support to be able to eat, speak and socialise and remain independent for as long as possible"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Older people have the proactive prevention and support that they need to maintain good oral health and wellbeing as they age. Any increased health needs are proactively managed to prevent pain, difficulty eating, malnutrition and maintain dignity	All services incorporate oral health into the assessment, treatment planning and care for all older adults to improve wellbeing and reduce need for treatment.	% adult care plans that include mouth care plan	n/a
		% people diagnosed with dementia with mouth care plan	
		% care home providers with meeting commissioning oral health for vulnerable older people guidance (policy, training, plans in place)	
	Dental services ensure that people aged 50+ and with long term conditions receive robust assessment, treatment planning, prevention and treatment to minimise the risk of future treatment need.	Number of practices that have achieved dementia friendly status.	

Strategic Outcome: Enabling resilient and thriving communities and neighbourhoods
"I" Statement: *"I will live, work and play in a strong and thriving community and neighbourhood"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Dental services seek to improve health and oral health	Healthy Living Dental practices are delivering a health and wellbeing offer	Number of healthy living dental practices	n/a
Programmes are in place to address poverty & wider determinants of health	Localities have considered oral health within plans to tackle Child Poverty	% children living in poverty	
		Presence of oral health in local plans to tackle child poverty	
Risk factors for oral cancer are reduced	Healthcare professionals identify potential risk factors for cancer and chronic conditions and all people offered guidance and support to reduce that risk.	Smoking prevalence in routine and manual workers	
		Incidence of oral cancer diagnosis.	
		Alcohol attributed mortality rate	

Additional relevant guidance for commissioners and providers (i.e NICE Guidance; National Strategy; GM Strategy; Associated GM Common Standards)

Name	*Link*
PHE Guidance: Commissioning Better Oral Health	https://www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities
PHE Guidance: Delivering Better Oral Health	https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention
Healthy Child programme	https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life
PHE guidance Commissioning better oral health for vulnerable older people	To be published 2018
NICE guidance NG48: Oral health in Care home residents	https://www.nice.org.uk/guidance/ng48
NICE guidance NG 30: Oral health Promotion: General Dental Practice.	https://www.nice.org.uk/guidance/ng30
NICE guidance PH 55: Oral Health: Local authorities and partners	https://www.nice.org.uk/guidance/ph55
Mouth Care Matters	www.mouthcarematters.hee.nhs.uk
GM Toolkit: Healthy Living Dentistry toolkit	[Link to be inserted]
GM Toolkit: Medical Histories do Matter	[Link to be inserted]
GM Toolkit: Baby Teeth do Matter	[Link to be inserted]

Appendix 5 – GM Common Standards: Sexual & Reproductive Health

GM Outcome Based Common Standard: Sexual and Reproductive Health

GM Shared Vision:

Poor sexual and reproductive health, including the ongoing transmission of HIV, has major impacts on Greater Manchester residents, and despite the progress made, there are still high rates of HIV and STIs in the conurbation. Continuing challenges include the rising rates of some sexually transmitted infections, the continuing transmission of HIV and continuing inequalities in outcomes. Almost half all HIV diagnoses in GM are late, which lead to poorer outcomes for the individual and increased risk of onward transmission. Further demands on services are anticipated with the potential introduction of pre-exposure prophylaxis (PrEP) and immediate initiation of anti-retroviral therapy (ART). The vision for Greater Manchester is that:

- all residents have the knowledge, skills and confidence to make informed choices about their sexual health, reproduction and relationships;
- sexual and reproductive health services are accessible, sensitive and appropriate for all;
- improved outcomes in sexual and reproductive health, bringing Greater Manchester to among the best in the country;
- working together to eradicate HIV in a generation

Our ambition is for a holistic system to ensure good sexual and reproductive health for all Greater Manchester residents with clear pathways, common standards and expectations set within it enabling people to access what they need, at a consistently high quality, when and where they need it. In addition, the aim to help people be more open about their sexual and reproductive health and reduce the stigma associated with poor sexual health outcomes. These reforms of the system aim to have the following impacts on the region:

- GM population will be able to exercise personal choice and self-management regarding sexuality, sexual health and contraception.
- Significantly reduced prevalence of STIs & HIV in GM, particularly amongst targeted, higher risk communities.
- Ensure that we are prepared for emerging challenges in sexual health including multidrug resistant gonorrhoea.
- Improved health and life expectancy for people living with HIV within GM, thus improving the quality of life for people living with HIV and reducing the cost to the sub-region's health and social care system.
- Maintain open access to sexual and reproductive health services, giving people the choice of where to attend.
- Agreed standards across the system to ensure that no matter where people gain access to the system, they are able to obtain the right, high quality care.
- Deliver a more consistent primary care offer, especially for reproductive health.

GM Common Standards:

Strategic Outcome: Improving the Health of the GM Population and Reducing Health Inequalities across GM

"I" Statement: *"I will live a long and healthy life in Greater Manchester"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Sexual & Reproductive Health is embedded within Health & Social Care	Sexual & Reproductive Health is a strategic consideration within overarching plans for health and social care transformation and is embedded within service provision.	Presence of Sexual & Reproductive Health in plans for Health and Social Care transformation.	n/a

Strategic Outcome: Start Well - Give every GM child the best start in life

"I" Statement: *"I will make sure that every GM child will has the best start in life and will develop well"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Maintain the uptake of syphilis, HIV and Hepatitis B testing in pregnancy	All pregnant women are screened for infectious diseases in line with NHS screening guidelines	% of uptake	New HIV diagnosis rate / 100,000 people aged 15+

Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential

"I" Statement: *"I will receive an appropriate, non-judgemental service by suitable trained staff"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Positive patient experience	Inclusion of questions around sexual & reproductive health in all annual patient surveys (surveys, focus groups)	Patient survey	n/a
Patient supported following an HIV diagnosis			
Delivering a responsive service			

"I" Statement: *"I will have swift access to the service(s) I need"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
48 hour access to STI treatment and advice for symptomatic patients	100% offer within 48 hours	Clinic data	New GM measure
Improve cervical cancer screening uptake	80% of women uptake cervial screening	NHS England uptake data	n/a

"I" Statement: *"I will be offered choice and support to make an informed decision regarding contraception"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Reduction in unwanted pregnancies	All under 18s within a locality are encouraged to visit a sexual & reproductive health service or GP before engaging in sexual activity and are having appropriate levels of contact with these services during adolescence.	Rate per 1,000 (15-17 year olds)	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)
	All schools to provide an up-to-date and appropriate age-related RSE programme	tbc	
	Open access to specialised services for young people up to the age of 19	No. of specialist clinic sessions per week for young people available across Greater Manchester	
	All young people to have access to school based drop-in sessions	School nurse drop-in sessions available in every secondary school	
Increase in uptake of long acting reversible contraception (LARC)	All women (15-44 years old) are fully informed about and, if clinically appropriate, encouraged to use LARC as their form of contraception	Rate per 1,000 (15-44 year olds)	
	For all women having a LARC removed and requiring contraception to have immediate access to an alternative, reliable method of contraception	Audit (tbc)	

"I" Statement: *"I will have access to the testing and treatment I need"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Reduction in new and late diagnosis of HIV	Routine offer of an HIV test in high prevalence areas and a regular, targeted offer to those in high risk groups	Number of new diagnoses and % of which are late	New HIV diagnosis rate / 100,000 people aged 15+
	Evidence of training re Blood Born Viruss for Primary Care every 3 years	Training to GPs/Pharmacies for advice and onward referral	
Improve Chlamydia detection rate	Achieve the agreed population level Chlamydia detection rate and meet PN standards	Rate per 100,000 (15-24 year olds) and maintain PN rate of 0.6	New GM measure
Reduction in the prevalence of STIs and onward transmission	Improved digital offer including self-assessment of risk, campaigns	Number of new diagnoses and rate per 100,000 residents	

"I" Statement: *"I will be given information and advice about reducing my personal risk of sexual health issues"*

Outcome	Standard	Method of Measuring Impact	GM Outcomes Framework measure
Reduction in abortions and repeat abortions	LARC offered post-abortion	Rate per 1,000 (15-44 year old women) and % of who are under 25	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)
Reduction in repeat STIs	Provision of personalise risk reduction support and information	% reinfected within 12 months	New GM measure

Additional relevant guidance for commissioners and providers (i.e NICE Guidance; National Strategy; GM Strategy; Associated GM Common Standards)

Name	*Link*
NICE Guidance - Sexually transmitted infections and under-18 conceptions: prevention [PH3]	https://www.nice.org.uk/guidance/ph3
NICE Guidance - HIV testing: increasing uptake among people who may have undiagnosed HIV [NG60]	HIV testing: increasing uptake among people who may have undiagnosed HIV
NICE Guidance - Sexually transmitted infections: condom distribution schemes [NG68]	https://www.nice.org.uk/guidance/ng68
NICE Guidance - Harmful sexual behaviour among children and young people [NG55]	https://www.nice.org.uk/guidance/ng55
NICE Guidance - Contraceptive services for under 25s [PH51]	https://pathways.nice.org.uk/pathways/contraceptive-services-for-under-25s
NICE Quality Standards - HIV testing: encouraging uptake Quality standard [QS157]	https://www.nice.org.uk/guidance/qs157
NICE Quality Standards - Contraception Quality standard [QS129]	https://www.nice.org.uk/guidance/qs129
NICE Pathways - Preventing sexually transmitted infections and under-18 conceptions overview	https://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions
NICE Pathways - HIV testing and prevention overview	https://pathways.nice.org.uk/pathways/hiv-testing-and-prevention
NICE Guidance - Long Acting Reversible Contraception [CG30]	https://www.nice.org.uk/guidance/cg30
BHIVA guidelines for the routine investigation and monitoring of adult HIV-1-positive individuals (2016)	http://www.bhiva.org/guidelines.aspx
BHIVA guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2015 (2016 interim update)	http://www.bhiva.org/HIV-1-treatment-guidelines.aspx
BHIVA guidelines for the management of HIV infection in pregnant women 2012 (2014 interim review)	http://www.bhiva.org/pregnancy-guidelines.aspx
UK National Guideline for the Use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE) 2015	http://www.bhiva.org/PEPSE-guidelines.aspx
Greater Manchester Sexual & Reprodutive Health Strategy	tbc
RCGP - Sexually Transmitted Infections in Primary Care	http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/sexually-transmitted-infections-in-primary-care.aspx
Faculty of Sexual & Reproductive Health - Contraception Guidelines	https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/
Faculty of Sexual & Reproductive Health - Management of SRH Issues Guidelines	https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/management-of-srh-issues/
NHS Cervical Screening Programme (CSP)	https://www.gov.uk/topic/population-screening-programmes/cervical
NICE Guidance - Antenatal care for uncomplicated pregnancies [CG62]	https://www.nice.org.uk/guidance/cg62/ifp/chapter/screening-and-tests

BRIEFING TO OLDHAM HEALTH AND WELLBEING BOARD

Report Title: Oldham Cares Outcomes Framework Update

Report Author: Katrina Stephens, Joint Acting Director of Public Health

Date: 26th June 2018

1. Developing the Outcomes Framework for Oldham Cares

1.1. The Oldham Cares outcomes framework sets out a range of high level outcomes based on the key changes we want to see in Oldham over the next decade. These are the headline outcomes for Oldham Cares, which the whole system will work together to deliver, in order to improve the health of the population and the way the local health and social care system operates. These outcomes will inform commissioning priorities and performance management. Twelve outcomes have been agreed and are grouped into the following categories:

- Healthy population
- Effective prevention, treatment and care
- Service quality / health of the system

1.2. Each high level outcome is supported by a small number of indicators against which progress can be assessed. These indicators are a range of specific measures that demonstrate the achievement (or otherwise) of a high level outcome. The indicators are population or performance measures where data is routinely collected and analysed.

1.3. Focusing on a small range of indicators provides a clear focus for transforming the delivery of health and care services and improving population health.

1.4. Supporting indicators have been selected in line with the following principles:

- They are consistent with the overall aims of Oldham Cares
- They can only be achieved in partnership and are outside the control of a single organisation
- There is an accepted case that the measure could be positively affected by integrated commissioning and service delivery

1.5. In addition, the availability and quality of data was a consideration in selecting indicators. As far as possible, indicators were prioritised for inclusion in the framework on the basis of:

- Analysis of recent performance (benchmarking Oldham's performance against other authorities in the North West and the rest of England)
- Trend data on Oldham's performance over a period of up to 7 years
- Availability of data below borough level to consider variations within Oldham (e.g. cluster, practice, ward level)
- The frequency of publication and robustness of the data source
- The change we want to see can easily be communicated and is meaningful to local residents.

1.6. The process of setting targets and ambitions will take into account variations in health and care outcomes across Oldham. It is important that targets take account of health inequalities within the borough and efforts to reduce them, as well as provide some focus on where resources are best allocated.

1.7. Across the system there are a plethora of outcomes frameworks, indicator sets and dashboards in use. Many of these contain a large number of outcomes and indicators. The Oldham Cares Outcomes Framework does not seek to replace these outcomes frameworks and indicator sets. Many of these frameworks include statutory measures and key performance and outcomes measures for understanding the quality and impact of services or changes in population health.

1.8. Whilst the indicators in each framework do not match exactly there is a good level of coherence between the frameworks. As the Oldham Cares Framework sets out to only include a small set of high priority indicators it is inevitable that it will not capture the range of measures included in other frameworks. Table 1 shows the frameworks most closely linked to Oldham Cares, and the purpose that they perform. These frameworks all have a role which is distinct to that of the Oldham Cares outcomes framework.

Table 1: Key performance frameworks and outcome indicator sets linked to Oldham Cares

Framework/indicator set/dashboard	Purpose
Oldham Cares Outcomes Framework	High level outcomes and indicators which set out the key improvements that we want to see in the health and wellbeing of local residents and across the health and social care system in Oldham over the next decade.
CCG Improvement and Assessment Framework	Performance framework for CCGs, designed and published by NHS England. Development of a GM framework has been proposed but has not yet been progressed, therefore this remains the primary framework for local NHS performance monitoring.
Oldham Council Corporate Plan Outcomes and Business Planning framework	The Corporate Plan Outcomes and Business Planning Framework sets out how Business Plans and Corporate Performance management support the strategic objectives set out the Oldham Plan and the Corporate Plan, and how everything we do is underpinned by our values and behaviours It provides a process for turning vision and aims into

	practical actions and real outcomes.
Locality investment agreement indicators	Set of indicators where we are aiming to improve performance through the use of transformation funding. Activity undertaken by programmes and projects receiving transformation funding should be able to demonstrate how they will achieve improvements in these indicators. Indicators selected locally are now being supplemented with a set of GM indicators which all localities are expected to include in their refreshed investment agreement.
Thriving Communities Index	A newly developed tool, now completing proof of concept stage, which seeks to capture strength of place, resident behaviours and reactive demand. It does this at a very local level (Neighbourhoods), which are intended to ensure a reflection of real communities. The index will allow us to make relative statements about the degree to which neighbourhoods are "thriving", and, if repeated, allow us to see which neighbourhoods are improving or worsening in ranking over time.
GM Population health outcomes framework	Set of measures which describe our progress in improving population health. Produced by GM Health and Social Care Partnership using nationally published data. Used by GM for assurance visits. Considering our performance against these indicators will assist us in setting our priorities for action to improve population health.
Adult Social Care Outcomes Framework	National framework which measures how well local care and support services achieve the outcomes that matter most to people.
Children's Social Care	Performance Framework for children's is informed by OFSTED's Inspecting Local Authority Children's Services (ILACS) framework and service priorities. This is managed and monitored through the Children Services Analysis Tool (ChAT Tool), the Director of Children Services Dashboard, and the Children Social Care Dashboard.

2. Progress to date and next steps

2.1. The aim of the Oldham Cares Outcomes Framework is provide a shared set of key outcome measures and indicators that the whole system will work together to achieve. As such the outcomes and indicators selected are those that require contributions from across the system for positive change to be achieved. This means that all parts of the system, including all organisations that are parts of Oldham Cares, and the range of Oldham Cares workstreams, will need to consider how they contribute to the achievement of these outcomes and indicators through their programmes and activities.

2.2. The framework has been discussed with the Alliance Provider Board, and providers are now providing feedback on the extent to which the outcomes and indicators fit with their existing operational priorities, as well as any areas which they feel are priorities for improvement. Alliance providers also highlighted that the number of outcomes and indicators in the framework was still high and that it may be helpful to select some initial areas of focus from within the framework indicators.

2.3. Work to map trajectories for each indicator is almost complete (example provided in Appendix 1). Anticipated trajectories for Oldham, England, and the best performing statistical neighbour have been modelled where possible for each indicator. This provides an initial basis for setting targets which would aim to bring outcomes for Oldham residents into line with the national average or the best amongst statistical neighbours. Further information still needs to be gathered on variation within Oldham, and this work is also underway.

2.4. Feedback from providers, combined with trajectory and variation data will underpin the final setting of targets and ambitions. These targets will be for Oldham Cares as a whole to achieve. The nature of the indicators selected is such that no one organisation or workstream can be expected to achieve the improvements requested in isolation.

2.5. Prior to the next Health and Wellbeing Board it is proposed that collated information on projections, variation and targets is discussed with relevant commissioners and partnership forums, for example mental health commissioners and mental health strategic partnership in the case of mental health indicators. The group of Health and Wellbeing Board members which met to refine the list of outcomes and indicators will also be reconvened to oversee this work. A report containing proposed targets for each indicator will then be brought back to the next Health and Wellbeing Board meeting for approval.

Appendix 1:

Infant Mortality (aged less than one year)

Definition and rationale

Rate of deaths in infants aged less than 1 year per 1,000 live births

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.

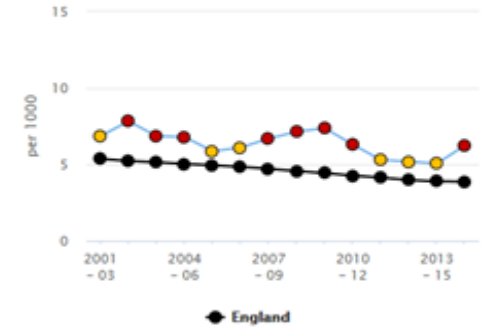
Current performance

From 2009-11 to 2013-15 infant mortality in Oldham decreased by 29.7% from 7.4 to 5.1 per 1,000 live births. The most recent data shows during period 2014-16 infant mortality rose marked by 21.6% to 6.2 per 1,000 live births. Oldham's most recent rate is more than 1½ times the England average (3.9). Within the Children's Services Statistical Neighbour Benchmarking Tool (CSSNBT) Oldham is ranked 2nd highest (worst) with the lowest being Bolton (3.3) and the highest Walsall (7.1).

Recent trend

Infant mortality Oldham — Crude rate - per 1000

Export chart as image | Show confidence intervals



Recent trend: –

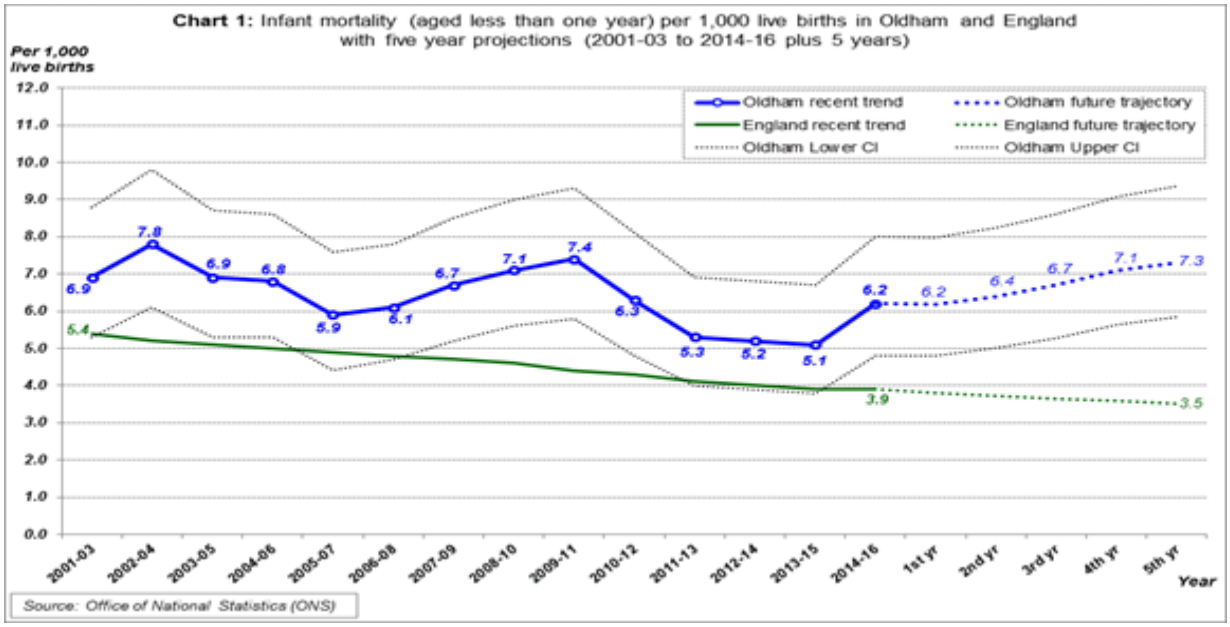
Period	Count	Value	Lower CI	Upper CI	England
2001 - 03	63	6.9	5.3	8.8	5.4
2002 - 04	73	7.8	6.1	9.8	5.2
2003 - 05	65	6.9	5.3	8.7	5.1
2004 - 06	66	6.8	5.3	8.6	5.0
2005 - 07	58	5.9	4.4	7.6	4.9
2006 - 08	61	6.1	4.7	7.8	4.8
2007 - 09	67	6.7	5.2	8.5	4.7
2008 - 10	71	7.1	5.6	9.0	4.6
2009 - 11	73	7.4	5.8	9.3	4.4
2010 - 12	62	6.3	4.8	8.1	4.3
2011 - 13	52	5.3	4.0	6.9	4.1
2012 - 14	51	5.2	3.9	6.8	4.0
2013 - 15	50	5.1	3.8	6.7	3.9
2014 - 16	62	6.2	4.8	8.0	3.9

Source: Office for National Statistics (ONS)

CSSNBT Oldham Ranking (2014-16): 2nd Highest – Bolton: lowest (3.3) ~ Walsall: highest (7.1)

Potential future trajectory

Infant mortality (per 1,000 live births)	2010-12	2011-13	2012-14	2013-15	2014-16	*1st yr*	*2nd yr*	*3rd yr*	*4th yr*	*5th yr*
Oldham potential future projection	6.3	5.3	5.2	5.1	6.2	*6.2*	*6.4*	*6.7*	*7.1*	*7.3*
England potential future projection	4.3	4.1	4.0	3.9	3.9	*3.8*	*3.7*	*3.7*	*3.6*	*3.5*



Tangible benefits (Scenarios)

1. ***Oldham potential future projection:***

   In Oldham by the 5th year there will be ***11*** more infant mortalities

2. ***Oldham matches England projection:***

   By the 5th year there would be ***23*** fewer infant deaths in Oldham. This is ***34*** fewer than in Scenario 1.

3. ***If Oldham matched best of closest statistical neighbours*** *(in 2014-16)**:***

   Over the period covering 2014-16 if Oldham had matched the rate in Bolton there would have been ***25*** fewer infant mortalities.

Issues with indicator

None

Agenda Item 14

BRIEFING TO OLDHAM HEALTH AND WELLBEING BOARD

Report Title: SEND Update

Report Author: Oliver Collins

Date: 18th June 2018

Requirement from the Health and Wellbeing Board:

- To note and discuss the key points of progress and achievement within the Written Statement of Action

Background:
In October 2017, Oldham underwent a joint inspection carried out by Ofsted and the CQC. The focus of the inspection was threefold:

1. Assessing the effectiveness of Oldham identifying children and young people's special educational needs and/or disabilities
2. The effectiveness of Oldham in meeting the needs of children and young people with SEND
3. The effectiveness of Oldham in improving outcomes for children and young people who have SEND

The purpose of this report is to provide an update to the Board as to the progress made against the Written Statement of Action since March 2018.

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BRIEFING TO OLDHAM HEALTH AND WELLBEING BOARD

Report Title: Healthwatch Oldham Work Programme

Report Author: Julie Farley, Interim Manager, Healthwatch Oldham

Date: 26th June 2018

Requirement from the Health and Wellbeing Board:

Background: Healthwatch Oldham (HWO) is the independent consumer champion for local people using health and social care services in Oldham. Just as the landscape of health and social care is changing, HWO also needs to review the impact of its services and review the way it works in light of developments at both a local and GM level.

This report sets out the key roles and responsibilities of Healthwatch; outlines some of the challenges it needs to address in the coming year; and asks for feedback on a suggested programme of service reviews. These reviews will enable service users to shape and influence services as part of the integration of health and social care, emerging neighbourhood clusters, and Northern Care Alliance.

What the issue is (If any): The issues are outlined in the report and presentation

Relationship with the Oldham Locality Plan: The report recommends a number of HWO and service user reviews designed to shape and influence services as part of the Oldham Locality Plan.

Recommendations:
The Board is asked to:

- note this report;
- recommend 5 review areas for HWO to focus on; and
- Oversee the findings and recommendations from the 5 review areas.

Healthwatch Oldham

1. Introduction

Healthwatch Oldham (HWO) is the independent health and social care consumer champion for local people using services in Oldham. As well as focusing on local issues, Healthwatch Oldham works in partnership with 9 other Healthwatch organisations across Greater Manchester to carry out reviews as part of Devolution Manchester and the GM Health and Social Care Partnership. HWO also collaborates on smaller cross boundary reviews as part of the emerging Northern Care Alliance.

However, just as the landscape of health and social care is changing to respond to current and predicted future demands, Healthwatch also needs to review the impact of its services and the way it works in light of developments at both the local and GM level.

This report, along with the presentation to the Health and Wellbeing Partnership Board (HWPB) will provide a reminder of the key roles and responsibilities of Healthwatch; set out some of the challenges it needs to address in the coming year; and ask for feedback on a suggested programme of service reviews. These reviews will enable service users to shape and influence services as part of the integration of health and social care, emerging neighbourhood clusters, and Northern Care Alliance.

2. Background

The vision for Healthwatch Oldham is to *provide an independent voice and source of information and influence for the residents of Oldham. It does this by listening, engaging and involving people in matters of health and social care in order to bring about service improvement and reduce health inequalities, in an open, honest, transparent, confidential and approachable manner.*

Healthwatch was set up in 2012 as part of the Government's Health and Social Care Act. It has a number of statutory and discretionary functions and its role can be summarised as providing:

1. **Insight**: by gathering feedback and first-hand experiences of patients and families, HWO is able to find out what matters most to local people. It monitors the quality of health and social care services in order showcase success and act as a critical friend where services fail to meet the required standards

2. **Information:** by providing information and signposting services HWO supports people to make informed choices about health and social care services available across Oldham, including primary care, acute service, pharmacy and dental services

3. **Influence:** through targeted reviews, Health Forums and engagement events HWO is able to gain insight and ensure the voice of service users are heard. It influences organisations responsible for both the commissioning and delivery of health and social care services and enables people to hold these services to account

4. **NHS Complaints Advocacy Service:** by listening to concerns and helping people to focus on the relevant facts, HWO can help people to make a complaint relating to an experience with a hospital, doctor, local surgery, dentist or other NHS provider. HWO also collates information on the type and frequency of complaint in order to identify trends or recurring issues.

Through a dedicated team of staff and volunteers Healthwatch Oldham delivers these functions through a combination of:

- Formal quarterly Health and Wellbeing Forums
- Informal weekly engagement and outreach sessions across a range of community settings
- Confidential one to one casework interviews for NHS complaints or signposting
- Membership on a range of local and regional strategic decision-making bodies
- Statutory Enter and View functions within hospitals, care home, nursing homes, residential units and day centres
- Detailed service user reviews of Health and social care services

3. Issues

Like all Healthwatch organisations, HWO faces a number of challenges.

Locally HWO needs to develop strong local partnerships with a range of statutory providers. However, it also needs to maintain a level of independence in order to carry out its health and social care scrutiny role. So traditionally, Healthwatch organisations have designed their work programmes based on local patient and public feedback and experiences. However, there is a danger that this reactive approach means we miss the opportunity to help inform the significant changes to health and social care services happening at a local and sub regional level.

Regionally each Healthwatch works in a slightly different way. In part this is due to different levels of funding for the Healthwatch organisations, and not all services have the addition of an NHS Complaints function. Over the last 12 months GM Healthwatch organisations have benefited from a central Healthwatch Liaison Manager. The result is a programme of work that aims to standardise a number of functions including research methods, service reviews, coordinating cross boundary reviews in order to benchmark performance with other areas, and coordinating GM Healthwatch reviews to support the GM health and social care agenda.

4. HWO Work programme

Against this backdrop HWO is proposing to split its service review programme as follows:

1. Patient led reviews – these reviews will be flexible and directly respond to feedback from local people/patients. They will be based on trends identified through the NHS Complaints service, Health Forums, engagement events and through feedback and intelligence gained from the quick survey work undertaken at a range of community locations. These reviews will be responsive and cannot be planned in advance so the work programme needs to ensure capacity to respond at short notice to emerging issues.

2. Planned reviews – these service reviews will be formally agreed in advance by OH&WPB, Oldham Patient Participation Network and the HWO Board. Potential topics will be based on intelligence gained from discussions with local partner organisations about service changes, or themes emerging at a local, regional or national level. Planned reviews will enable HWO to align with work streams set up to deliver the Oldham Locality Plan.

Appendix 1 sets out a shortlist of potential areas for planned reviews to be undertaken between July 2018 and June 2019. However, as these will be undertaken alongside our existing work programme, we are asking for views from the H&WPB and Oldham Patient Participation Network to identify which of these reviews we should focus on. The reviews will be covered in more detail in the Board presentation.

Finally, we also want to make sure the reviews make a difference. To help with this we are requesting that the H&WPB provide an oversight role to consider findings and oversee any associated recommendations or action plans that emerge from the reviews.

5. Recommendations

The Board is asked to:

- note this report;
- recommend 5 review areas for HWO to focus on; and
- Oversee the findings and recommendations from the 5 review areas.

Appendix 1

Healthwatch Oldham: Planned Reviews July 2018 to June 2019

1. Experiences of Carers during hospital discharge - Family are often overlooked during the hospital discharge process and health professionals sometimes have unrealistic caring expectations. The Care Act (2014) sets out the minimum support that should be available to family members who provide a caring role/s

2. 'End of Life' care and choice - Patient Choice is a national agenda that sets out standards for patients to choose how their care is provided and who provides it. However, this is a vulnerable group whose wishes often go unheard or get lost in multi-agency working.

3. Children and Young People's Community Mental Health services - Emerging as a GM Health and Social Care Partnership issue and raised nationally as a potential gap in service provision. Issues related to timely access to services and young people going through the transition to adult mental health services

4. Oldham's Neighbourhood Clusters - Proposed changes locally will see the development of neighbourhood clusters with multi agency health, social care and voluntary sector teams providing holistic support. Focus on the patient experiences in different neighbourhood clusters.

5. Young People's Health services - National issue of low take up of cervical screening and sexual health services identified by young people at Oldham College as an issue

6. Review of Care Home Provision - Care home residents often find it difficult to have their voice heard and the focus tends to be on internal care home provision rather than quality of access to routine GP, dentist, optician, chiropodist, and hearing services whilst in a care home setting

7. Discharge to Assess and Intermediate Care - Aim to provide a more accurate assessment of future independent living/care home needs within an intermediate care setting, rather than assessment of need in a hospital ward setting. Joint approach with health, social care, reablement, care coordinators, VCS, patients and families

8. Accessible services for the Deaf Community and people with sight loss - Care Act states that health and social care services should have due regard for people with sensory impairment. Need to consider what reasonable adjustments can be made to ensure key services are fully accessible as part of service redesign in Neighbourhood clusters and acute settings.

9. Experiences of refugees and asylum seekers accessing primary and acute healthcare services - Vulnerable group who may struggle to navigate services and experience language barriers, especially for minority languages where a translation services are not readily available, and also experience cultural barriers.

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