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HEALTH AND WELL BEING BOARD
Agenda

Date	Tuesday 25 June 2019
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 Mark Hardman at least 24 hours in advance of the meeting. 2. CONTACT OFFICER for this agenda is Mark Hardman Tel. 0161 770 5151 or email mark.hardman@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 on Thursday, 20 June 2019. 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 Ball, M Bashforth, Chadderton, Chauhan, Harrison (Chair) and Sykes Independent Members: Dr Zubair Ahmad, Dr Zuber Ahmed, Mike Barker, Jill Beaumont, Julie Daines, Neil Evans, Julie Farley, Nicola Firth, Majid Hussain, Val Hussain, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Donna McLaughlin, Dr. John Patterson, David Smith, Katrina Stephens, Charlotte Stevenson, Mark Warren, Carolyn Wilkins OBE and Liz Windsor-Welsh

Item No

1 Appointment of Chair and Vice Chairs

To note the appointment of Councillor Harrison as Chair and to invite the appointments of Vice Chairs of the Health and Wellbeing Board for the 2019/20 Municipal Year.

2 Apologies For Absence

3 Urgent Business

Urgent business, if any, introduced by the Chair

4 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

5 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

6 Minutes of Previous Meeting (Pages 1 - 6)

The Minutes of the meeting of the Health and Wellbeing Board held on 26th March 2019 are attached for approval.

7 Minutes of the Health Scrutiny Sub-Committee (Pages 7 - 22)

The minutes of the meetings of the Health Scrutiny Sub-Committee held on 19th February and 26th March 2019 are attached for noting.

8 Resolution and Action Log (Pages 23 - 24)

9 Meeting Overview (Pages 25 - 26)

10 Common Standards for Population Health in Greater Manchester (Pages 27 - 98)

For the Board to receive an overview of the GM Common Standards for Population Health, have the opportunity to provide feedback on the suite of standards and consider local adoption and implementation.

11 Suicide Prevention Update (Pages 99 - 158)

For the Board to consider Oldham's Suicide Prevention Plan and the future governance arrangements for the Oldham Suicide Prevention Group

12 Updates from Sub-Committees

For the Board to receive an update and assurance from the following sub-groups:

- Joint Strategic Needs Assessment
- Health Protection and Air Quality
- Children and Young People's Strategic Partnership

This report to follow.

13 Date and Time of Next Meeting

The next meeting of the Health and Wellbeing Board will be a development session and it will take place on Tuesday 26th July 2019 at 2.00pm.

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HEALTH AND WELL BEING BOARD
26/03/2019 at 2.00 pm

Present: Councillor Harrison (Chair)
Councillors M Bashforth, Jacques and Sykes

Mike Barker	Strategic Director of Commissioning/Chief Operating Officer
Jill Beaumont	Director of Children's Health and Wellbeing
Majid Hussain	Lay Chair Clinical Commissioning Group (CCG)
Merlin Joseph	Interim Director of Childrens Services
Stuart Lockwood	Oldham Community Leisure
Donna McLaughlin	Alliance Director, Oldham Cares
Dr. John Patterson	Clinical Commissioning Group
Katrina Stephens	Interim Director of Public Health
Mark Warren	Director, Adult Social Care
Carolyn Wilkins OBE	Chief Executive/Accountable Officer

Also in Attendance:

Andrea Entwistle	Principal Policy Officer - Health and Wellbeing
Dr. Henri Giller	Independent Chair LSCB
Lori Hughes	Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Chadderton, Councillor Chauhan, Dr. Jeffery, Julie Farley, Val Hussain, Dave Smith and Rebekah Sutcliffe.

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the Health and Wellbeing Board held on 29th January 2019 be approved as a correct record.

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

RESOLVED that the minutes of the Health Scrutiny Sub-Committee held on 18th December 2018 be noted.

7 **RESOLUTION AND ACTION LOG**

RESOLVED that Resolutions and Action Log from the meeting held on 29th January 2019 be noted.

8 **MEETING OVERVIEW**

RESOLVED that the Meeting Overview for the meeting held on 26th March 2019 be noted.

9 **SAFEGUARDING BOARD ANNUAL REPORTS**

The Health and Wellbeing Board gave consideration to the Oldham Safeguarding Board's Annual Report and Business Plan.

The report outlined the key messages from the Safeguarding Adults Board Annual Report for 2017/18, progress made against the Safeguarding Adults Board Business plan 2018/19, the implications for Safeguarding Adults arising from the integration of adult and social care in Oldham, the developing links between the Oldham Safeguarding Adults Board and the Oldham Safeguarding Children's Board and the outcome of the Safeguarding Adults Review and proposed implementation plan.

In accordance with the statutory requirements of the Care Act 2014, Oldham Safeguarding Adults Board must produce and publish a three-year strategy, annual business plan and annual report. The Health and Wellbeing Board had requested updates from the Safeguarding Adults Board on progress against the annual business plan. The update served to provide evidence of how partnership working supported adults to live safely in Oldham, free from abuse and neglect.

The Safeguarding Adults Boards 2017/18 annual report demonstrated the progress made on adult safeguarding and individual partner organisations in 2017/18. The latest annual report brought to a conclusion the previous three-year strategy of the Board.

The new three-year strategy, 2018 – 2021 Priorities, articulated a vision that:
"The people of Oldham had a right to live safely, free from abuse and neglect, and are supported to do so by co-operative communities and organisations which;

- Do not tolerate abuse and neglect.
- Champion making safeguarding personal.
- Work preventatively through early identification of new safeguarding issues.
- Deliver excellent practice as the norm.
- Share information effectively.
- Ensure that the public feel confident that adults are protected."

Board partners prioritised their commitment to the board, held one another to account effectively and promoted and embedded learning." The strategic objectives for 2018 – 2021 were outlined at Section 2.2 of the report. These priorities were reflected in the 2018/19 business plan of the board and monitored via the board executive and the Board.

It was acknowledged that further work was required to raise the profile of the Safeguarding Adults Board and to address the priority status of transitions.

The integration of community health and social care services across Oldham took place in 2019 as part of the development of Oldham Cares Integrated Care Organisation (ICO). The ICO had seen the integration of CCG and social care commissioning which in Oldham currently included strategic adult safeguarding services. Alongside significant benefits, a number of unintended consequences linked to local integration were recognised. In January 2019, Oldham Safeguarding Adults Board endorsed 22 individual recommendations regarding how the current local model could be strengthened and improved. An implementation programme brief had been developed to propose an approach to deliver the changes involved and the workstreams to delivery the recommendations. Delivery was expected to take place through three phases of activity. A programme team which included Programme Board arrangements, were in place to direct, co-ordinate and deliver the programme.

The Board remarked on the activity to date benchmarking information. Members were informed that stakeholder engagement was stronger than when the LSAB first stated.

The Board were informed of the effectiveness of integrated working and concrete proposals should be developed in six months. The proposals would come back to the Health and Wellbeing Board to asked what needed to be developed.

Members commented on the Prevention Strategy and were informed that Oldham was seen as an advanced player and the joint approach was influential in reducing conflict.

Members noted the benchmarking with regard to ethnicity of the population and were informed of work with the faith communities and that links needed to be strengthened. Some initiatives were needed to engage communities.

Consideration was also given to the Local Safeguarding Children's Annual Board Annual Report 2017/18 and the 2018/19 Business Plan. The annual report detailed the partnership's safeguarding activity over the 12 month period and assessed the impact this activity against the LSCB's Strategic Plan for 2015/18.

The report identified the strategic safeguarding priorities for the next three-year period – 2019/2021 which were:

1. Domestic Abuse
2. Complex and Contextual Safeguarding
3. Children not accessing education including elective home education
4. Transitions

5. Understanding the impact of trauma on children and young people
6. Child's lived experience.

The Business Plan 2018/19 was guided by the priorities outlined in the Strategic Plan. It was noted that the LSCB had commissioned a large number of Serious Case Reviews during the 12-month period which had impacted on the ability to progress some action to the desired stage. Some actions were agreed to be carried into the 2019/20 business plan.

RESOLVED that:

1. The Local Safeguarding Adults Board Annual Report for 2017/18, the Business Plan 2018/19 and Safeguarding Review be noted.
2. The Local Safeguarding Children's Board Annual Report for 2017/18, the Business Plan 2018/19 be noted.

10 **TOBACCO CONTROL**

The Health and Wellbeing Board gave consideration to a report which provided an update on tobacco control across Oldham. On 14th March 2017, the Board agreed outcomes and actions for Oldham's Tobacco Control Action Plan and a vision to create a smoke free borough. The outcomes were to reduce the number of tobacco users in Oldham; reduce exposure to second-hand smoke (focussing on children and young people) and reduce tobacco related health inequalities.

The Board were requested to note progress against the three actions set out in the Tobacco Control Action Plan. The tree actions were:

- To complete the first phase of the CLeaR process;
- Review the Council's smoking policy; and
- Reduce the number of women who smoke during pregnancy.

The Board were requested to commit continued support of the Tobacco Control agenda which included:

- Consideration of the next steps of the CLeaR self-assessment process;
- Support to the implementation of the CURE project in Royal Oldham Hospital;
- Support to the continuation of the Supporting a Smokefree Pregnancy Scheme; and
- Support to the improvement of access to stop smoking treatments including e-cigarettes.

The report provided a current position on the three priorities which included the option to invite a 'peer-assessment team' to make a report for the Council to decide how to move forward, the Council smoke free policy which would go live on 1st April 2019 and support for a Smokefree Pregnancy Scheme (SaSFPS).

The report also outlined CURE (Conversation, Understand, Replace, Experts and Evidence-base treatments). The Greater Manchester tobacco control plan, Making Smoking History (MSH) advocated a comprehensive whole system approach to tackling tobacco. The CURE programme was an integral component of delivering the plan and was included in its strategy. Rollout had begun with the launch of CURE at Wythenshawe Hospital in October 2018. Royal Oldham Hospital was in the first wave of hospitals asked to rollout out CURE and an initiation meeting had been scheduled for 10th April 2019.

In October 2018, Oldham had launched the annual Stopober campaign with an event hosted by the Greater Manchester Fire and Rescue Service (GMFRS), Turning Point, Positive Steps and Oldham Council. The event included an official signing of a partnership agreement between the organisations which encouraged close partnership working and a set out a number of objectives.

The report also set out the latest findings related to E-cigarettes which concluded electronic cigarettes generated higher quit rates than nicotine replacement therapies (NRT), e-cigarettes achieved this at a much lower cost; and e-cigarettes starter packs should become one of the Stop Smoking Services (SSS) treatment options.

It was noted that the number of people accessing the stop smoking services had decreased year on year, both locally and nationally. Stop smoking services had been in existence for almost 20 years, models of delivery had evolved but some of the processes and mechanisms that supported delivery had not developed. People who continued to smoke were some of the most addicted smokers who required more intensive support and easier access to services and treatments. Access could be improved through the utilisation of pharmacies. Another option could be to disaggregate the costs of stop smoking treatments from the prescribing budget. The options would be explored as part of the Thriving Communities and Health Improvement workstream of Oldham Cares.

The Board were informed that according to the latest data Oldham was in line with the national average but reductions were not significant in manual occupations and those with long term mental conditions. Progress was noted against actions and an assessment had been undertaken. The Board were informed of the smoke free initiative and the next stage in terms of a peer assessment. The Board were also informed smoke free pregnancy scheme, additional training being provided. The Board were also informed about the CURE Programme and support to those to quit whilst in acute care. The stop smoking model had not changed and a different model of support may be needed.

Members asked if people who smoked cannabis were classed as smokers or if it was categorised differently. It was explained that it depended on how individuals identified themselves.

Members asked about the smoking ban on sites and how this was going to be policed and in terms of the Council ban if this included vaping and if Tommyfield Market was included. Members were informed that the ban included all Council spaces and no smoking would be encouraged in all public places. Members asked about the possibility of banning e-cigarettes. E-cigarettes were being kept under review. Members asked if chewing tobacco was monitored and it was not.

The Board were informed of engagement with the voluntary sector and private businesses. The Board also discussed support to residential workers in stressful situations and children looked after where there was a high incidence of smoking. Support would need to be thought through and staff taking on leadership roles for young people. Members also commented on smoking ban in schools. The Board were informed of a full communications plan and a refresh to keep momentum going.

RESOLVED that:

1. The progress on the three key actions as set out in the Tobacco Control Action Plan be noted.
2. A commitment of continued support of the Tobacco Control Agenda be supported which included:
   a. The next steps of the CLeaR self-assessment process.
   b. The implementation of the CURE project in Royal Oldham Hospital.
   c. The continuation of the Supporting a Smokefree Pregnancy Scheme.
   d. The improvement of access to stop smoking treatments including e-cigarettes.

11 **DATE AND TIME OF NEXT MEETING**

RESOLVED that the date and time of the next meeting would be agreed at Annual Council.

The meeting started at 2.00 pm and ended at 3.28 pm

HEALTH SCRUTINY
19/02/2019 at 6.00 pm

Present: Councillor McLaren (Chair)
Councillors Ball (Vice-Chair) and Taylor

Also in Attendance:

Karen Maneely	Associate Director Mental Health & Specialist Services – Oldham Borough
Barry Williams	External Partnerships Manager (Strategy & Planning), Northern Care Alliance
Andrea Entwistle	Principal Policy Officer Health and Wellbeing
Sian Walter-Browne	Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Leach.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the Health Scrutiny Sub-Committee meeting held on 18th December 2018 be approved as a correct record.

6 **MINUTES OF THE HEALTH AND WELLBEING BOARD**

RESOLVED that the minutes of the Health and Wellbeing Board meeting held on 13th November 2018 be noted.

7 **MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE**

RESOLVED that the minutes of the Greater Manchester Joint Health Scrutiny Committee meeting held on 14th November 2018 be noted.

8 **MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR PENNINE ACUTE HOSPITALS NHS TRUST**

RESOLVED that the minutes of the Joint Health Overview and Scrutiny Committee for Pennine Acute Hospitals NHS Trust meeting held on 15th October 2018 be noted.

9 **MINUTES OF THE JOINT SCRUTINY PANEL FOR PENNINE CARE (MENTAL HEALTH) TRUST 4 OCTOBER 2018**

RESOLVED that the minutes of the Joint Scrutiny Panel for Pennine Care (Mental Health) Trust meeting held on 4th October 2018 be noted.

10 **RESOLUTION AND ACTION LOG**

RESOLVED that the Resolution and Action Log for the meeting held on 18th December 2018 be noted.

11 **MEETING OVERVIEW**

RESOLVED that the today's Meeting Overview be noted.

12 **PENNINE CARE FOUNDATION TRUST – CQC INSPECTION**

The Sub-Committee gave consideration to a report and supplementary update of the Associate Director Mental Health and Specialist Services – Oldham Borough, which informed them of the progress made by Pennine Care Foundation Trust (PCFT) against their CQC improvement action plan.

Karen Maneely, Associate Director Mental Health & Specialist Services – Oldham Borough, attended the meeting and highlighted the following from the latest inspection report:

- CQC inspected PCFT across all 5 of the domains
- Still overall: Requires Improvement
- Good progress made since 2016 report by the time they were re-inspected in August 2018
- Some challenges re care of male patients – have now re-opened refurbished male ward (Oak Ward)
- Single gender wards now – Aspen (female) and Oak (Male)
- Significant challenges previously re funding for staffing – Commissioners have now invested across Oldham adult and older adult inpatient wards. Multi-disciplinary standards have improved in all wards.
- Therapy hub is now an outstanding facility
- Staff also have a range of physical skills as well as mental health skills base
- Now have a female lounge on Cedars Ward
- Therapeutic offer on ward massively improved
- Workforce development and recruitment/engagement at a GM and local level – making PCFT the best place where people would want to work.

Members asked for and received clarification of the following:

- Support for potential staff who want to come back to work/have families/caring needs - It was explained that the Trust offered options lot to encourage people to work for them including flexible working that was open and accessible for all staff. There was a need to ensure the wards were covered as necessary and the Trust tried to accommodate flexible working requests where possible. Newly qualified health professionals were supported in their development.
- Concerns about staffing shortages in light of current national picture – It was explained that, as well as improving recruitment, the Trust had a good record of staff retention and had looked to make the Trust a good place to work and remain, including offering rotation

patterns for staff development. A new Executive Director of HR and Workforce had been recruited and it was accepted staffing would be a challenge in the future.

- Areas for improvement – It was acknowledged there were still issues around data as some areas were still using paper records. The PCFT was moving towards all-electronic records and three more areas in Oldham had gone live this week. In relation to Mental Health, progress was being made and there were two practitioners to support and teach people at a local level re mental health law and legislation. This was a standard agenda item at the forum meetings so progress could be tracked.
- Were electronic records going to be accessible to all staff – The Trust had moved to mobile working where each practitioner had a personal tablet they could use to access the system remotely.
- Progress made as part of the transitional change – It was explained that Community Services were the subject of formal consultation with the proposal that they move to a new provider. The Trust was working hard from HR/Finance perspective to confirm what would stay or move. It was clarified that a Trust-wide action plan would be available from 1 April 2019 which would set out the action plan.
- Budget management – It was recognised that the Trust had fewer resources than other organisations and the Board were working to improve their bids for funding to ensure parity. The Board were focusing on gaining extra investment.
- Action Plan – Confirmation would be sought that the action plan due on 1st April could be shared. Action: Action Plan to be brought back in June 2019 (pending agreement by PCFT)

Members agreed they would to take up the offer of a visit to the improved facilities.

RESOLVED that the progress as outlined in the report be noted.

13 **NORTH EAST SECTOR CLINICAL SERVICES STRATEGY**

The Sub-Committee gave consideration to a report and presentation led by the Head of Public Affairs, NHS Oldham CCG and the External Partnerships Manager, Northern Care Alliance NHS Group, which provided them with a narrative that set out why the NHS was changing in Oldham, Rochdale and Bury, and set the scene for current and future service change in the North East Sector of Greater Manchester.

The session set out the local NHS services and why they are what and where they were. It clarified the national, regional and local drivers for change, and the work completed so far to introduce new ways of working and models of care. It showed how services may start to feel different in the future and how this

may affect patients, using case studies. The Sub-Committee noted some 'myth busters' about common misconceptions about the NHS.

Members were informed that the update had been developed by the North East Sector Clinical Services Transformation Programme Board as the basis for communications and engagement work with local people (including public and patients, local leaders and influencers and staff) to prepare them for future change This could at a future point entail formal consultation.

Members asked for and received clarification of the following:

- When using the central booking line (choose and book), most people would choose the hospital with the shortest wait time, regardless of where that hospital was, but this was not so easy if reliant on public transport – It was explained that this was being considered. The aim was to reduce the need to go to a hospital in the first place, but consideration would also be given to reducing the need to travel.
- Lack of discharge planning – This would be further investigated. Discharge planning should start from the moment a patient entered a ward. Patients should be safe and supported when they went home.
- GP clusters/Neighbourhood Hubs – some of the areas did not follow natural neighbourhoods and residents did do not understand how the different areas had been linked. This would be raised with CCG colleagues and an explanation requested.
- Speed of test results, GP surgeries were not getting the results as quickly as they could – It was explained that IT issues were being considered with a view to results being reported more quickly.
- Northern Care Alliance timeframe – It was clarified that strategic plans were due to be submitted, however there were no firm dates. Once the strategic plans were accepted, business cases would be worked up. There was currently no firm timeframe.
- Management of the voluntary sector – It was explained that the model being used in Rochdale would be followed. Champions linked to GP surgeries would interact with the voluntary organisations. When a GP identified a patient who might benefit, they would refer to the champions who will make the links between the patient and the community organisations.
- Statement re 'fragmented services, unfilled vacancies, antiquated estates and struggle to balance the books'. How would the plan fill the vacancies whilst also addressing the deficit – It was clarified that the Trust was looking at different ways to fill vacancies and support staff – helping them to secure housing, supporting aspiring staff to grow/achieve, working with local communities to engage and offering apprenticeships.

- Publicity and simple messages to help the public understand the changes – It was explained that Communications teams were working collaboratively to develop a range of marketing and comms materials, taking a multi-layered approach. The message would be as concise as possible, with further detail available. The offer of assistance from Members was appreciated and the time for going out with messages had not yet been reached.
- Use of facilities at community centres – It was explained that this would be considered as part of the locality plan, which would identify resources and how best to use them.
- Next steps – When the strategic plans had been submitted, this would act as catalyst for further work. An update on the position would be provided in July 2019.

RESOLVED that the contents of the report, presentation and discussion be noted and an update be provided to the meeting of the Health Scrutiny Sub-Committee in July 2019.

14 **OUTCOME OF PUBLIC CONSULTATION ON PROPOSED IVF CHANGES**

The Sub-Committee gave consideration to a report of the Head of Public Affairs, NHS Oldham CCG, which informed them of the methodology and outcome of Oldham CCG's recent consultation on the funding of In Vitro Fertilisation (IVF) and the subsequent decision of the CCG Governing Body on IVF Funding.

RESOLVED that:

1. Consideration of the item be deferred with a view to arranging a separate meeting. The outcome of that discussion would be brought back to the meeting in March under the work programme item.
2. The CCG be requested to review the decision as soon as possible and the Health Scrutiny Sub-Committee updated on an annual basis.

15 **COUNCIL MOTIONS**

The Sub-Committee gave consideration to a report of the Principal Policy Office – Health and Wellbeing, which provided a summary of a health-related motion in relation to Sustainable Health Funding that was discussed and agreed by Council on 12th December 2019 and an update on the actions to date.

RESOLVED that the update as outlined in the report be noted.

16 **MAYOR'S HEALTHY LIVING CAMPAIGN**

The Sub-Committee considered a progress report of the Principal Policy Officer – Health and Wellbeing on recent activities undertaken by the Mayor of Oldham in connection with the Mayor's Healthy Living Campaign to promote and divulge the message of healthy living across the Borough.

RESOLVED that:

1. The update be noted;
2. Continuous support to the Mayor's Healthy Living Campaign be provided by the Sub-Committee.

17 **HEALTH SCRUTINY FORWARD PLAN**

Consideration was given to the Health Scrutiny Forward Plan for 2018/19. Members agreed that the workload of the Sub-Committee was increasing consistently and ways to manage the greater workload needed to be explored.

RESOLVED that the Health Scrutiny Forward Plan for 2018/19 be noted.

18 **DATE OF NEXT MEETING**

RESOLVED that it be noted that the next meeting of the Health Scrutiny Sub-Committee would be held on Tuesday 26th March 2019 at 6 p.m.

The meeting started at 6.10 pm and ended at 7.45 pm

HEALTH SCRUTINY
26/03/2019 at 6.00 pm

Present: Councillor McLaren (Chair)
Councillors Ball, Leach and Taylor

Also in Attendance:

Andrea Entwistle	Principal Policy Officer - Health and Wellbeing
Lori Hughes	Constitutional Services
Zahid Chauhan	Cabinet Member, Health and Social Care
Mark Drury	Oldham CCG
Dr. John Patterson	Clinical Commissioning Group
Peter Pawson	Principal Consultant
Steve Wilson	Greater Manchester Health and Social Care Partnership

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Toor and Councillor Williamson.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the Health Scrutiny Sub-Committee held on 19th February 2019 be approved as a correct record subject to the amendment that Councillor Toor and Councillor Williamson were not present at the meeting.

6 **MINUTES OF THE HEALTH AND WELLBEING BOARD**

RESOLVED that the minutes of the Health and Wellbeing Board held on 29th January 2019 be noted.

7 **MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY**

RESOLVED that the minutes of the Greater Manchester Joint Health Scrutiny Committee held on 16th January 2019 be noted.

8 **MINUTES OF THE JOINT SCRUTINY PANEL FOR PENNINE CARE (MENTAL HEALTH) MEETING**

The minutes of the Joint Scrutiny Panel for Pennine Care (Mental Health) Trust meeting held on 24th January 2019 be noted.

9 **RESOLUTION AND ACTION LOG**

RESOLVED that the actions from the meeting held on 19th February 2019 be noted.

10 **MEETING OVERVIEW**

RESOLVED that the meeting overview for the meeting held on 26th March 2019 be noted.

11 **PENNINE ACUTE HOSPITALS NHS TRUST TRANSACTIONS PROGRAMME**

The Committee were presented with an update regarding the Pennine Acute Hospitals NHS Trust (PAT) Transitions Programme.

The Transactions Programme was a technical process and services had been stabilised. The programme would now move to the next phase in order to embed improvements in services. A preferred option was that the Salford Royal Trust formally take over Oldham, Bury and Rochdale and North Manchester to be taken over by the Manchester Trust. The two separate transactions were intrinsically linked and improvements would be delivered on all sites.

The Transactions Programme was being run as part of the NHS Improvement Guidance with a board created to oversee the programme which included all involved parties including Commissioners, Clinical Commissioning Groups and local authorities.

The benefits to patients were identified which included approach to quality, investment on sites, quality of care, patient experience and securing funding from the Department of Health.

Communications and engagement was outlined and members were informed that a joint plan was in place. Business cases were submitted as to how current services would be provided, and, as part of the process the final business cases would be agreed. Patient and public engagement was key. All staff should be briefed. The best way to create sustainable quality was to commit to the transaction programme.

Members asked about more funding and were informed of significant capital investment and ongoing discussions with NHS Improvements.

Pennine Acute were working toward good and also addressing a budget deficit. Other issues included parameters for financial modelling, interest rate obligation, clinical negligence premium and a reasonable trajectory for improvement.

Members queried that North Manchester as part of Pennine Acute was still treated by the Care Quality Commission (CQC) as part of Pennine Acute. Members were informed that sites had individual ratings and North Manchester would be picked up as part of the Manchester Trust assessment.

Members queried staffing issues and working toward a full complement of staff. Members were informed that there had been an issue of Pennine Acute's reliance on agency and

temporary staff. There was a plan to reduce this as well as a plan for staff retention. Members referred to staffing issues related to bursaries and Brexit and were informed there was work ongoing on recruitment and retention. Members suggested establishing a nurse bank and informed that was being addressed on an individual basis and across Greater Manchester.

Members referred to the period of ongoing changes and ensuring the wider community understood arrangements in place for hubs and Royal Oldham Hospital through publicity. Members were informed on how this would be addressed with the Clinical Commissioning Group working with the local authority, Pennine Acute and Salford to make people aware and locality plans.

RESOLVED that:

1. The progress on the Pennine Acute Hospitals NHS Trust (PAT) Transitions Programme be noted.
2. An update on the Transactions Programme be provided in six months.

12 **THRIVING COMMUNITIES**

The Committee were provided an update on the progress of the Thriving Communities Programme.

The Council and its partners were committed to a co-operative future for Oldham where 'everyone does their bit and everybody benefits' and the Partnership's Oldham Plan 2017 – 2022 sets out the Oldham model for delivering tangible and sustained change through an integrated focus on inclusive economy, thriving communities and co-operative services.

Key projects highlighted included:

- More than medical support (also known as social prescribing) including the Social Prescribing network in Oldham West
- The Fast Grants
- The Social Action Fund
- Workforce Development
- A stronger focus on evidence and evaluation with the Thriving Communities index

The current position for each area was provided.

A decision had been made related to the award of the contract for the Social Prescribing Innovation Partnership which had been awarded to a consortium of partners which included Action Together, Age UK, Positive Steps, TOG MIND with Action Together being the lead organisation for the partnership. The partnership would be mobilised and the social prescribing offer rolled out borough-wide over the coming months.

The first pot of £60k Fast Grants which provided funding into grassroots community groups had been used. Grants ranged from £50 to £500. A number of funding pots would be available from 1st April 2019.

The Social Action Fund had been launched in January 2019. There had been 23 expressions of interest.

A Community and Volunteer 'Making Every Contact Count' pilot training took place. An evaluation of the sessions had been conducted and would feed into the workforce and leadership offer. This offer would be linked into the Oldham Cares wider piece of work on Organisational Development.

The Thriving Communities Index allowed relative statements to be made about the degree to which neighbourhoods were thriving and allowed us to see which 'neighbourhoods' (circa 2000 population) had pressures in terms of place, residents and service demand.

Members requested the number of organisations contacted could be widened and queried the number of schools who had received fast grants. Members were informed that due to year end some grants had not yet been provided. Members requested better communications for elected members.

Members queried the work with Action Together and were informed that Action Together were administering the Fast Grants. Action Together did some due diligence. Safeguarding was important and needed to be monitored carefully.

Members queried the obesity issue as part of social prescribing on a practical level. Members were informed that there were community assets that could support people around improved physical activity and healthier lifestyle choice but that there was more work that could be done in that area and considered by commissioners in the health and care economy.

Members asked what arrangements were in place to address problems and enable groups to access support and were informed that the workforce would be upskilled and a wider programme rolled out.

RESOLVED that:

1. The progress on the Thriving Communities Programme be noted.
2. An update on the Thriving Community Programme be provided in 12 months.
3. An update on Social Prescribing be provided in September 2019.

13 **OVER THE COUNTER MEDICINES REVIEW**

The Committee gave consideration to a report which provided information on the 'Over the Counter Medicines Review' and the

related public engagement work designed to communicate and engage with the public on the proposed changes. The Committee were invited to participate in the engagement work and give consideration to the questions being asked of the public as per the engagement survey.

NHS England had issued guidance to CCGs which described two items of limited clinical value and 35 conditions which might be self-limiting and therefore suitable for patient self-care. Key aspects were encouraging self-care, the stopping of prescribing drugs of limited clinical effectiveness and where products were available over the counter for the treatment of minor conditions, these should not be routinely prescribed. The guidance was condition based and outlined at Appendix 1 to the report. Supporting people to self-manage common conditions could help reduce England's 57 million GP consultations which cost the NHS approximately £2 billion. The promotion of self-care and increasing the awareness to alternatives to making appointments would encourage patients to explore self-care in the future. The GM Clinical Standards Board had previously adopted self-care as a priority area. NHS Oldham was working with Stockport, Bury, Manchester and Wigan Clinical Commissioning Groups (CCGs).

The CCG wanted views of local patients, the public and stakeholders on the NHS England proposals before deciding whether and how the products were removed from routine prescriptions locally. Participants were asked to read supporting information and then complete the survey in order for an informed decision to be made.

NHS Oldham CCG had spent £2.2m on medicines that were available over the counter and it was recognised that much of the cost was attributable to long-term or complex conditions. Removing medications for certain conditions from routine prescriptions would release money to treat conditions such as heart disease and diabetes. The medications that were suggested for stopping routine prescription were for conditions that could be considered to be self-limiting or were suitable for self-care so that the person suffering did not normally need to seek medical advice and could manage the condition by purchasing directly over the counter.

The policy had been written following a GM-wide public consultation and was in line with guidance from NHS England.

People with minor ailments could seek the right care and treatment after being signposted to community pharmacies where over the counter treatments could be purchased. The CCG were aware that some individuals and families were unable to afford to pay for medication and as health professionals wanted to retain the power to prescribe from the list of recommended treatments as and when appropriate.

The CCG has taken into consideration the GM and NHSE consultation work, recommendations and guidance and had

begun work to engage with the public. Thirty responses had been received so far, the majority of which supported the recommendations. The engagement period would last until 1st April 2019. The responses would be reviewed by the Clinical Committee and a decision made there or at the NHS Oldham CCG Clinical Commissioning Committee.

The Health Scrutiny Sub-Committee were asked to consider if the Committee supported the principle that the local NHS should not routinely prescribe for conditions which were self-limited or deemed suitable for self-care and what mitigating steps could be put into place to reduce the impact upon individual and families who where unable to afford to pay for medication.

Members were provided with the background on the consultation undertaken by the NHS. CCGs had been asked to make local decisions outlined in the conditions. It was a long list to consider and allowed exceptions for social reasons, i.e. situations where people were vulnerable. Members were referred to the NHS England guidance and asked for their views and what allowances be made for social rationale. Members were advised that the savings to the CCG were considerable.

Members asked and it was confirmed that 30 responses had been received from the general public which had been a questionnaire. There had also been a national consultation.

Members asked if the policy applied to hospitals and concerns were expressed about hospital pharmacies and 'trapped' audiences and the prices at hospital pharmacies. Members were advised of developing formal partnership arrangements with pharmacies. Members were advised of the spend on drugs and most number of drugs. The support from the Committee on putting pressure on local pharmacists was welcomed. This could be addressed through a task and finish group approach and included in the work programme.

Members referred to change of behaviour, management of change and how information was publicised, what type of information was available in GP practices related to NHS Choices and promotion of self-care. Members were informed that information was initially shared on social media. Posters were recommended to be supplied to GP practices and pharmacies. Members queried information provided to GPs and were informed it was intended to benchmark information and that unions had also written to GPs as well as a letter from the Secretary of State. Members were informed of criteria to ensure patients were able to afford medications. It was discussed that there was some leverage with pharmacies as health care professionals as the first duty of care was towards patients.

RESOLVED that:

1. The principle that the Local NHS should not prescribe for conditions that were self-limiting or deemed suitable for self-care be supported.

2. A task and finish group be established to address local pharmacies and to look at how to highlight and promote changes in medication behaviour.

14 **URGENT PRIMARY CARE**

The Committee were provided an update on Urgent Primary Care from a previous presentation which had been provided in November 2018.

The Committee were provided an update on the walk-in centre. Consultation had been undertaken on different models of urgent primary care. There was not an alternative to the walk-in centre at this time. The winter had brought into focus the reconfiguration of the North East Sector and the adaptations in provisions. The members were informed that it had been a difficult winter with a significant effect on accident and emergency provision, but the level of safety had been maintained. Members were also informed of the 88% customer satisfaction level. The four hour waiting time had been difficult to achieve. Members were also informed that when demand had been analysed, 42% presented at A&E had not been from Oldham, and 14% of individuals who had attended the walk-in centre had not been from Oldham.

Members were also provided an update on the business case for the express care hub. Members were also provided an update on the 7-day access and routine primary care for those unable to access services during normal hours which provided 8000 minutes over four sites on top of general practice hours.

Members sought clarification on any expansion of the services and were informed that the funding was only for 8000 minutes over the four sites.

Members advised that they had used the 7-day service at Royton but could not find the way in. Members were informed that this feedback had not been provided before and would be investigated.

Members asked about the Integrated Care Centre and were informed of the One Oldham Estate review. Members sought and received an update about the service hours of the ICC. Members raised the issue of waiting times at A&E and the use of call-out doctors. Members were informed of the Urgent Care Review and that this will come back to a future meeting. Members were informed that the '111' helpline was used more in the North West than anywhere else. Members were also informed that out-of-hours capacity problems were due to decisions beyond the CCG's control and issues were being resolved.

Members commented on the experiences of this winter and lessons to be learned. Members were informed of the unbalanced demand with the number of ambulances and the problems with flu. Another review was pending for the Winter 2019/20.

Members were informed of the IT situation, i.e. access issues and compatibility of systems. Progress had been made with every practitioner being able to access date. Members were informed of issues related to GDPR and the need for a data sharing agreement.

RESOLVED that:

1. The progress made on the implementation of the new model of Urgent Primary Care be noted.
2. An update be provided in six months' time.
3. Out-of-Hours Access to the Royton Medical Centre be reviewed.

15 **COUNCIL MOTIONS**

The Committee were provided an update on Council motions.

RESOLVED that the update on Council motions be noted.

16 **MAYOR'S HEALTHY LIVING CAMPAIGN**

The Committee gave consideration to an update on the Mayor's Healthy Living Campaign.

The Mayor continued to explore opportunities to role model and promote increased physical activity as part of his mayor duties. The Mayor continued to walk regularly and raise awareness of the benefits of walking.

The Committee were informed of upcoming events which included a Triathlon on 28 April 2019, the feasibility of hosting a Charity 10k run and Cycling Colour Blast.

RESOLVED that the update on the Mayor's Health Living Campaign be noted.

17 **HEALTH SCRUTINY FORWARD PLAN**

Consideration was given to the Health Scrutiny Forward Plan for 2018/19.

The Committee were also provided an update on the All Age Obesity/Oral Health and Obesity in Secondary Schools.

The Committee noted the outcome of the discussion on the outcome of the public consultation on the proposed IVF changes.

RESOLVED that the Health Scrutiny Forward Plan for 2018/19 be noted.

18 **DATE AND TIME OF NEXT MEETING**

RESOLVED that the date and time of the next Health Scrutiny meeting to be held on Tuesday, 2nd July 2019 at 6.00 p.m. be noted.

The meeting started at 6.00 pm and ended at 8.03 pm

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Resolutions and Actions from the March 2019 meeting of the Health and Wellbeing Board

Board Meeting	Agenda Item	Resolution / Action	Action Update
March	**SAFEGUARDING BOARD ANNUAL REPORT**	**RESOLVED that:** 1. The Local Safeguarding Adults Board Annual Report for 2017/18, the Business Plan 2018/19 and Safeguarding Review be noted. 2. The Local Safeguarding Children's Board Annual Report for 2017/18, the Business Plan 2018/19 be noted.	
	TOBACCO CONTROL	**RESOLVED that:** The progress on the three key actions as set out in the Tobacco Control Action Plan be noted. A commitment of continued support of the Tobacco Control Agenda be supported which included: a) The next steps of the CLeaR self-assessment process. b) The implementation of the CURE project in Royal Oldham Hospital. c) The continuation of the Supporting a Smokefree Pregnancy Scheme. d) The improvement of access to stop smoking treatments including e-cigarettes.	

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Meeting Overview

Oldham Health and Wellbeing Board

25 June 2019
Crompton Suite
2pm – 4pm

No	Item	Timings
1 - 9	(1) Appointment of Chair and Vice Chairs (2) Apologies, (3) Urgent business, (4) Declarations of interest, (5) Public question time, (6) Minutes from last meeting**,** (7) Health Scrutiny minutes, (8) Resolution and Action log, (9) Meeting Overview	2.00pm *15 mins*
10	**Common Standards for Population Health in Greater Manchester** *Katrina Stephens, Director of Public Health* For the Board to receive an overview of the GM Common Standards for Population Health, have the opportunity to provide feedback on the suite of standards and consider local adoption and implementation.	2.15pm *30 mins*
11	**Suicide Prevention Update** *Dr Keith Jeffery, Clinical Director for Mental Health (Oldham CCG) and Vicki Gould, Public Health Programme Manager* For the Board to consider Oldham's Suicide Prevention Plan and the future governance arrangements for the Oldham Suicide Prevention Group	2.45pm *30 mins*
12	**Update from Sub-committees** For the Board to receive an update and assurance from the following sub-groups: • JSNA • Health Protection and Air Quality • Children and Young People's Strategic Partnership	3.15pm *15 mins*
13	**Any other Business and Close** *Chair*	3.30pm *10 mins*
	Next Meeting: Thursday 23 July, 2pm – 4pm, Crompton Suite (Development Session)	

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Report to HEALTH AND WELLBEING BOARD

Greater Manchester Common Standards for Population Health

Portfolio Holder: Councillor Zahid Chauhan, Cabinet Member – Health and Social Care

Report Author: Mark Brown, Programme Manager, Greater Manchester Health and Social Care Partnership; Wendy Meston, Consultant in Public Health, Rochdale Council

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25th June 2019

Purpose of the Report

For the Board to receive an overview of the Greater Manchester Common Standards for Population Health, have the opportunity to provide feedback on the suite of standards and consider local adoption and implementation.

Executive Summary

Following the development of a Greater Manchester Population Health Outcomes Framework, Greater Manchester Health and Social Care Partnership has coordinated a programme of work to develop a suite of core standards for population health. Public Health Practitioners and subject matter experts from the 10 Greater Manchester localities have co-designed a suite of *Greater Manchester Standards for Population Health* describing the evidence-based activity proven to improve population health outcomes for 7 core population health themes:

- Mental Health and Wellbeing
- Oral Health
- Sexual and reproductive health
- Drug and Alcohol service standards
- Physical activity
- Health Protection
- Tobacco Control

Linked to the GM Population Health Outcomes Framework, the Standards aim to reduce variation in population health outcomes across our city regions, and to increase uptake of activities which are proven to be effective. The Standards for the above themes have been consolidated into a single document to provide localities with an evidence-based tool to review current local activity and identify any gaps in evidence.

Greater Manchester Standards for Population Health were endorsed by Greater Manchester Directors of Public Health Group in March 2019 with the recommendation that they be shared with locality Health and Wellbeing Boards for local implementation.

Recommendations/Requirement from the Health and Wellbeing Board

There is no compulsion for localities to adopt or implement Greater Manchester Common Standards for Population Health. However, this document provides localities with an evidence-based tool to enable population health / public health practitioners to review current practice and identify any gaps in evidence.

Oldham Health and Wellbeing Board are requested to:

- Review GM Population Health Common Standards for each topic area
- Provide feedback on the GM Population Health Common Standards
- Endorse the use of GM Population Health Common Standards within the locality

Greater Manchester Common Standards for Population Health

1. Background

1.1. In March 2017, following a review of the current public health system across Greater Manchester, Greater Manchester Health & Social Care Partnership (GMHSCP) agreed to a set of proposals to facilitate the creation of a unified population health system to support the delivery of the Greater Manchester Population Health Plan at pace and scale.

1.2. This included a commitment to the reduction of unwanted variation in standards and outcomes and an ambition to see a more consistent adoption of evidence-based practice and the use of benchmarking data. This confirms the vision to drive improvements in population health across and within Greater Manchester and through the 10 GM localities, reducing inequalities and setting outcomes that are aligned to place based priorities.

1.3. The creation of a Greater Manchester Population Health Outcomes Framework (and accompanying on-line Dashboard) enables us to focus upon the key Population Health outcomes which adversely impact upon the health and wellbeing of the GM population and seeks to place focus and emphasis on a number of key indicators.

1.4. The Framework was reviewed and endorsed by GMHSCP Performance and Delivery Board on 14th March 2018, and GMHSCP Senior Management Team on 20th March 2018, and was formally signed off by GM Population Health Programme Board on 29th March 2018.

1.5. In order to reduce variance, enhance consistency and improve population health outcomes across Greater Manchester, a programme of work has been undertaken to develop a suite of core **Common Standards for Population Health in Greater Manchester**.

1.6. Under the leadership of Wendy Meston, Consultant in Public Health, Rochdale Council, existing and new Greater Manchester task groups have worked to consolidate existing standards, evidence and guidance to produce a suite of Population Health Common Standards for key areas of Population Health activity. The Standards are designed to support localities to achieve the best health gain for their population, and to reduce unwanted variation in population health outcomes across Greater Manchester.

2. Current Position

2.1. This first publication of GM Common Standards for Population Health provides standards for 7 population health themes. Additional standards will be developed in due course for more population health topic areas.

3. Data and Intelligence

3.1. Greater Manchester Common Standards for Population Health seek to drive improvements in population health outcomes for 7 thematic areas by describing evidence-based activities known to improve population health.

3.2. The evidence-base used to develop Common Standards is drawn from a range of publications which include clinical expertise, current best evidence, and client/patient perspectives. Web-links to these publications are embedded throughout the pack.

4. Links to Health and Wellbeing Outcomes

4.1. Each suite of Standards describes the activity required in any defined place / locality to support continuous improvement in population health outcomes.

5. Key Issues for Health and Wellbeing Board to Discuss

5.1. Initial feedback on the pack and views on local implementation.

6. Key Questions for Health and Wellbeing Board to Consider

6.1. Will the Board consider adopting and using Greater Manchester Common Standards for Population Health within the locality?

7. Additional Supporting Information

7.1 GM Common Standards for Population Health align with population health outcomes detailed in the Greater Manchester Population Health Outcomes Framework

8. Consultation

8.1. Details of Greater Manchester groups consulted for each population health theme are recorded in the pack.

9. Appendices

9.1. Appendix 1 – GM Common Standards for Population Health Pack

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Common Standards for Population Health

Introduction

In March 2017, following a review of the current public health system across Greater Manchester, Greater Manchester 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 Greater Manchester Population Health Plan at pace and scale.

This included a commitment to the reduction of unwanted variation in standards and outcomes and an ambition to see a more consistent adoption of evidence-based practice and the use of benchmarking data. This confirms the vision to drive improvements in population health across and within Greater Manchester (GM) and through the 10 GM localities, reducing inequalities and setting outcomes that are aligned to place based priorities.

The creation of a Greater Manchester Population Health Outcomes Framework (and accompanying on-line Dashboard) enables us to focus upon the key Population Health outcomes which adversely impact upon the health and wellbeing of the GM population and seeks to place focus and emphasis on a number of key indicators.

The Greater Manchester 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. The Framework, formally signed-off by the Greater Manchester Population Health Programme Board in March 2018, contains a suite of outcomes and output measures which are integral to the single integrated assurance process.

Greater Manchester Common Standards for Population Health

In order to reduce variance, enhance consistency and improve population health outcomes across GM, a programme of work has been undertaken to develop a suite of core **Common Standards for Population Health in GM**. Existing and new GM task groups have worked to consolidate existing standards, evidence and guidance to develop a suite of evidence-based standards for key areas of Population Health activity. The Standards are designed to support localities to achieve the best health gain for their population, and to reduce unwanted variation in population health outcomes across Greater Manchester.

There is no compulsion for localities to adopt and implement GM Common Standards for Population Health. However, this document provides localities with an evidence-based tool to enable population health / public health practitioners to review current local activity and identify any gaps in evidence. This first publication includes standards for the following 7 population health themes and additional standards will follow in due course:

- Mental Health and Wellbeing
- Oral Health
- Sexual and reproductive health
- Drug and Alcohol service standards
- Physical activity
- Health Protection
- Tobacco Control

GM Common Standards for Population Health have been developed through a process of co-design and agreement with subject matter experts and representatives from all 10 GM localities. They draw on existing standards such as those produced by NICE and Primary Care, and the development of new standards that will drive improvements in outcomes and quality. Each suite of Standards describes the activity required in any defined place / locality to support continuous improvement in population health outcomes.

Details of all GM groups been consulted and contributed to the development of these standards are recorded in this document. Links to evidence-based guidance (such as NICE, PHE and other professional bodies) are embedded for reference.

Each suite of topic-based standards provides a clearly defined outcome and method for measuring impact though it is acknowledged that for some standards appropriate impact measures are yet to be defined. Phase 2 of the development of the GM Population Health Outcomes Framework seeks to develop additional measures / metrics.

GM Common Standards for Population Health will be reviewed and updated regularly by the GM Common Standards Network Group* should existing evidence / guidance change. The group will meet again following the publication of PHE / ADPH Core Principles for Quality Improvement in Public Health: *What Does Good Look Like. (expected 2019).* Further Population Health common standards will be developed for additional population health themes as required.

**GM Common Standards Network Group is chaired by a Consultant in Public Health and consists of lead officer(s) for each topic-based suite of GM Population Health Common Standards.*

Greater Manchester Common Standards for Population Health: Prescribed and non-prescribed local authority public health functions

In addition to topic-based standards, a suite of GM Common Standards has been developed for prescribed and non-prescribed local authority public health functions. These detail headline standards for the prescribed functions that are outlined in the Public Health Ring fenced Grant Guidance for 2018/19 to Local Authorities.

Headline GM Common Standards for Population Health 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, standards are included relating to *Drug and Alcohol services*, *Tobacco Control*, *Mental Health and Wellbeing* as these are also key functions related to the Public Health Grant and are of significance to the improvement of GM population health outcomes.

Headline Population Health GM Common Standards have been chosen based on sound evidence and reasoning on how we can best meet the prescribed function and seek to achieve population health improvement for residents within Localities and across GM.

Self-evaluation matrix

To support localities to review current activities a simple self-evaluation matrix is embedded throughout this document. Positioning current activity using this scale will help professionals identify areas for improvement and to track progress over time. Again, there is no compulsion to use this matrix and localities may wish to use alternative methods to assess and review local activity.

Score	Assessment	Findings / Conclusion	Action Required
1	Standard not met	Significant gaps / weaknesses exist (generally non-compliant)	Actions are identified to secure improvements and move towards compliance.
2	Standard partially met	Some gaps / weaknesses exist (partial compliance)	Evidence is signposted in support of areas of compliance. Actions are identified to secure improvements and achieve compliance.
3	Standard fully met	Very few or no gaps / weaknesses exist (compliant)	Evidence is signposted in support of areas of compliance.

Greater Manchester Population Health Common Standards

Table of contents

1. Greater Manchester Common Standards for prescribed and non-prescribed public health functions

	Local Authority Function	Population Health Common Standard	SCORE			Measurement
			1	2	3	
PRESCRIBED FUNCTIONS	**Statutory Post**	Locality has a named Director of Public Health	☐	☐	☐	Named Director of Public Health / Population Health
	Sexual health services - STI testing and treatment	Timely open access to STI advice and treatment service (appointment offered within 48 hours)	☐	☐	☐	New HIV diagnosis rate / 100,000 people aged 15+
		Personalised risk reduction support and information for all who attend sexual health services & their partners	☐	☐	☐	
		Routine offer of an HIV test in high prevalence areas and a regular, targeted offer to those in high risk groups	☐	☐	☐	
	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	☐	☐	☐	Total Prescribed Long Acting Reversible Contraception (LARC) (Excluding Injections)
		Open access to specialised services for young people up to the age of 19	☐	☐	☐	
		All women (15-44 years old) are fully informed about and, if clinically appropriate, encouraged to use Long-acting Reversible Contraception (LARC) as their form of contraception	☐	☐	☐	
		For all women having a LARC removed and requiring contraception to have immediate access to an alternative, reliable method of contraception	☐	☐	☐	
	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	☐	☐	☐	Under 75 mortality rate from CVD considered preventable
		All identified at high risk to receive the advice and support to manage that risk	☐	☐	☐	
	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	☐	☐	☐	n/a

PRESCRIBED FUNCTIONS	**National Child Measurement Programme**	Completion of the National Child Measurement Programme with above average uptake	☐	☐	☐	Prevalence of overweight children (including obese) as measured by NCMP
		Documented service offer for children and families identified as being overweight, obese or underweight identified through the NCMP	☐	☐	☐	
	Prescribed Children's 0-5 services	Commissioning and delivery of the national 0-5 Healthy Child Programme in line with agreed targets	☐	☐	☐	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
NON-PRESCRIBED PH FUNCTIONS	**Drug 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	☐	☐	☐	Alcohol-related hospital admissions (narrow definition)
	Tobacco	All pregnant women who smoke are referred to services which can help them to quit during their pregnancy	☐	☐	☐	% of women who smoke at time of delivery; Smoking prevalence in adults - current smokers (APS)
		Publicised arrangements in place for smokers to access pharmacotherapy and motivational support in all areas (Including advice about nicotine inhaling products)	☐	☐	☐	
	Oral Health	Commission oral health preventive programmes in line with Commissioning Better Oral Health guidance and ensure oral health is embedded within children's services	☐	☐	☐	Proportion of 5-year-old children free from dental decay
	Mental Health and Wellbeing	Localities to (1) support GM Suicide Prevention Strategy & GM/Locality suicide prevention action plans in place and adopt Mentally Healthy Schools and Colleges principles	☐	☐	☐	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.	☐	☐	☐	% of GM population who are Active or Fairly Active
			☐	☐	☐	% of physically inactive adults (>30 minutes per week)

2. Greater Manchester Common Standards - Mental Health and Wellbeing

Mental Health & Wellbeing

Outcome measures affected in GM Population Health Outcomes Framework:

4.10 Suicide Prevalence

Improving child and adult mental health, narrowing their gap in life expectancy, and ensuring parity of esteem with physical health is fundamental to unlocking the power and potential of GM communities. Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in GM requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and wellbeing of GM residents.

We propose a whole system approach that includes involvement from the independent and third sector, to improve the mental health and wellbeing of individuals and their families, supported by resilient communities, inclusive employers and services that maximise independence and choice.

• Children and Young People's mental health forms an integral part of our overall strategy. We will use the opportunities through devolution to collectively respond to the challenges outlined within Futures in Mind and in doing so transform the provision of services for the young people in GM.

• We will promote employment for people with mental health problems and provide timely and effective support to help people stay in employment through building on the current GM Working Well whole population approach.

• We will support those most vulnerable in society to help reduce the risk of developing poor mental health, and those with existing mental health conditions from deteriorating further. In doing this we will build on GMs existing approach to supporting people with complex needs with a particular focus on looked after children, child sexual exploitation, those with learning difficulties and disabilities.

This document provides a list of standards and measures and core outcomes linked to the Greater Manchester Mental Health Strategy and GM Health and Social Care Partnership Population Health Plan. Commissioners, providers and health and social care professionals are asked to:

• Review current practice against these standards
• Identify gaps in the evidence and implement these standards
• Develop actions to address these gaps and provide evidence and feed into the development of local transformation plans
• Agree a small number of KPIs to feed into the performance frameworks for local care organisations.

Greater Manchester Common Standards for Mental Health and Wellbeing					
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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	2	3	
Support the delivery of the GM Suicide Prevention strategy and the 10% reduction in suicide rates (baseline 2016/7) by 2020	All Localities will have a suicide prevention action plan in place.	☐	☐	☐	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population
Reduction in self harm and suicide	All health and social care staff frontline staff to receive the following training as part of workforce development mental health awareness, suicide awareness and mental health literacy training	☐	☐	☐	Presence of mental health and suicide awareness training and mental health literacy within local health and social care transformation plan
					% of workforce who have received defined training
					Staff feedback confirming mental health/suicide training
Public mental health, parity of esteem and health inequalities is a strategic consideration within overarching plans for health and social care transformation and is embedded within service provision	Joint strategic needs assessment (JSNA) to adequately address mental health and the public health outcomes framework. JSNAs should include parity of esteem, health inequalities and address mental and physical health needs of children and young people	☐	☐	☐	***Locality Transformation Plans for Health and Social Care address:***
					Public mental health: primary/secondary prevention and recovery interventions
					Parity of esteem: Annual Health Checks, Smoking, Weight, Drugs & Alcohol
					Health inequalities: Healthy Equity Audit for people with SMI
					The impact will be measured by:
					The reduction of specific physical health problems
					Increased physical health assessments

Greater Manchester Common Standards for Mental Health and Wellbeing					
STRATEGIC OUTCOME: Give every GM child the best start in life **"I" Statement:** *"I will make sure that more children in GM of all ages and backgrounds will have better wellbeing and good mental health"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	2	3	
Mentally Healthy Schools and Colleges	Develop strategic framework based on whole school /college and approach with principles that focus on leadership and management, curriculum, working with students and parents, staff development and wellbeing, targeted interventions for Children and Young People at risk of poor emotional and mental health alongside universal mental health promotion approaches	☐	☐	☐	% of schools and college in the borough participating in recognised whole school / college programme and Hospital admissions as a result of self-harm (10-24 years)

Greater Manchester Common Standards for Mental Health and Wellbeing					
STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential **"I" Statement:** *"I will maintain good mental health and wellbeing and have access to timely early preventative interventions"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Mental health and wellbeing should be embedded across all the local authority's areas of responsibility, including housing, education, community safety and planning.	All Local Authorities will have at least one elected member mental health champion	☐	☐	☐	Number of LAs with at least one mental health champion Number of mental health champions in LAs
Individuals return to, or remain in work	Support to retrain, retain or gain employment will be part of care plans for all accessing primary, secondary MH services and commissioned VCSE mental health services	☐	☐	☐	Reduced gap in employment rate for those in contact with secondary mental health services and the overall employment rate *(PHOF 1.08iii)* ***Secondary mental health to measure:*** Length of time people are off work Percentage of successful return to work ***Primary care to:*** routinely record Employment / benefit status make appropriate connections /referrals to services
Improved quality of life for the individual with SMI including greater independence, improved health, greater choice of options on where and how to live and lessened dependence	People with SMI will be supported to find secure accommodation	☐	☐	☐	% of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support

Greater Manchester Common Standards for Mental Health and Wellbeing					
STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential *(continued)* **"I" Statement:** *"I will maintain good mental health and wellbeing and have access to timely early preventative interventions"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Improvement the physical health of people living with mental health problems	Robust pathways between mental health services and life style interventions e.g. smoking, weight management, dental and oral health and physical activity	☐	☐	☐	Excess under 75 mortality rates in adults with serious mental illness: ratio of observed to expected mortalities (expressed as a percentage)
Prevention of physical ill health, increasing early detection of illness and reducing premature morbidity, enabling people to live healthier and longer lives.	All mental health staff will receive competency-based behaviour change training to address physical health needs are assessed and responded too.	☐	☐	☐	% of mental health staff receiving competency-based behaviour change training to address physical health needs
Multi-faceted campaigns including anti-stigma, targeted work with organisations and BAME communities	All Statutory organisations and key partners will sign up to the Time to Change programme	☐	☐	☐	% of time to change workplaces in the borough
	Any local surveys to include questions relating to attitudes to mental ill-health and mental wellbeing	☐	☐	☐	

Greater Manchester Common Standards for Mental Health and Wellbeing					
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 talk about my feelings, keep active, learn, ask for help and participate in social and community life to maintain good mental health "*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Reduction in social isolation and Loneliness	Develop local social prescribing offer targeting older people that addresses social isolation and loneliness	☐	☐	☐	% of adult social care users who have as much social contact as they like *(Public Health Outcomes Framework 1.18 Social Isolation)*

STRATEGIC OUTCOME: Enabling resilient and thriving communities **"I" Statement:** *"As my needs change I will talk about my feelings, keep active, learn, ask for help and participate in social and community life to maintain good mental health"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Improved access to interventions that promote social activities and strong social networks to improve levels of mental wellbeing in the population	All localities will facilitate / commission a range of interventions that enhance social interaction (capital) such as arts, music, creativity, learning volunteering and timebanks	☐	☐	☐	The proportion of people who use services and carers, who report that they have had as much social contact as they would like *(Adult Social Care Outcomes Framework)*

Greater Manchester Common Standards for Mental Health and Wellbeing

GM Common Standards for Mental Health and Wellbeing have been co-designed by the following Greater Manchester groups using national guidance.

- GM Adult Mental Health Board
- GM Children's Mental Health Board
- GM Mental Health and Wellbeing Group
- GM Suicide Prevention Executive

Guidance	Link
The British academy for humanities and social sciences "IF YOU COULD DO ONE THING..." Nine local actions to reduce health inequalities	http://www.britac.ac.uk/sites/default/files/If%20you%20could%20do%20one%20thing%20-%20full%20report.pdf
Joint Commissioning Panel for Mental Health: Guidance for Commissioning public mental health services	http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf
DH: No Health Without Mental Health: Implementation Framework	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
DH: Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
Mental Health Foundation: Mental Health and Prevention: Taking local action for better mental health	https://www.mentalhealth.org.uk/publications/mental-health-and-prevention-taking-local-action-better-mental-health
PHE: Measuring and monitoring C&YP mental wellbeing: A toolkit for schools and colleges	https://www.annafreud.org/media/4612/mwb-toolki-final-draft-4.pdf
Centre for Public Health: A Scoping Study of the Implementation of Routine Enquiry about Childhood Adversity (REACh) Blackburn with Darwen	http://www.cph.org.uk/wp-content/uploads/2015/07/REACh-Scoping-Study-BwD.pdf
LGA: Being Mindful of mental health June 2017	https://www.local.gov.uk/being-mindful-mental-health-role-local-government-mental-health-and-wellbeing

Guidance	Link
NHS: England Five Year Forward View -Mental Health	https://www.england.nhs.uk/?s=five%20year%20forward%20view&paged=4
NHS England: Improving the physical health of people with mental health problems: Action for mental health nurses	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf
Mental Health Foundation: Mental Health and Prevention: Taking local action for better mental health	https://www.mentalhealth.org.uk/publications/mental-health-and-prevention-taking-local-action-better-mental-health
NHS: Stepping Forward to 2020/21: The mental health workforce plan for England	https://www.hee.nhs.uk/sites/default/files/documents/CCS0717505185-1_FYFV%20Mental%20health%20workforce%20plan%20for%20England_v5%283%29.pdf
DH: The Mental Health Core Skills Education and Training Framework	http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework
PHE (2015) Promoting children and young people's emotional health and wellbeing	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf

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3. Greater Manchester Common Standards for Oral Health

Outcome measures affected in GM Population Health Outcomes Framework:

(4.02) Proportion of 5 year old children free from dental decay

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 oral 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

Greater Manchester's 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 and identify any gaps in evidence. Actions should be developed to address these gaps with supporting evidence and KPIs developed to feed into the performance framework for Local Care Organisations.

3. Greater Manchester Common Standards for Oral Health					
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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**3**	**3**	
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.

Greater Manchester Common Standards for Oral Health					
STRATEGIC OUTCOME: Start Well - Give every GM child the best start in life **"I" Statement:** *"Every GM child can grow up able to eat speak and smile free from pain and distress of dental disease*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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 dental decay
	Parents, Carers & individuals take good oral hygiene & diet and access dental care when needed	☐	☐	☐	

Greater Manchester Common Standards for Oral Health					
STRATEGIC OUTCOME: Start Well - Give every GM child the best start in life **"I" Statement:** *"Every GM child can grow up able to eat speak and smile free from pain and distress of dental disease*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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 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

Greater Manchester Common Standards for Oral Health					
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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Services improve health and wellbeing	Healthy Living Dental practices are delivering a health and wellbeing offer	☐	☐	☐	Number of healthy living dental practices
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.

Greater Manchester Common Standards for Oral Health					
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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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
					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

Greater Manchester Common Standards for Oral Health

GM Common Standards for Oral Health have been co-designed by the following Greater Manchester groups using national guidance.

- Greater Manchester Local Dental Network
- Managed clinical networks
- Local Dental Committees
- Dental and primary care advisory groups
- Local Authorities
- GM oral health steering group and within the GM Health and Social Care Partnership

Guidance	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	https://www.gov.uk/government/publications/commissioning-better-oral-health-for-vulnerable-older-people
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
PHE Guidance: Commissioning Better Oral Health	https://www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities
Mouth Care Matters	www.mouthcarematters.hee.nhs.uk
GM Toolkit: Healthy Living Dentistry toolkit	http://www.cpgmhealthcare.co.uk/dental.html
GM Toolkit: Medical Histories do Matter	http://www.gmhsc.org.uk/wp-content/uploads/2018/04/Putting-The-Mouth-Back-in-the-Body-The-Dental-Contribution-FINAL.pdf
GM Toolkit: Baby Teeth do Matter	https://www.nwpgmd.nhs.uk/sites/default/files/Request%20Access%20to%20Baby%20Teeth%20Do%20Matter.pdf

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4. Greater Manchester Common Standards for Sexual and Reproductive Health

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	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
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	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
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

Greater Manchester Common Standards for Sexual and Reproductive Health					
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"* **"I" Statement:** *"I will have swift access to the service(s) I need"* **"I" Statement:** *"I will be offered choice and support to make an informed decision regarding contraception"* **"I" Statement:** *"I will have access to the testing and treatment I need"* **"I" Statement:** *"I will be given information and advice about reducing my personal risk of sexual health issues "*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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					
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 cervical screening	☐	☐	☐	NHS England uptake data

STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential *(continued)*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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 clinic sessions available per week with staff trained to work with young people 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)
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 Borne Viruses for Primary Care every 3 years	☐	☐	☐	Training to GPs/Pharmacies for advice and onward referral

STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential *(continued)*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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

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 maintain good health and wellbeing and will have good and equitable access to information, support and services"* **"I" Statement:** *"I will have swift access to the service(s) I need"* **"I" Statement:** *"I will be offered choice and support to make an informed decision regarding contraception"* **"I" Statement:** *"I will have access to the testing and treatment I need"* **"I" Statement:** *"I will be given information and advice about reducing my personal risk of sexual health issues "*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Reduction in prevalence of STIs and reduction in new and late diagnosis of HIV	Older people will have their diverse/various sexual health and wellbeing needs recognised in the delivery of health service in primary and secondary care and in specialist sexual health services	☐	☐	☐	To be defined
Reduce physical, psychological, social, cultural and relationship issues that relate to sexual activities of older people	Health and care staff across all sectors to have evidence-based education about the sexual health needs and difficulties that older adults may encounter. The programs of education should take account of the physical, psychological, social, cultural and relationship issues that impact on sexual activities and intimacy.	☐	☐	☐	To be defined

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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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	☐	☐	☐	% re-infected within 12 months

GM Common Standards for Sexual and Reproductive Health have been co-designed by the following Greater Manchester groups using national guidance.

- GM Sexual Health Strategic Partnership Board
- GM Sexual Health Commissioners Group
- GM H&SCP Common Standards Network Group

Guidance	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

Guidance (continued)	Link
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 & Reproductive Health Strategy	In development
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
FPA the sexual health charity – Older People Policy	https://www.fpa.org.uk/sites/default/files/older-people-policy-statement.pdf

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5. Greater Manchester Common Standards – Drug and Alcohol service standards

Drug and alcohol services

Outcome measures affected in GM Population Health Outcomes Framework:

(10.01) Admission episodes for alcohol-related conditions (narrow definition)

Drug and Alcohol Common Standards have been developed by GM substance misuse commissioners for the services they commission. As such they are 'service standards'. There is not direct reference to important wider system elements such as hospital-based Alcohol Liaison Nurses as typically these are not directly commissioned by local authorities. However, the need for clear pathways between hospital and community-based services to prioritise improving outcomes for people with co-existing drug, alcohol and mental health problems is clearly addressed. Similarly, brief interventions that would be delivered by partner agencies are not directly considered but the need for drug and alcohol services to link with Public Service Hubs, Place Based Teams and targeted services is. GM substance misuse commissioners fully appreciate that the next stage in the process of developing these service standards is to work with providers to ensure implementation.

The vision is to make Greater Manchester a place where everyone can have the best start in life, live well and age well, safe from the harms caused by drugs and alcohol:

- A place where children, young people and families have the best start in life and future generations grow up protected from the impact of drug and alcohol misuse.
- A place where people who drink alcohol choose to do so responsibly and safely.
- A place where people are empowered to avoid using drugs and alcohol to cope with adversity and the stresses and strains of life.
- A place where our services and communities work together to build resilience and address the harms caused by drugs and alcohol.
- A place where individuals who develop drug and alcohol problems can recover and live fulfilling lives in strong resilient communities.

We will achieve the vision by:

- Recognising that substance use is diverse and complex, and collectively responding to changing patterns of substance use and behaviour to provide the most effective route to recovery from all types of substance misuse.
- Rooting our approach in prevention and early intervention, anticipating future cost and escalating demand on services, and ensuring responses are appropriate to levels of need and health risk.
- Basing our approach to treatment and harm reduction on a growing evidence base, and a shared understanding of challenges, opportunities and changing circumstances - ensuring that we share learning, expertise and resources.
- Using asset-based approaches to enable long-term and sustained recovery from all types of substance misuse.
- Adopting a whole-person approach to working with complex families and individuals and integrating provision with wider delivery models tackling Complex Dependency.

5. Greater Manchester Common Standards for Drug and Alcohol service standards

Strategic Priority: Prevention and Early Intervention

STRATEGIC OUTCOME: Start Well - Give every GM child the best start in life

"I" Statement: *"I will live in a place where children, young people and families have the best start in life and future generations grow up protected from the impact of drug and alcohol misuse."*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Reduce alcohol exposed pregnancies and eliminate new cases of Foetal Alcohol Spectrum Disorder (FASD).	Services will provide specific pathways for pregnant women that support them to remain alcohol free during pregnancy	☐	☐	☐	Reduction in the number of alcohol exposed pregnancies
	Services will provide additional focus for women with significant and complex needs who are at high risk of using alcohol whilst pregnant	☐	☐	☐	
A targeted approach to young people, adults and families most at risk of harm from drugs and alcohol	Services will provide targeted early interventions for high risk young people	☐	☐	☐	Number of high risk young people engaged (NDTMS risk profile data)
	Services will provide support for high risk families	☐	☐	☐	Availability and uptake of family support: Number of families supported per local area (Local Audit and Data)

Strategic Priority: Reducing drug and alcohol related harm

STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential

"I" Statement: *"I will live in a place where people are empowered to avoid using drugs and alcohol to cope with adversity and the stresses and strains of life."*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
A place based approach that prioritises early help	Services will be linked to Public Service Hubs, Place Based Teams and targeted services.	☐	☐	☐	Clear evidence of service pathways and processes in place to identify and address the needs of those most at risk. (PSR Local Audit & Self-Assessment Tool)
	Services will work closely with primary care and other health and social care agencies established to help meet the complex and overlapping needs of children, young people, adults and their families, including pathways for pregnant women.	☐	☐	☐	
Reduce the number of deaths caused by drugs and alcohol	Services will offer access to relapse prevention after exit	☐	☐	☐	Reduction in number of drug related deaths and alcohol mortality rates (PHE data)
Develop a GM approach to understanding and reducing drug and alcohol related deaths.	Services will guarantee that those who need to re-enter treatment are able to do so	☐	☐	☐	Local audit approach to be developed as part of GM approach
	Naloxone will be available for all opiate users regardless of treatment status across GM	☐	☐	☐	

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASUREING OUTCOME
		1	2	3	
Address the impact of drug and alcohol on our most vulnerable people	Services will deliver targeted interventions for those with the most complex needs and work with PSR hubs to do so	☐	☐	☐	Clear evidence of joint working and integration with PSR hubs (Local Audit. PSR team self-assessment tool) (Local Audit)
	Service care plans should identify the full range of an individual's complexities to facilitate joint working and support from other agencies	☐	☐	☐	Clear evidence of care plans identifying need
	Services will offer women only provision, including group support	☐	☐	☐	Clear evidence of provision and uptake. (Local Audit including service user feedback)
	Services will align and integrate working with women's centres and other organisations that work with vulnerable women	☐	☐	☐	Clear evidence of joint working. (Local Audit including service user feedback)
	Services will have agreed transitional pathways between all young people's and adult services	☐	☐	☐	Clear evidence of pathways. (Local Audit)
	Services will be part of a multi-agency response to safeguarding	☐	☐	☐	Clear evidence of engagement in safeguarding processes. (Local Audit)
	Services will target complex families in partnership with other agencies	☐	☐	☐	Clear evidence of engagement with complex families. (Local Audit)

Strategic Priority: Reducing drug and alcohol related harm
Strategic Outcome: Live Well - Ensure every GM resident is enabled to fulfil their potential
"I" Statement*:"I will live in a place where people are empowered to avoid using drugs and alcohol to cope with adversity and the stresses and strains of life."*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Prioritise improving outcomes for people with co-existing drug, alcohol and mental health problems	There will be reciprocal arrangements for joint support between substance misuse and mental health services.	☐	☐	☐	Protocols between mental health and substance misuse for supporting adults and young people with coexisting mental health and substance misuse issues. (Local Audit)
	There will be clear pathways between hospital and community based services inclusive of recovery support.	☐	☐	☐	Clear evidence and uptake of pathways. (Local Audit)
	Community based services will facilitate access to inpatient, detox and residential rehab provision.	☐	☐	☐	Uptake and successful completion of provision (NDTMS data) Provision will meet CQC requirements. (Local Audit)
	An individual's mental health will be assessed appropriately before discharge from inpatient, detox and residential rehab services.	☐	☐	☐	Requirement through GM Tier 4 framework.
Focus on blood bourne viruses to help achieve the strategic aims of eliminating HIV and Hepatitis C as public health issues	Services will screen and test for BVBs, offer vaccinations, and support clients to start and complete treatment (e.g. for Hep C)	☐	☐	☐	Uptake of screening, testing, vaccination and support. (NDTMS data)
	Needle Exchange facilities will be available and accessible throughout GM.	☐	☐	☐	Mapping of provision and monitoring of needle exchange data (Local Audit)
	Services will meet the specific needs of image and performance enhancing drug users.	☐	☐	☐	Monitoring of needle exchange data and engagement. (Local Audit)

Strategic Priority: Reducing drug and alcohol related harm

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

"I" Statement: *"I will live in a place where people are empowered to avoid using drugs and alcohol to cope with adversity and the stresses and strains of life."*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Improve the physical health of adults with drug and alcohol problems through screening, early identification and onward referral	Services will conduct routine and ongoing physical assessments for those in treatment.	☐	☐	☐	Monitoring of screenings and referrals (Local Audit / NDTMS data)
	There will be will be clear referral pathways linking treatment services with primary care and the wider health system	☐	☐	☐	
Reduce drug and alcohol related fires	Services will make referrals to the Greater Manchester Fire and Rescue Service for 'Safe and Well' home assessment visits	☐	☐	☐	Monitoring of referrals and home visits (Local Audit /GMFRS data)
Improve recovery outcomes through a detailed understanding of the different needs of our treatment populations	Services will ensure the effective stratification of treatment populations in line with national guidance so that pharmacological and psychological interventions are appropriately targeted.	☐	☐	☐	Monitoring of recovery outcomes (Local Audit / NDTMS data)
	Services should deliver asset based continuous assessment	☐	☐	☐	Local audit

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Clearly link treatment systems to key support services (e.g. mental health, housing and homelessness, employment, education and training)	Treatment systems will evidence clear pathways to and from key support services	☐	☐	☐	Local Audit + NDTMS data
	At a neighbourhood level, we are focusing on helping people to help themselves through developing integrated place based services that are responsive to local need, build on the assets of the community and create capacity to deliver change. These integrated teams will work to improve individual and community resilience by understanding individual needs in the context of the family and their community.	☐	☐	☐	Local Audit
	Ensure that residential rehab and detox have pathways and links back into community and recovery services with appropriate information sharing	☐	☐	☐	Local Audit + NDTMS data
Promote wellbeing and recovery by clearly linking treatment systems with voluntary and community based organisations	Services will promote approaches that focus on people's assets, reduce stigma and encourages people to help themselves and others in recovery communities	☐	☐	☐	Local Audit + NDTMS data
	Services will maximise the role played by local people and the VCSE in supporting long term sustained recovery	☐	☐	☐	Local Audit + NDTMS data
Services will connect with communities of identity and ensure that barriers to seeking advice and engaging in treatment are removed	Communities of identity will be engaged in the co-production and co-design of services	☐	☐	☐	Local Audit

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Ensure recovery is visible in our communities and throughout treatment journeys	Services will ensure that those in successful recovery are clearly visible to their peers as examples of hope and what is achievable.	☐	☐	☐	Local Audit
	Services will conduct treatment exit plans which assess recovery support required	☐	☐	☐	Local Audit + NDTMS data
Involve those with lived experience in the design and delivery of person and community centred approaches	To support rehabilitation and build recovery in our communities, we involve service users and people with lived experience in the design and delivery of drug and alcohol services.	☐	☐	☐	Local Audit

Strategic Priority: Reducing drug and alcohol related crime and disorder

STRATEGIC OUTCOME: Enabling resilient and thriving communities and neighbourhoods

"I" Statement: *"I will live in a place where our services and communities work together to build resilience and address the harms caused by drugs and alcohol."*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
The development of a set of common offers that clearly identify "what works" in reducing drug and alcohol related offending	Services will participate in the development and endorsement of common GM offers across police custody, courts, community orders and *Through The Gate* to create consistent GM approaches	☐	☐	☐	Clear evidence of GM agreement and application (including interaction between services)
Maximise every opportunity to address offending behaviour that is driven by the use of drugs and alcohol	Ensure criminal justice and treatment agencies work closely together to improve the effectiveness of out of court disposals and community sentences, such as drug, alcohol and mental health treatment requirements.	☐	☐	☐	Increase in the number of Out of Court Disposals and Community Sentence Treatment Requirements. Reduction in repeat appearances. Court data + data from NPS/CRC
	Work closely with prisons in the resettlement of offenders to improve continuity of care	☐	☐	☐	Reduction in the number of people returning into prison custody. Court data + data from NPS/CRC
	Ensure suitable post prison offer for people who have become abstinent in prison	☐	☐	☐	Audit of availability and monitor provision
Work with criminal justice partners to ensure that responses to young people's drug and alcohol related offending are appropriate to their needs.	Ensure local agencies review how to take every opportunity to identify young people at an early stage and work together to put in place appropriate support.	☐	☐	☐	Reduction in young people's reoffending
Focus on targeted geographical problem-solving approaches which involve our communities.	Work with Community Safety and local partners to develop local strategies which address open use of drugs and drug and alcohol related anti-social behaviour.	☐	☐	☐	Improved public confidence

5. Greater Manchester Common Standards – Drug and Alcohol service standards

Guidance	Link
Advisory Council on the Misuse of Drugs	
'Hidden harm' report on children of drug users (2011)	https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users
Recovery from drug and alcohol dependence: An overview of the evidence (2012)	https://www.gov.uk/government/publications/acmd-recovery-from-drug-and-alcohol-dependence-an-overview-of-the-evidence-2012
What recovery outcomes does the evidence tell us we can expect? (2013)	https://www.gov.uk/government/publications/acmd-second-report-of-the-recovery-committee-november-2013
How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? (2015)	https://www.gov.uk/government/publications/how-can-opioid-substitution-therapy-be-optimised-to-maximise-recovery-outcomes-for-service-users
Prevention of drug and alcohol dependence (2015)	https://www.gov.uk/government/publications/prevention-of-drug-and-alcohol-dependence
Reducing opioid-related deaths in the UK (2016)	https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk
Department of Health	
You're welcome - Quality criteria for young people friendly health services (2011)	https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services
The Green Book: Immunisation against infectious diseases (2014)	https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
Widening the availability of Naloxone (2016)	https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone
Drug misuse and dependence: UK guidelines on clinical management (2017)	https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Guidance (continued)	Link
National Institute for Health and Care Excellence (NICE)	
CG51 Drug misuse in over 16s: Psychosocial interventions (2007)	https://www.nice.org.uk/Guidance/CG51
CG52 Drug misuse in over 16s: Opioid detoxification (2007)	https://www.nice.org.uk/Guidance/CG52
PH4 Substance misuse interventions for vulnerable under 25s (2007)	https://www.nice.org.uk/Guidance/PH4
PH6 Behaviour change: General approaches (2007)	https://www.nice.org.uk/Guidance/PH6
PH7 Alcohol: School-based interventions (2007)	https://www.nice.org.uk/Guidance/PH7
TA114 Methadone and buprenorphine for the management of opioid dependence (2007)	https://www.nice.org.uk/guidance/ta114
TA115 Naltrexone for the management of opioid dependence (2007)	https://www.nice.org.uk/guidance/ta115
CG100 Alcohol-use disorders: Diagnosis and management of physical complications (2010)	https://www.nice.org.uk/Guidance/CG100
CG110 Pregnancy with complex social factors: a model for service provision for pregnant women with complex social factors (2010)	https://www.nice.org.uk/Guidance/CG110
PH24 Alcohol-use disorders: Prevention (2010)	https://www.nice.org.uk/Guidance/PH24
CG115 Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence (2011)	https://www.nice.org.uk/guidance/CG115
CG120 Psychosis with substance misuse in over 14s: Assessment and management (2011)	https://www.nice.org.uk/guidance/CG120
QS11 Alcohol-use disorders (2011)	https://www.nice.org.uk/guidance/QS11
PH43 Hepatitis B and C testing: people at risk of infection (2012)	https://www.nice.org.uk/Guidance/PH43
QS23 Drug use disorders in adults (2012)	https://www.nice.org.uk/Guidance/QS23
PH50 Domestic violence and abuse: Multi-agency working (2014)	https://www.nice.org.uk/Guidance/PH50

Guidance (continued)	Link
National Institute for Health and Care Excellence (continued)	
PH52 Needle and syringe programmes (2014)	https://www.nice.org.uk/guidance/PH52
TA325 Nalmefene for reducing alcohol consumption in people with alcohol dependence (2014)	https://www.nice.org.uk/guidance/ta325
NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015)	https://www.nice.org.uk/guidance/ng5
QS83 Alcohol: Preventing harmful use in the community (2015)	https://www.nice.org.uk/guidance/qs83
Alcohol care teams: reducing acute hospital admissions and improving quality of care (2016)	https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?id=2603
NG33 Tuberculosis (2016)	https://www.nice.org.uk/guidance/NG33
NG58 Coexisting severe mental illness and substance misuse: Community health and social care services (2016)	https://www.nice.org.uk/guidance/ng58
NG64 Drug misuse prevention: Targeted interventions (2017)	https://www.nice.org.uk/guidance/ng64
National Treatment Agency	
The role of residential rehabilitation in an integrated treatment system [with 'Findings' analysis] (2012)	http://findings.org.uk/count/downloads/download.php?file=NTA_25.txt
Medications in recovery: Re-orientating drug dependence treatment [with 'Findings' analysis] (2012)	http://findings.org.uk/count/downloads/download.php?file=Strang_J_27.txt
Novel Psychoactive Treatment UK Network	
Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances (2015)	http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf
Harms of synthetic cannabinoid receptor agonists (SCRAs) and their management (2015)	http://neptune-clinical-guidance.co.uk/wp-content/uploads/2016/07/Synthetic-Cannabinoid-Receptor-Agonists.pdf

Guidance (continued)	Link
Public Health England	
Medications in recovery: best practice in reviewing treatment (2013)	https://www.gov.uk/government/publications/treating-drug-dependence-recovery-with-medication
People who inject drugs: infection risks, guidance and data (2013)	https://www.gov.uk/guidance/people-who-inject-drugs-infection-risks-guidance-and-data#common-infections-among-pwid
Routes to recovery from substance addiction (2013)	https://www.gov.uk/government/publications/routes-to-recovery-from-substance-addiction
Developing local substance misuse safeguarding protocols: Information on developing local joint protocols between drug and alcohol services, and children and family services (2013)	https://www.gov.uk/government/publications/developing-local-substance-misuse-safeguarding-protocols
New psychoactive substances: A toolkit for substance misuse commissioners (2014)	https://www.gov.uk/government/publications/new-psychoactive-substances-toolkit-for-commissioners
Non-medical prescribing in the management of substance misuse (2014)	https://www.gov.uk/government/publications/non-medical-prescribing-in-the-management-of-substance-misuse
The role of addiction specialist doctors in recovery orientated treatment systems (2014)	https://www.gov.uk/government/publications/role-of-addiction-specialist-doctors-in-drug-and-alcohol-services
Optimising opioid substitution treatment: turning evidence into practice (2014)	https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/optimising-opioid-substitution-treatment-turning-evidence-into-practice
Preventing drug-related deaths: turning evidence into practice (2014)	https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/preventing-drug-related-deaths-turning-evidence-into-practice

Guidance (continued)	Link
Public Health England (continued)	
Improving access to hepatitis C treatment: turning evidence into practice (2014)	https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/improving-access-to-hepatitis-c-treatment-turning-evidence-into-practice
Services for image and performance enhancing drug (IPED) users: turning evidence into practice (2014)	https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/services-for-image-and-performance-enhancing-drug-iped-users-turning-evidence-into-practice
Treating substance misuse and related harm: turning evidence into practice (2014)	https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice
Alcohol and drug treatment quality governance (2015)	https://www.gov.uk/government/publications/alcohol-and-drug-treatment-quality-governance
Service user involvement in alcohol and drug misuse treatment (2015)	https://www.gov.uk/government/publications/service-user-involvement-in-alcohol-and-drug-misuse-treatment
Substance misuse services for men who have sex with men involved in chemsex (2015)	https://www.gov.uk/government/publications/substance-misuse-services-for-men-involved-in-chemsex
Preventing drug and alcohol misuse: international evidence and implementation examples (2015)	https://www.gov.uk/government/publications/preventing-drug-and-alcohol-misuse-effective-interventions
The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review (2016)	https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review
Understanding and preventing drug-related deaths (2016)	https://www.gov.uk/government/publications/preventing-drug-related-deaths

Guidance (continued)	Link
Public Health England (continued)	
People with co-occurring conditions: commission and provide services: Guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions (2017)	https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services
Take-home Naloxone for opioid overdose in people who use drugs (2017)	https://www.gov.uk/government/publications/providing-take-home-naloxone-for-opioid-overdose
Alcohol and drug misuse prevention and treatment guidance collection (last updated 2018)	https://www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance#guidance-for-commissioners-and-providers-of-alcohol-and-drug-services
Strategies	
Greater Manchester Drug and Alcohol Strategy (2018)	In development
The Government's Alcohol Strategy (2012)	https://www.gov.uk/government/publications/alcohol-strategy
National Drug Strategy (2017)	https://www.gov.uk/government/publications/drug-strategy-2017

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6. Greater Manchester Common Standards – Physical Activity

Outcome measures affected in GM Population Health Outcomes Framework:

- **% 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 days in the last week)**
- **% of GM children aged 2-15 who are active or fairly active**
- **% of GM population who are Active or Fairly Active**
- **% of physically inactive adults (current method)**
- **% physically active for at least one hour per day seven days a week**

The ambition is everyone in Greater Manchester to be more active to secure the fastest and greatest improvement to the health, wealth and wellbeing of the 2.8m people of Greater Manchester.

Greater Manchester (GM) Moving: The Plan for Physical Activity and Sport (2017-21), is the comprehensive framework to reduce inactivity and increase participation in physical activity and sport that is aligned to the Greater Manchester Population Health Plan priority themes and wider reform agenda. Its shared purpose is to positively change the lives of people across Greater Manchester through physical activity and sport. Building from our strengths and through system wide collaboration, we will double the rate of past improvements, reaching the target of 75% of people active or fairly active by 2025.

The 12 key priorities/drivers to achieve the above are:

1. Lead policy, legislation and system change to support active lives, ensuring that physical activity becomes a central feature in policy and practice related to planning, transport, health and social care, economic development, education and the environment.
2. Provide strategic leadership to secure system change for physical activity and sport across the life course, with person centred, preventative approaches in an integrated system.
3. Ensure that children aged 0-4 have the best active start in life with physical literacy prioritised as a central feature of starting well.
4. Make Greater Manchester the best place in England for children, young people and young adults aged 5-25 to grow up, developing their life chances through a more active lifestyle, with a focus on reducing inequalities.
5. Increase physical activity and sport across the adult population, reducing inequalities and contributing to health, wealth and wellbeing.
6. Make active ageing a central pillar within the Greater Manchester Ageing Hub supporting the Greater Manchester ambition for an age friendly city region, which will lead to better health, wellbeing and independence.
7. Develop more active and sustainable environments and communities through active design and infrastructure.
8. Maximise the contribution of the physical activity and sport sector to economic growth across Greater Manchester.
9. Build the knowledge, skills and understanding of the workforce across Greater Manchester to embed physical activity, make every contact count and develop a diverse workforce fit to deliver the ambitions of Greater Manchester Moving.
10. Ensure that evidence, data and insight inform the development of policy and practice to support active lives.
11. Embed high quality evaluation into all Greater Manchester Moving work, developing quality standards, helping to understand impact, learn and improve, and support advocacy.
12. Deliver high quality marketing and communications to support messaging and engagement of people from priority audiences in active lives.

6. Greater Manchester Common Standards – Physical Activity

STRATEGIC OUTCOME: Improving the Health of the GM Population and Reducing Health Inequalities across GM
"I" Statement: *"I will live a long and active life in Greater Manchester no matter my gender, social class, ethnicity or ability"*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Increase participation in physical activity within the underrepresented groups.	Physical Activity is a central feature (re-engineered) in policy and practice related to planning, transport, health and social care, economic development, education, and the environment.	☐	☐	☐	Presence of Physical Activity plans within the named fields of planning, transport, health and social care, economic development, education, and the environment
	Each area in GM will adopt a Making Every Contact Count approach: all frontline staff are able to talk about the risks associated with being inactive.	☐	☐	☐	% of GM meeting 30-149 and 150 minutes per week of moderate level physical activity broken down by underrepresented groups: (Gender / Social class / Ethnicity / Disability)
	All commissioners and providers focus on reducing inactivity where significant inequalities exist.	☐	☐	☐	

STRATEGIC OUTCOME: Start Well - Give every GM child the best start in life

"I" Statement: *"I will ensure that every GM child will have the best active start in life and will develop their life chances through a more active lifestyle"*

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
Young people aged 0-4 will be physically active	Every parent will be supported to understand and embrace the recommended levels of activity for their babies and children, supporting physical literacy and good health	☐	☐	☐	% of children in early years meeting CMO recommended levels of activity
	Every early year's settings will embed physical literacy as part of their approach to learning, wellbeing and school readiness.	☐	☐	☐	% of Early Year Settings with physical literacy frameworks
					% Number of Schools meeting Ofsted guidelines
Children and young people aged 5 - 25 have enhanced life chances through an active lifestyle.	Every school, college and university will support and enable children and young people to meet 60 minutes per day of physical activity.	☐	☐	☐	% of schools completing the daily mile % of children meeting 60 minutes per day of physical activity
	Every community will offer a range of high quality spaces and opportunities for young people to live active lives, supported by welcoming leaders and suited to different motivations, attitudes and interests.	☐	☐	☐	% of adults meeting - and 150 minutes per week of moderate level physical activity.

STRATEGIC OUTCOME: Live Well – Ensure every GM resident is able to fulfil their potential **"I" Statement:** *"I will maintain an active lifestyle and will have good and equitable access to information, support and services"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Increased physical activity across the adult population.	Every employer will support and enable their employees to meet 150 minutes per week of physical activity	☐	☐	☐	% of adults meeting 30-149 and 150 minutes per week of moderate level physical activity. % of adults inactive % of workplaces completing the daily mile. Number of providers who are industry
	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.	☐	☐	☐	
	Every provider, health professional and influencer in the lives of adults will understand, advocate for, and support the role of activity in healthy, happy, successful lives.	☐	☐	☐	

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 able to be active and independent for as long as possible "*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
More older adults live active lives leading to better health, wellbeing, socialisation and independence	Physical activity will be embedded in to age friendly community work, creating a range of high quality spaces and opportunities for people to live active lives.	☐	☐	☐	% of adults meeting 30-149 and 150 minutes per week of moderate level physical activity
	Every provider, health professional and influencer in the lives of older adults will understand and advocate for the role of activity while using person centred conversations	☐	☐	☐	

STRATEGIC OUTCOME: Enabling resilient and thriving communities and neighbourhoods **"I" Statement:** *"I will live, work and be active in a strong and thriving community and neighbourhood"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
All planning, design and layout of urban and rural places and spaces across GM will inspire, encourage and support active lives	Every Local Plan, Planning decision, residential and commercial development will meet GM Active Design standards	☐	☐	☐	KPI's from GM Spatial Framework
	Every infrastructure development will meet the standards for walking and cycling/active travel identified in 'Made to Move'.				
	Community, leisure and activity spaces will be high quality, with a broad offer to appeal to a wide range of needs and demands, meeting required standards of to encourage engagement and reduce inequalities.	☐	☐	☐	Implementation of the boroughs playing pitch and indoor facility strategies

6. Greater Manchester Common Standards – Physical Activity

GM Common Standards for Physical Activity have been co-designed by the following GM groups using NICE Guidance; National Strategy; GM Strategy:

- GM Physical Activity Commissioners Group (represented by all ten localities)
- GM Sports Managers Network (represented by all ten localities)
- GM Active (represented by all thirteen Leisure Trusts)
- GM Active Aging
- Director of Public Health - Oldham
- Planning & Health Group
- GM Walking and Cycling Commissioner
- GM Early Years

Guidance	Link
GM Moving	http://www.greatersport.co.uk/_media/uploads/5247c0d2-54a5-47f4-b166-1e20f2cbaaff.pdf
Sport England Strategy - Towards an Active Nation	https://www.sportengland.org/active-nation/our-strategy/
DCMS Strategy - Sporting Future: A New Strategy for an Active Nation	https://www.gov.uk/government/publications/sporting-future-a-new-strategy-for-an-active-nation
GreaterSport - Changing Our Lives Together	http://www.greatersport.co.uk/about-us/our-strategy
PHE - Everybody Active Everyday	https://www.gov.uk/government/publications/everybody-active-every-day-a-framework-to-embed-physical-activity-into-daily-life
NICE - Physical Activity Guidelines	https://pathways.nice.org.uk/pathways/physical-activity
Active Lives Survey	https://www.sportengland.org/research/active-lives-survey/
Made to Move	https://www.greatermanchester-ca.gov.uk/downloads/download/131/walking_and_cycling_report

7. Greater Manchester Common Standards – Health Protection

Outcome measures affected in GM Population Health Outcomes Framework:

- **MMR vaccination rate**

Health protection seeks to prevent or reduce the health impact from infectious diseases and environmental hazards such as chemicals and radiation. This is achieved through altering the environment to reduce spread or exposure; the design and provision of health services to prevent, detect and treat infectious diseases; surveillance of health effects and effective response to incidents and outbreaks. Health protection therefore covers follow up of individual cases; outbreak management; surveillance; emergency planning, resilience and response; infection prevention and control; environmental public health; and immunisation.

There is an opportunity to set and raise common standards through taking a GM system wide view of arrangements to identify and share best practice as well as opportunities for more efficient and effective ways of working. These are a set of core common standards for health protection, infection prevention control and EPRR for the developing ICOs / LCOs to create a culture of continuous improvement.

We will work with the LCO Network to ensure common standards are embedded within evolving accountable care systems for reducing long term risk, business as usual and for responding to emergencies within our localities. We want our communities to be empowered and enabled to take action individually or collectively to manage risks and prepare for the consequences of emergencies. In addition to the activity undertaken by the wider public health workforce, there are many individuals and volunteers in our communities that represent a huge resource for peer group health advice, support and community liaison.

Health protection issues and indicators are included in other common standards including sexual health and drugs and alcohol services. These are not duplicated by inclusion here. These standards do not include screenings or civil contingency arrangements outside public health.

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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Minimise the harm caused by outbreaks and incidents	A written protocol / plan is in place for the management and governance of local outbreaks and incidents	☐	☐	☐	Sector Led Improvement review / PHE national stocktake
	Roles and responsibilities of all organisations in outbreaks and public health incidents are clearly defined, agreed and documented	☐	☐	☐	
	Incident Management Team structure and responsibilities are defined	☐	☐	☐	
	Responsibilities for commissioning and paying for interventions in outbreaks and public health incidents are agreed and documented	☐	☐	☐	
	Process for capturing and embedding learning from outbreaks and public health incidents is in place	☐	☐	☐	
	Activation and escalation processes are documented for outbreaks and public health incidents	☐	☐	☐	
	Arrangements are in place to collect samples (swabbing, blood and stool samples etc) if required in outbreaks and public health incidents	☐	☐	☐	
	Arrangements are in place for environmental monitoring and sampling (food, water, premises etc) in outbreaks and public health incidents	☐	☐	☐	

	Arrangements are in place for the delivery of clinical interventions (antivirals, antibiotics, vaccines) in outbreaks and public health incidents	☐	☐	☐	

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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Minimise the harm caused by outbreaks and incidents	IPC service in place for primary care, social care and other settings (including: tattoo parlours, nurseries, hospices, domiciliary care, prisons, dental, private enterprises and any care provider outside hospital) in line with NICE Quality Standard 61, IPS quality assurance audit and RCN IPC commissioning toolkit	☐	☐	☐	Rate of health care associated Gram Negative Blood Stream Infections (Fingertips) MRSA C. difficile
	Locality plan is in place and being implemented across the health and social care economy to tackle Gram Negative Blood Stream Infections in line with NHS Improvement resource	☐	☐	☐	Rate of health care associated Gram Negative Blood Stream Infections
	Health and Social Care providers comply with the code of practice on the prevention and control of infections and related guidance	☐	☐	☐	Routine audits of social care providers
	Providers contribute to relevant surveillance systems to allow early detection of outbreaks	☐	☐	☐	
Reduce harms and longer term risks from	Antimicrobial Stewardship arrangements and initiatives are implemented to reduce inappropriate antibiotic prescribing in line with NICE QS121 on Antimicrobial				sepsis CQUIN indicators

Antimicrobial resistance	stewardship and GMMMG strategy	☐	☐	☐	Total number of prescribed antibiotic items per STAR-PU by Clinical Commissioning Group (CCG); proportion of trimethoprim class prescribed antibiotic items as a ratio of trimethoprim to nitrofurantoin

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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Children are protected against key diseases by immunisation	Arrangements are in place enable providers of vaccination to call and recall for immunisations as recommended in the national schedules, to achieve the national ambition for each programme and when appropriate inform the local CHIS department.	☐	☐	☐	MMR vaccination rate (2 doses at age 5) (COVER) Seasonal influenza vaccine uptake in children of primary school age Pertussis vaccine uptake in pregnant women
	Babies born to Hepatitis B positive mothers receive a full course of Hep B vaccine and testing at 12 months.	☐	☐	☐	Rates of timely completion of HBV vaccination in high risk babies: COVER. Rates of HBV testing in high risk infants at 12 months
Spread of common infections amongst children is reduced through hand and respiratory hygiene	Promotion of hand and respiratory hygiene in early years settings and schools	☐	☐	☐	Local audit
	Provision of hand hygiene facilities in a range of setting including schools and childcare facilities	☐	☐	☐	

STRATEGIC OUTCOME: Live Well – Ensure every GM resident is enabled to fulfil their potential **"I" Statement:** *"I will make maintain good health and wellbeing and will have good and equitable access to information, support and services"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Adults in risk groups are protected against key infectious diseases by immunisation	Reduce respiratory disease by ensuring high rates of protection in the most at-risk groups through the influenza and pneumococcal vaccination programmes	☐	☐	☐	Flu vaccination rate in clinical risk groups Pneumococcal vaccination rate in clinical risk groups Flu immunisation for pregnant women
Transmission of Hepatitis B and Hepatitis C within GM is minimised	Prevent new HBV and HCV infections through ensuring adequate coverage of needle and syringe provision in communities to reduce the risk of sharing injecting equipment (and alternative measures in prisons)	☐	☐	☐	NICE PH52 coverage estimates
	Prevent new HBV and HCV infections by achieving high rates of HBV vaccination coverage in all high-risk groups	☐	☐	☐	Persons entering substance misuse treatment - Percentage of eligible persons completing a course of hepatitis B vaccination: National Drug Treatment Monitoring System
	Increase testing for HBV and HCV in primary care and secondary care for all patients within higher risk groups for infection, including those from intermediate and high-risk countries (NICE PH43).	☐	☐	☐	Number of HBV and HCV tests (and proportion testing positive) in key laboratories
	Clinical pathways in place for HBV and HCV from testing to treatment completion with appropriate data collection to enable quality improvement	☐	☐	☐	Offer and uptake of HCV testing in adults currently or previously injecting - both newly presenting to, and all in, drug treatment: National Drug Treatment Monitoring System.

STRATEGIC OUTCOME: Live Well – Ensure every GM resident is enabled to fulfil their potential (continued) **"I" Statement:** *"I will make maintain good health and wellbeing and will have good and equitable access to information, support and services"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Reduce transmission of TB, including drug resistant TB	GM commissioners and providers work to TB service specification developed by Greater Manchester TB collaborative group and in line with NICE guidelines	☐	☐	☐	TB incidence (three-year average) https://fingertips.phe.org.uk/profile/tb-monitoring
	Participation in TB quality initiatives including cohort review	☐	☐	☐	Cohort Review
	Arrangements in place to support TB patients with social risk factors during diagnosis and treatment including those who are homeless and those with no recourse to public funds	☐	☐	☐	Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months (Fingertips)
	Age appropriate BCG provision to risk groups aged up to 16	☐	☐	☐	Service implemented and rate of uptake

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 able to be safe and independent for as long as possible"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
Older adults are protected against key infectious diseases through vaccination	Reduce preventable illness by ensuring high rates of protection through the vaccination programme	☐	☐	☐	**Flu vaccination rate in over 65s**
	Implementation of recommendations in the Greater Manchester Age Friendly Strategy	☐	☐	☐	Shingles vaccine uptake rate in the eligible cohort
					Pneumococcal vaccination rate (those aged 65 years and over)

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	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
People in GM live and work in areas with good air quality	Health is included as key consideration in local plans to reduce exposure to air pollution in line with NICE Guideline NG70	☐	☐	☐	Modelled estimates of population-weighted annual average $PM_{2.5}$ concentrations

7. Greater Manchester Common Standards – Health Protection

GM Common Standards for Health Protection have been co-designed by the following GM groups using NICE Guidance; National Strategy; Greater Manchester Strategy:

- GM Health Protection Confederation
- GM Infection Prevention Control Collaborative
- GM Civil Contingencies Resilience Unit
- GM HSCP Screening and Immunisation Team

In addition to the above GM groups the GM Common Standards were reviewed at a GM Workshop on 16th March 2018 which included representation from a range of groups: LA Public Health, GM Local Care Organisation Network, GM Public Protection Group, Environmental Health, Civil Contingencies Resilience Unit, GMHSCP Screening and Imms Team, GMCA, Emergency Planning and Acute Providers.

Guidance	Link
NICE Quality Standard 61 Infection prevention and control	https://www.nice.org.uk/guidance/qs61/
NICE Quality Standard 121 on antimicrobial stewardship	https://www.nice.org.uk/guidance/qs121/
NICE Guidelines 33 and Quality Standards 141 on Tuberculosis	https://www.nice.org.uk/guidance/qs141
IPS Quality Assurance Tools	https://www.ips.uk.net/professional-practice/quality-improvement-tools1/
RCN Infection Prevention and Control Commissioning Toolkit	https://www.rcn.org.uk/professional-development/publications/pub-005375
Provision of Public Toilets	https://publications.parliament.uk/pa/cm200708/cmselect/cmcomloc/636/636.pdf
NICE Guidelines PH43 - Hepatitis B and C testing: people at risk of infection	https://www.nice.org.uk/guidance/ph43
NICE Guidelines CG165- Hepatitis B - (chronic): diagnosis and management	https://www.nice.org.uk/guidance/cg165
Nice Quality Standard QS65 - Hepatitis B	https://www.nice.org.uk/guidance/qs65

Guidance	Link
The Health and Social Care Act 2008- Code of Practice on the prevention and control of infections and related guidance	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf
Preventing healthcare associated Gram-negative bacterial bloodstream infections	https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/
NHS Improvement GNBSI Resource	https://www.nice.org.uk/guidance/ng70/
NICE Guideline 70 Air pollution: outdoor air quality and health	https://www.nice.org.uk/guidance/ph52/

7. Greater Manchester Common Standards – Health Protection

NICE Public health guideline [PH52] Needle and syringe programmes	https://www.nice.org.uk/guidance/qs61/

8. Greater Manchester Common Standards – Tobacco Control

Outcome measures affected in GM Population Health Outcomes Framework:

- **Smoking prevalence in adults - current smokers (APS)**
- **Smoking prevalence in adults in routine and manual occupations - current smokers**

2017 saw the launch of the government's new tobacco control strategy for England, Towards a Smokefree Generation which articulates our 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 an environmental 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

STRATEGIC OUTCOME: Improving the Health of the GM Population and Reducing Health Inequalities across GM
"I" Statement: ***"I will be increasingly unlikely to be affected by tobacco related health disease as a GM resident"***

STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential "I" Statement: *"All smokers in GM are given the help they need to quit"*					
OUTCOME	COMMON STANDARD	1	2	3	
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.

STRATEGIC OUTCOME: Start Well - Give every GM child the best start in life "I" Statement: *"I will ensure that babies, children and young people are protected from the harm caused by tobacco from conception through to adulthood"*					
OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
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 (GM Maternity Dashboard)
	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	☐	☐	☐	Smoke free outdoor spaces for children Smoke free homes programme in place

STRATEGIC OUTCOME: Live Well - Ensure every GM resident is enabled to fulfil their potential					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
All smokers in GM understand the risks of smoking and tobacco related harm and tobacco addiction	Each area in GM will adopt a Making Every Contact Count approach: all health and social care staff are able to talk about tobacco addiction and the risks associated with smoking. (NB. suggest front line NHS staff, Housing Officers, Social Care Professionals).	☐	☐	☐	Numbers of staff trained per year to understand tobacco addiction (type of training to be determined locally) Numbers of health and social care 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 that do not contain tobacco).	☐	☐	☐	Evidence of communication and advice on pharmacotherapy and nicotine inhaling products that do not contain tobacco Local plan for the provision of pharmacotherapy to support people to quit % of smokers helped to quit through local tobacco addiction services.
Tobacco Control measures (including tobacco addiction 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 and uptake of services Adult smoking prevalence rates Evidence of quit support for people in the areas and groups with the highest prevalence of smoking
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. All inpatients and outpatients receive appropriate advice and support to quit.	☐	☐	☐	An appropriate service model such as the “CURE” programme is in place across secondary care settings

"I" Statement: *"All smokers in GM are given the help they need to quit"*					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
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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 that do not contain tobacco).	☐	☐	☐	Evidence of communication and advice on pharmacotherapy and nicotine inhaling products that do not contain tobacco Local plan for the provision of pharmacotherapy to support people to quit % of smokers helped to quit through local tobacco addiction services.
Tobacco Control measures (including tobacco addiction 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 and uptake of services Adult smoking prevalence rates Evidence of quit support for people in the areas and groups with the highest prevalence of smoking
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. All inpatients and outpatients receive appropriate advice and support to quit.	☐	☐	☐	An appropriate service model such as the "CURE" programme is in place across secondary care settings

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 supported to give up smoking to improve my quality of life and smoking related disease at any age.”					
OUTCOME	**COMMON STANDARD**	**SCORE**			**METHOD OF MEASURING IMPACT**
		1	**2**	**3**	
All smokers in GM, who receive a Safe and Well visit from Greater Manchester Fire and Rescue Service (GMFRS), understand how to access support to quit or to have a smoke-free home	GMFRS will provide smokers with Very Brief Advice and offer a referral or signpost to Stop Smoking Services (or other support) during Safe and Well visits.	☐	☐	☐	Number of GMFRS staff Trained per year (GMFRS electronic training input ‘Smoking Related Fires and Tobacco Control – includes VBA)
					Referral rates from GMFRS to partners
					Delivery of Very Brief Advice (recorded on Safe and Well visit records)

OUTCOME	COMMON STANDARD	SCORE			METHOD OF MEASURING IMPACT
		1	2	3	
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
					Numbers of staff trained per year by GMFRS
access to fire safety advice and interventions to reduce their risk of fire.	GMFRS for a Safe and Well visit				smokers Numbers of smoking-related accidental dwelling fires, injuries and deaths recorded by GMFRS
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 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

Guidance	Link

8. Greater Manchester Common Standards – Tobacco Control

GM Common Standards for Health Protection have been co-designed by Tobacco Control Leads for each of the 10 GM localities using NICE Guidance; National Strategy; GM Strategy:

- GM Fire and Rescue Service
- GM Health and Social Care Partnership (Tobacco Programme)
- Age Friendly Manchester and Greater Manchester
- CURE Programme Lead
- Christie Hospital
- Cancer Research UK

	https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-
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

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Report to HEALTH AND WELLBEING BOARD

Suicide Prevention in Oldham

Portfolio Holder:
Councillor Zahid Chauhan: Cabinet Member for Health and Social Care

Officer Contact: Dr. Keith Jeffery, Clinical Director for Mental Health

Report Author: Vicki Gould, Public Health Programme Manager
Ext. 1951

25th June 2019

Purpose of the Report

For the Board to consider Oldham's Suicide Prevention Plan and the future governance arrangements for the Oldham Suicide Prevention Group.

Recommendations/Requirement from the Health and Wellbeing Board

The Suicide Prevention Partnership recommends that the governance for the delivery of the Oldham Strategy for Suicide Prevention 2017-20 be formally taken on by the Health and Wellbeing Board.

Suicide Prevention in Oldham

1. Background

1.1. Suicide is a significant cause of death in young adults and is seen as an indicator of underlying rates of mental ill-health in a local area. Nationally, suicide rates have been on the rise since 2015.

1.2. In Oldham during the period 2013-17 the suicide rate per 100,000 population was as follows:

- 10-34 years of age: 13.6 per 100000 against an England average of 10.5
- 35-64 years of age: 17.2 per 100000 against an England average of 20.1
- 65+ years of age: 11.1 per 100000 against an England average of 12.4

1.3. Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

1.4. Since 2012, Local Authorities have been involved in suicide prevention work. Following the publication of the 2012 national strategy, LAs were given the responsibility of developing local suicide action plans through their work with their Health and Wellbeing Boards. A deadline of 2017 was set by the Government by which the local action plan was to be agreed.

1.5. Oldham, in line with the picture nationally, has also formed a multi-agency suicide prevention partnership, incorporating public health, the clinical commissioning group, social care, primary and secondary care, the voluntary sector, criminal justice system and those affected by suicide.

1.6. On an ongoing basis, data on the local picture in Oldham is received by the group – this may be anecdotal information and come from a number of sources, including the media. Or it may be gathered from coroners' reports. In addition, service level data from, health, social care and community agencies (both specialist mental health and others) has provided vital information about any patterns, trends, geographic hotspots and risk factors.

1.7. Oldham's Suicide Prevention Strategy and action plan (2017-2020) has been in place since 2017 and is currently owned and reviewed by the partnership group.

1.8. As part of the Oldham Locality Plan for Health & Social Care Transformation 2016-2021 mental is recognised as being central to good health. The plan highlights its commitment to addressing mental health in Oldham, which includes promoting good mental wellbeing, tackling stigma, preventing poor mental health and actions to promote recovery.

2. Current Position

Oldham Context

2.1 The Chair of the local Suicide Prevention group in Oldham is currently with the CCG and Dr Jeffery. This is a new and interim arrangement following the Public Health Consultant leaving the authority and the vacancy in the public health team as a result. The work is still being supported and managed through the public health team. This approach is uncommon across the country, where nationally either the local authority safeguarding lead or public health team chair and manage the group. There are local benefits to this arrangement as Dr Jeffery is also the Chair of the Mental Health Partnership Board.

2.2 Following the passing of the Chair from Safeguarding in the LA to public health in mid-2018, a decision was made to revisit the local action plan. The plan didn't take into account the Greater Manchester focus and priority areas as well as being made up of largely completed actions. A workshop to address this was held in January 2019. Attendees included the members of the local multi-agency group (including the Clinical Director for Mental Health at the CCG) as well as colleagues who are leading on the Greater Manchester Strategy. Discussions focussed on the elements included in the action plan; how the action plan is managed; membership; structure of the meetings.

2.3 Following the workshop, a range of proposed changes were put forward including:

- Changing the structure of the group to a Suicide Prevention Partnership which will have wider membership and meet 6-monthly; and a smaller Implementation Group which will meet more regularly and aim to deliver the action plan.
- Reviewing the membership to include more people in the partnership and a more focussed group in the implementation group
- Rewrite of the action plan to include new areas (leadership & governance; high risk groups including bereavement/depression/self-harm/acute MH patients; training; and data monitoring) and to ensure better delivery (having named leads for actions and timescales for delivery). It was also suggested that the action plan reflect the Greater Manchester priorities where they were also known issues in Oldham. It was felt by the group that although an exact mirror of the plan wasn't needed there were areas in the GM strategy that as intelligence has changed over the years, should also be in the Oldham plan.

2.4 The workshop also addressed the issue of governance and to who and how the newly formed Suicide Prevention Partnership was going to be accountable. It was agreed to seek steer on this from both the Mental Health Strategic Partnership as well as the Health and Wellbeing Board.

Greater Manchester Context

2.5 Following the formation of the Greater Manchester Health and Social Care partnership in 2016, Mental Health and Suicide Prevention has been a key area of focus.

2.6 In September 2018, with the lead from the Mayor of Greater Manchester and on World Suicide Prevention Day, the re-fresh to the GM Strategy was launched. The

Mayor attended this event and talked about the new national (and increased) focus on suicide prevention politically, with the appointment of the first Suicide Prevention Minister. Mayor Burnham went on to talk about the challenges faced in Greater Manchester and the investment from the H&SC Partnership into mental health services across the region to support the ambition of a significant reduction in the suicide rate in Greater Manchester. The new strategy also focused for the first time on self-harm and further expanded the known high-risk groups of people.

2.6 In late 2018 the Greater Manchester Suicide Prevention Executive appointed their first full time, dedicated Suicide Prevention Programme Manager for the region.

3. Data and Intelligence

3.1. The following information is taken from Oldham's JSNA;
Ensuring the population of Oldham experiences good mental health continues to be an important public health priority for a range of reasons. Good mental health is important for ensuring the development and maintenance of family relationships and friendships, our education, training and ability to fulfil our potential in employment. It is also important for ensuring good physical health and as it impacts on all aspects of people's lives it is the responsibility of not only the individual, but also families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health.

3.2. The JSNA goes on to reference the data that is available on the Public Health England, Fingertips website for details of the local prevalence rate of suicides on Oldham.

3.3. The data from Fingertips, along with the Coronial information received by the Public Health team post inquest, make up the local intelligence picture.

4. Key Issues for Health and Wellbeing Board to Discuss

5.1 Health and Wellbeing Board are requested to note the report, current strategy 2017-20 and recent recommendations for structural changes to the local partnership, discuss and provide appropriate challenge where required.

5. Key Questions for Health and Wellbeing Board to Consider

5.1. The key question for the Board to consider is; does the Health and Wellbeing Board support the governance arrangements for Oldham's Suicide Prevention Strategy 2017-20 as they are proposed in this paper?

5.2. Pending the decision made about future governance arrangements, a further update could be received by the Health and Wellbeing Board in the autumn of 2019.

6. Appendices

6.1. Appendix 1 - Oldham's Suicide Prevention Strategy 2017-2020.
Appendix 2 - The Greater Manchester Suicide Prevention Strategy

Oldham Council Suicide Prevention Strategy and Action Plan 2017-2020

Author	Contributors
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Foreword

The number of deaths to suicide in Oldham is significant, with seventeen deaths occurring in 2016. This is seventeen too many. The majority of suicides occur in men, with increased risk seen in those within the lowest socioeconomic groups and living in the most deprived geographical areas. Other at risk groups include those who self-harm, children and young people and those with untreated depression. Individuals who have been bereaved by suicide, those who are isolated, and those with a history of drug and alcohol misuse are also at increased risk.

This strategy builds on Oldham Council's work to date and sets out a bold and ambitious five year plan for reducing and ultimately eliminating suicides in Oldham. To do this will require a co-ordinated effort with our partners to ensure that suicide prevention becomes everyone's business.

Many of our partners and third party mental health providers have been involved in the development and creation of Oldham's Suicide Prevention Strategy and Action Plan.

We have taken guidance from the National Suicide Prevention Strategy 2012, the Five Year Forward View for Mental Health, the recently published PHE resource for local Suicide Prevention Planning 2016 and the Greater Manchester Suicide Prevention Strategy 2017-2021. In doing so we have developed a plan for action which fits with both the national and GM guidance.

Alan Higgins

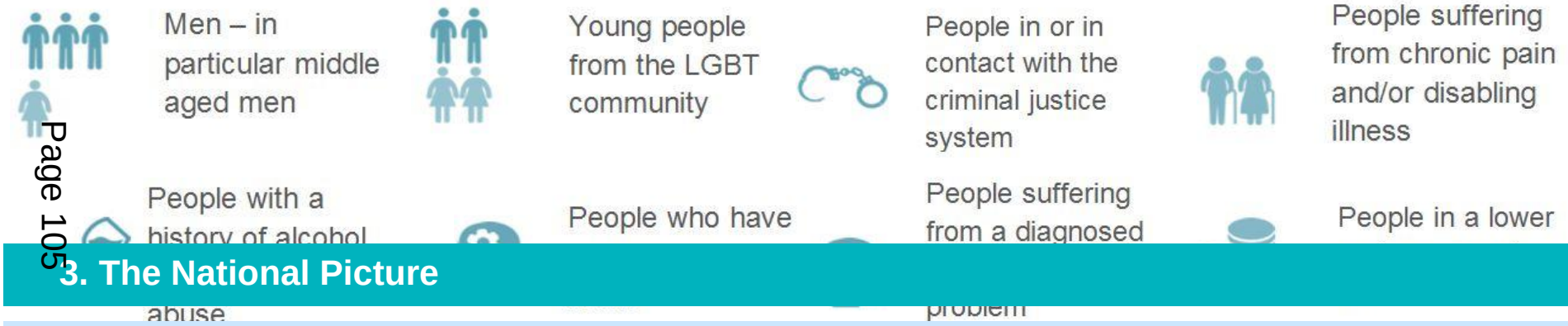
1. Introduction

Every suicide is an individual tragedy and a loss to society, with suicide being one of the top twenty leading causes of death worldwide. More than one million deaths per year are attributed to suicide globally (ONS 2016), with more than 6,000 people across the United Kingdom and Republic of Ireland alone becoming victims of suicide each year. Approximately 75% of all deaths by suicide are committed by men.

It is estimated that 60 people are significantly and negatively impacted for each suicide, including family and friends, work colleagues, health professionals, and police. Those that are bereaved and affected by suicide are in turn at a heightened risk of experiencing suicidal thoughts and ideation themselves.

In addition to the significant emotional cost, the financial cost of a death by suicide is considerable. It is estimated that the cost of a completed suicide is £1.67 million, or alternatively put, costs of £66,797 may be averted for every year of life as a result of each individual suicide.

2. Who is at risk?



3. The National Picture

3.1 In 2012, the government published a new national strategy: *Preventing Suicide in England.* This encompasses six key areas for action;

1) Reduce the risk of suicide in key high-risk groups
2) Tailor approaches to improve mental health in specific groups
3) Reduce access to the means of suicide
4) Provide better information and support to those bereaved or affected by suicide
5) Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6) Support research, data collection and monitoring

3.2 Additionally, the responsibility of local authorities to develop their own suicide prevention strategies was identified in this document. The National Strategy recommended that local authorities should aim to tackle all six areas of the national strategy in the long term, with recommended priorities for short term action below;

1) Reducing risk in men, especially in middle age, with a focus on: economic factors such as debt, social isolation, drugs and alcohol, developing treatment and support setting that men are prepared to use.
2) Preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychological assessment for self-harm patients.

4. The Greater Manchester Picture

4.1 The total population of Greater Manchester is approximately 2.8million people and in 2015 there were 201 deaths by suicide in Greater Manchester. The greatest numbers were seen in Wigan, with the lowest in Trafford.

Figure 1: Numbers of suicides by Borough (2015)

	Total	Male	Female
Bolton	20	17	<5
Bury	14	12	<5
Manchester	36	30	<5
Oldham	12	10	<5
Rochdale	15	14	<5
Salford	23	18	5
Stockport	14	8	6
Tameside	18	17	<5
Trafford	9	9	0
Wigan	40	32	8

4.4 The recent Greater Manchester Suicide Audit completed in 2016 identified a number of key trends

Social Isolation; lack of relationships and friendship groups

Physical health issues – injuries, chronic illnesses, severe illnesses

Contact with Police

Job loss and financial issues

Occupation; especially the construction industry

Bereavement; in particular for those bereaved by suicide

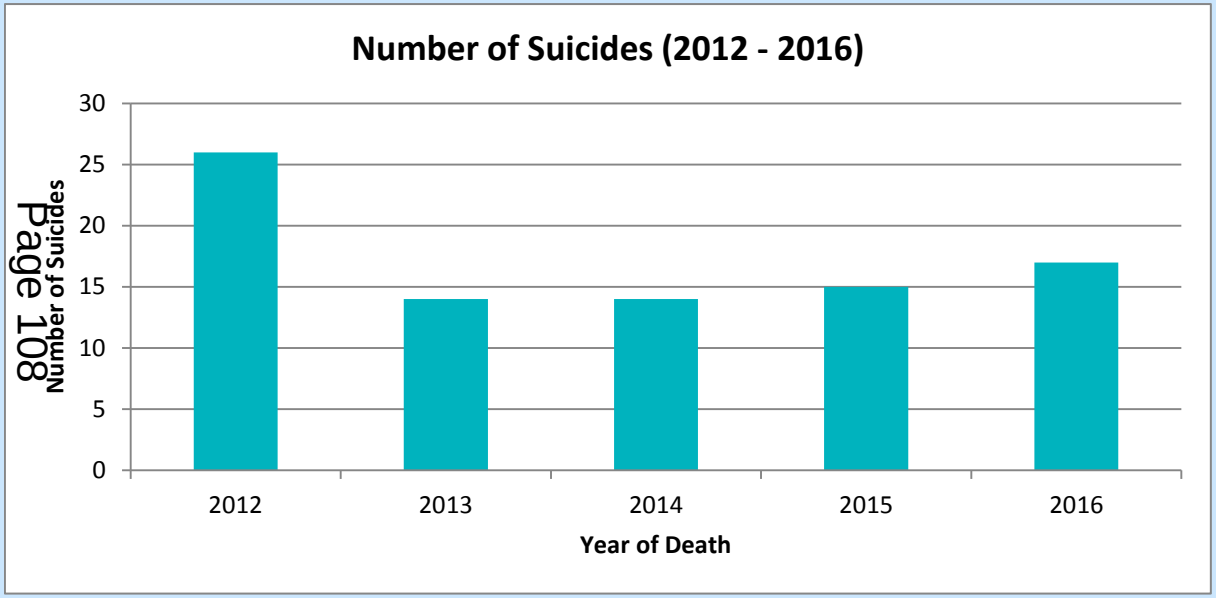
Relationship breakdown; in particular for men

Internet; to access information on methods

5. Oldham Suicide Audit

5.1 Suicide by number

Figure 1: Number of Residential Suicides 2012-2016

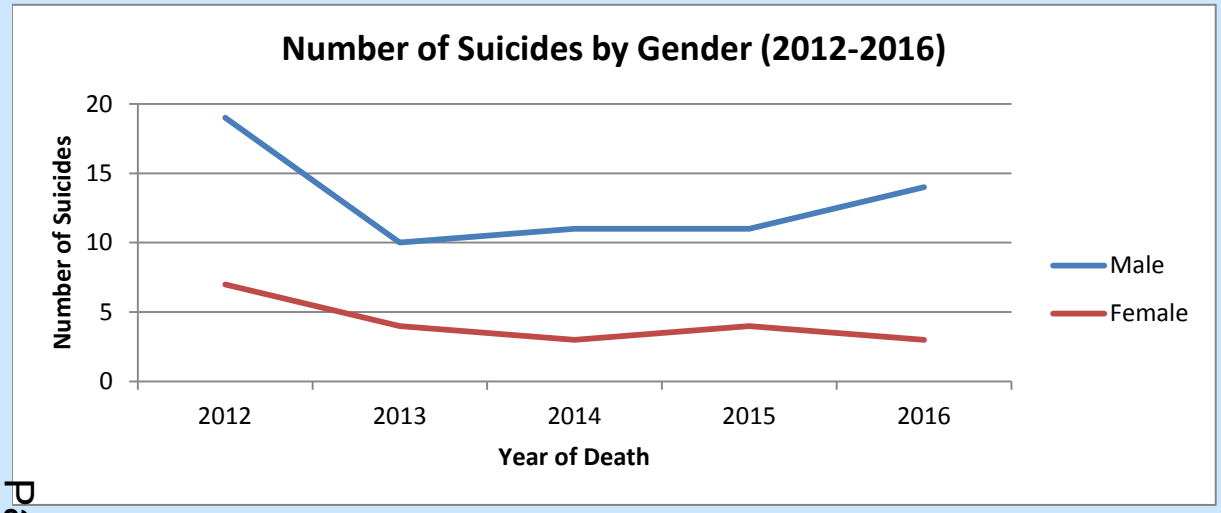


Source: PCMD 2012-2016

5.1.1 The table above shows us that there has been an overall decrease in suicide in Oldham from 2012 to 2016. The previous audit identified 161 verdicts of suicide between 2004 and 2011. There were 86 verdicts of suicide between 2012 - 2016. The above chart illustrates that suicides have decreased since 2012, however a slight increase is beginning to emerge from 2015 and suicide remains an area of concern for Oldham.

5.2 Suicide by gender

Figure 2: Number of Residential Suicides by Gender 2012-2016

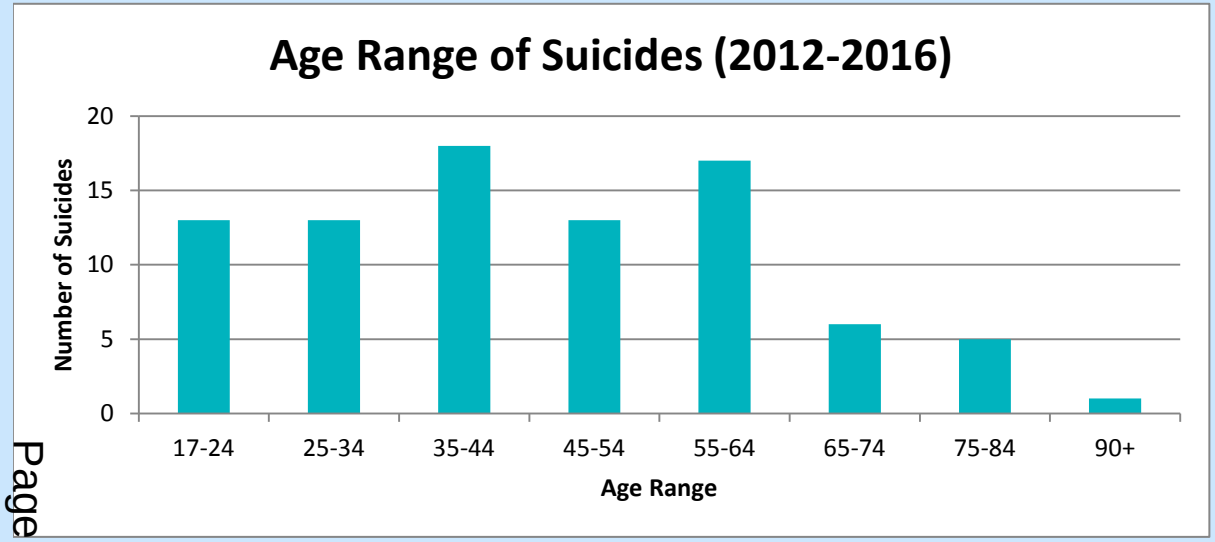


Source: PCMD 2012-2016

2.1 Rates of suicide are higher in males (76%) than females (24%) in Oldham, and this is representative of both the national picture and Greater Manchester. While both male and female suicides dropped in 2013, male suicide has begun to rise as of 2015, whereas female suicide has remained constant in its lower precedence.

5.3 Suicide by Age

Figure 3: Age range of Residential Suicides 2012-2016



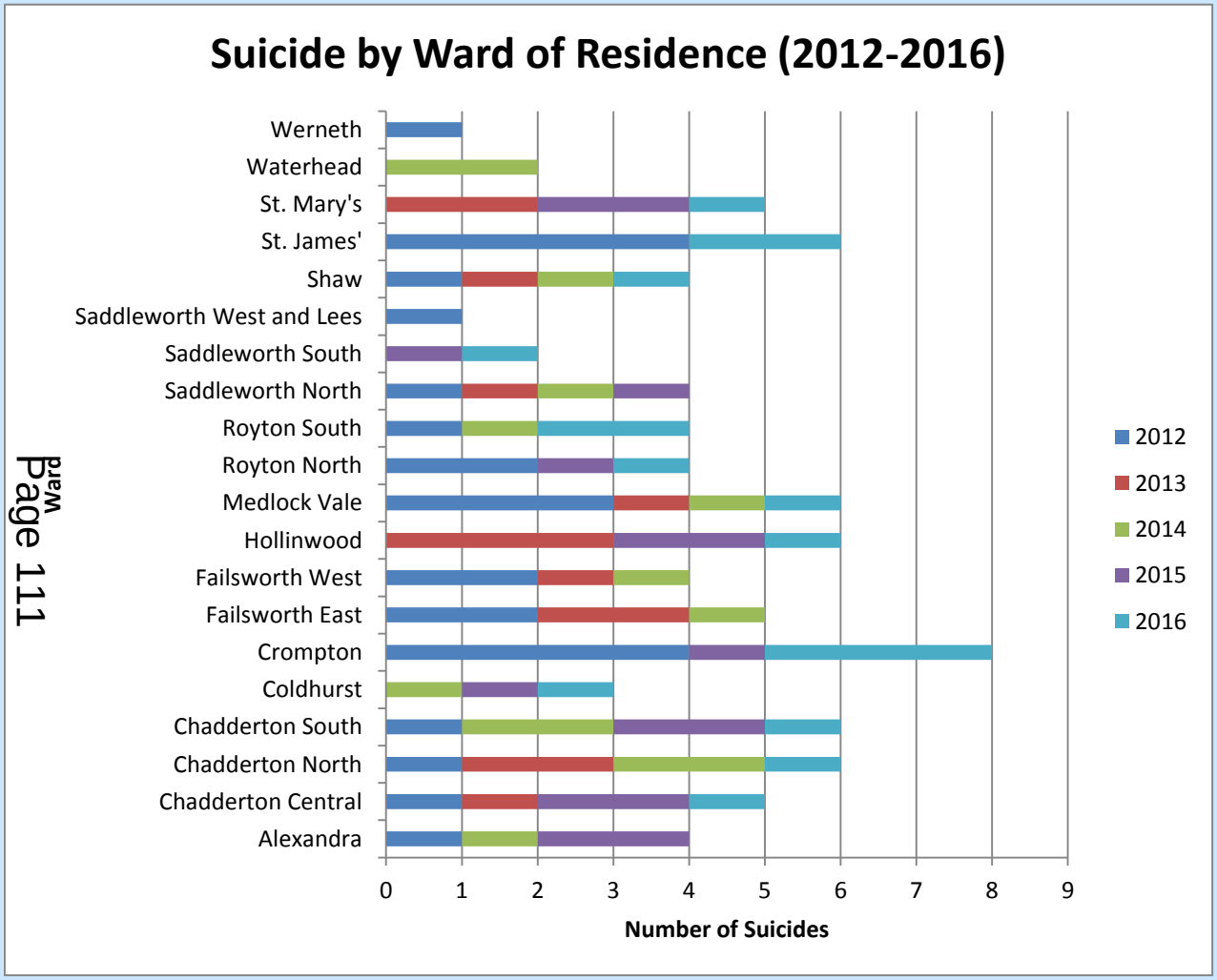
Source: PCMD 2012-2016

5.3.1 Suicides affect all age groups but for Oldham the highest proportion of residential suicides are in the age group 35 to 44 years, similar to the national average. There are also a high number of suicides in the age group 55 to 64 years compared to the national average, where nationally rates decline after the age of 50. For Oldham, the decline in suicides is after the age of 64 years.

5.3.2 Another area for concern is the relatively high rate of suicide amongst young people in Oldham (17-34 years), with a rate of 21.1 suicides per 100,000 people. Rates of suicide among younger people are higher in Oldham both compared to the national average and amongst our neighbours in Greater Manchester – Oldham has the second highest rate of suicide in the 10-34 years age group in Greater Manchester.

5.4 Suicide by Oldham District Area

Figure 4: Suicide by Ward of Residence 2012-2016



Source: PCMD 2012-2016

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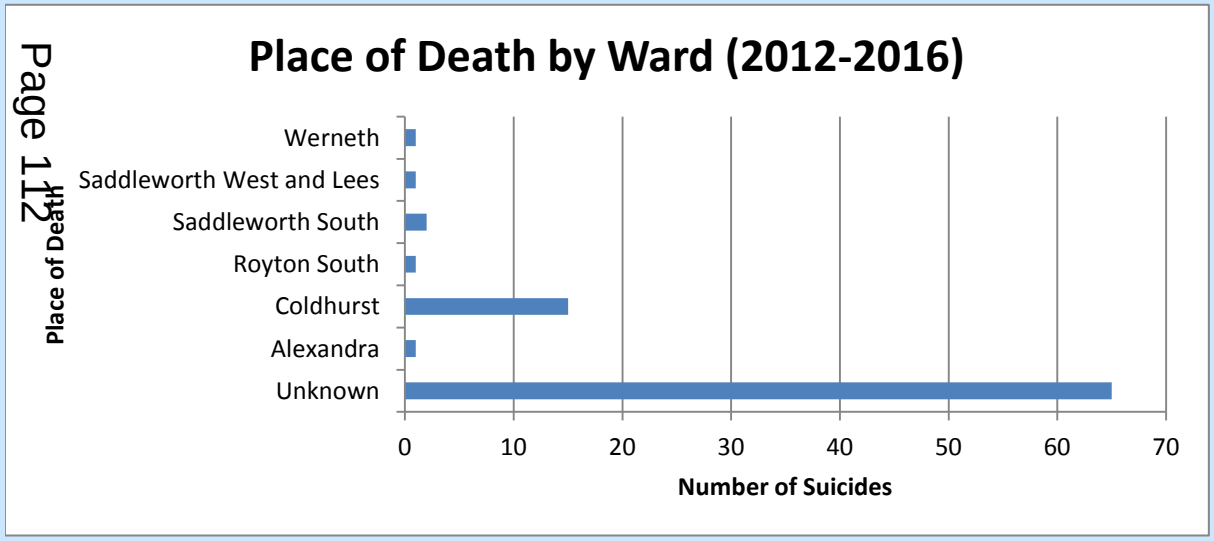
5.4.1 Suicide is generally higher in more deprived areas and on average the wards of Crompton, Chadderton North and South, and Hollywood, Medlock Vale, St James's and St Mary's have higher than average suicide rates and historically have been higher than the more affluent areas of Oldham.

5.4.2 Locally suicide rates vary significantly across the borough. However a trend has begun to emerge with more affluent areas of Oldham's suicide rates beginning to increase from 2012.

5.5 Suicide by Place of Death

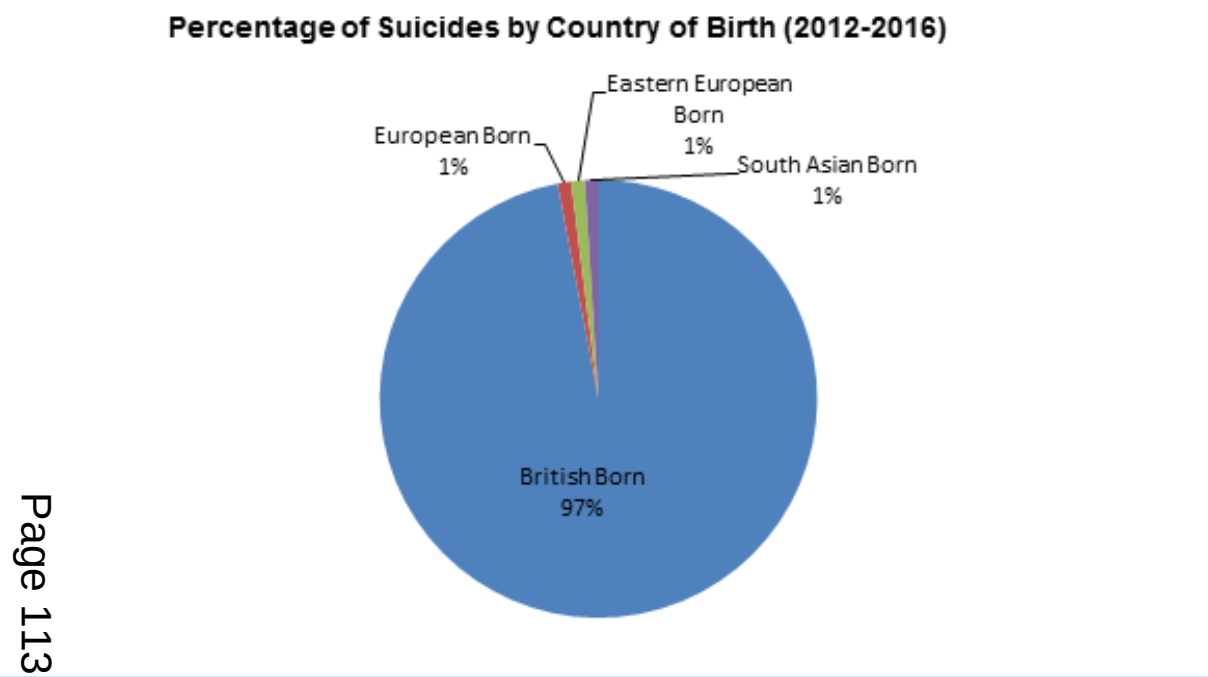
Figure 5: Suicide by place of Death 2012-2016



5.5.1 The ward in which the most suicides took place is Coldhurst, although data for the location of the majority of suicides was not available to the audit.

5.6 Ethnicity

Figure 5: Suicides by Country of Birth of Deceased 2012-2016

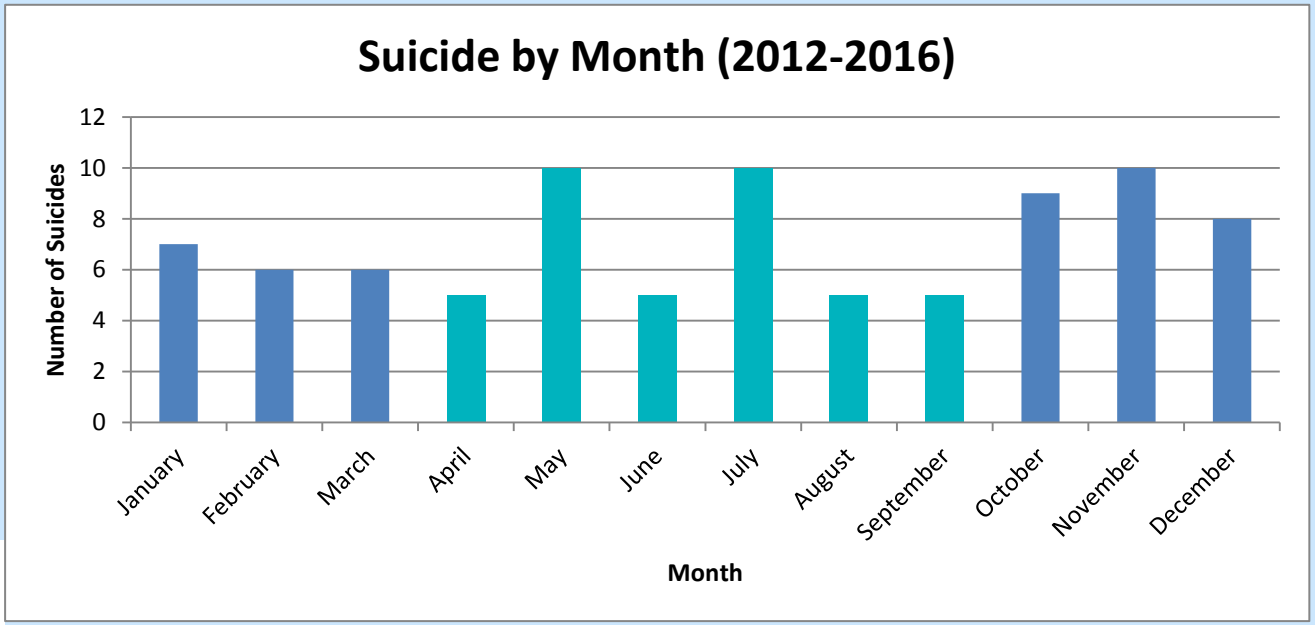


Source: PCMD

5.6.1 The recording of ethnicity in the deaths databases refers to country of birth rather than ethnicity of the deceased. Therefore, deaths occurring in the British born section could be from any ethnic group born in the UK. The chart does clearly illustrate that the majority of suicide occur in people born in the UK.

5.7 Suicide by Month

Figure 6: Suicides by Month 2012-2016

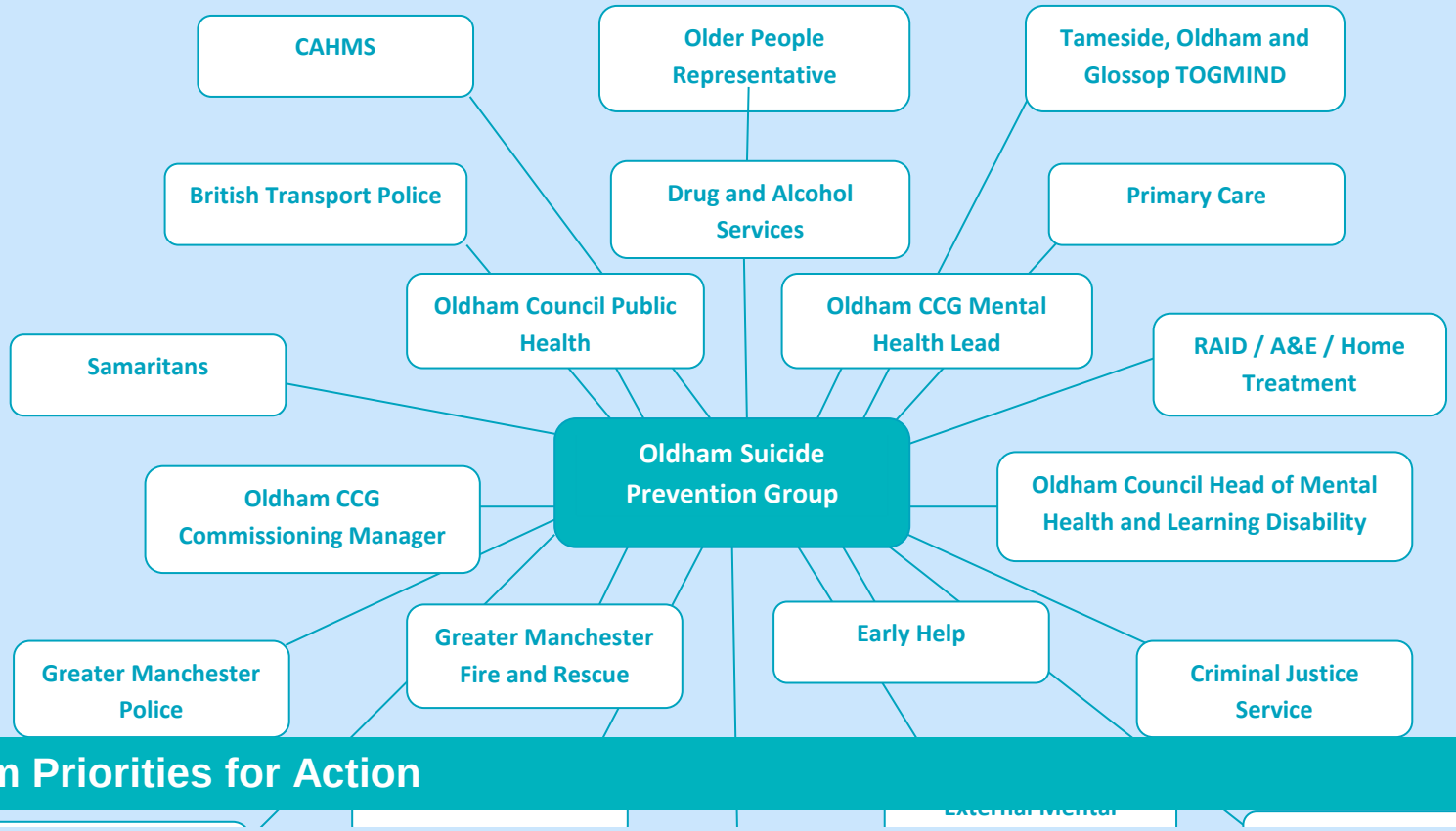


Source: PCMD

5.7.1 The chart above (figure 6) illustrates the number of suicides by month. The chart shows that the number of suicides peak in May, July and November. A slightly higher number of suicides occur in the winter months, with 53% occurring during the winter months October to March compared to 47% during the summer months April to September. However, suicides rates fluctuate widely throughout the year.

6. Oldham Multi-Agency Suicide Prevention Group

Oldham Council relaunched a multi-agency suicide prevention group in October 2016. The group's aim is to identify and agree improvements for the prevention of suicide in all services and age groups; including children, older people and people of working age. Additionally, this Strategy and Action Plan has been developed in partnership with the group.



7. Oldham Priorities for Action

We have grouped our actions into six areas for action. These have been developed taking into consideration the priority areas for action recommended in the National Suicide Prevention Strategy and the Greater Manchester Suicide Prevention Strategy. The full Action Plan can be found in Appendix A.

1) Male Suicide

There is a clear disparity between the sexes in terms of suicide in Oldham. Male deaths account for three quarters of the total number of local suicides over recent years: between 2012 and 2016 there were 65 male deaths (75.5%) and 21 female deaths (24.5%) in Oldham. This is representative of both the national picture and Greater Manchester. The chart below illustrates the disparity between the sexes for Oldham.

- Develop and implement initiatives to support the delivery of the Whole School and College Approach to Mental Health and Emotional Wellbeing in Schools and Colleges
- Identify and support children/young people/vulnerable families where children are at risk of emotional and behavioural problems
- Provide accessible and engaging interventions for children and young people who offend, in their area and in custodial or secure settings in order to improve their mental health.
- Help seeking information such as leaflets referring to services provided in Section136 Suite in the Royal Oldham Hospital

3) Tackling High Frequency Locations

Suicides in Oldham take place largely in the home of the deceased. Outside of the home, a key area of concern is Greenfield Railway Station, where three suicides and one suicide attempt has been carried out since 2013. In the past, there has been suicides both Acute care settings and from buildings of height in the borough.

4) Media Engagement

Research shows that inappropriate reporting of suicide may lead to imitative or 'imitational' behavior. Reporting on suicide and the inquests that follow can be difficult for media outlets. As a Council, our Communications department along with GMP, Samaritans and local media outlets must report the story sensitively while still ensuring that the public are kept informed.

Oldham will;

- Ensure that any reporting on suicide;
  - Provides information about sources of support and helplines when reporting suicide
  - Avoids insensitive and inappropriate graphic illustrations with media reports of suicide
  - Avoids use of photographs taken from social networking sites without relative consent
  - Avoids the re-publication of photographs of people who have died by suicide
  - Reports appropriately where there is evidence of a cluster

- Share the 'Samaritans' Media Guidelines for Reporting Suicide with Council Communications Team, GMP and NHS media teams and ensure that they are aware of the sensitive nature of suicides.

- Challenge, where possible, the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide

5) Bereavement Support

Death causes great pain and sadness whatever the cause of death, with those bereaved through suicide facing additional pressures and pain.

To achieve this aim, the following actions are being taken;

- Provide resources for primary care staff to raise awareness of the vulnerability and support needs of family members when someone takes their own life.
- Provide bereaved families with an explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result. Refer families to Oldham Bereavement Support Services.
- Develop an offer for specific suicide bereavement support services in Oldham. This could involve partnering with out of borough services such as SOBS, or 'fast-tracked' bereavement support services through CCG commissioned services
- Promote Public Health England Help Is At Hand document to key partners and make available in Oldham libraries.
- Provide accessible, concise information on the processes and standards in a Coroner's enquiry to family members.

6) Treatment of Depression in Primary Care

Primary Care plays an important role in treating depression, as the first point of contact for many. 80% of people who had taken their own life in 2015 had visited their GP in the six months prior to their death, presenting opportunities to identify suicide risk. For this reason, the treatment of depression in Primary Care has been identified as a priority area for action for Oldham.

Actions being taken are:

- Potential pilot of suicide risk assessment to commence in Primary Care, potentially through EMIS.

- Safe prescribing of painkillers and anti-depressants, plus skilling up primary care practitioners in identification and initial management of risk.

Key Guidance Documents and Toolkits

- *Greater Manchester Suicide Prevention Strategy*
- *Cheshire and Merseyside Suicide Prevention Strategy*
- *Preventing Suicide in England: A cross government outcomes strategy to save lives*
- *HM Government (2014) Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives*
- *Suicide prevention: developing a local action plan (Public Health England)*
- *Samaritans, Suicide Statistics Report 2014*
- *Samaritan's Best Practice Suicide reporting tips*
- *MIND guidance on supporting someone who feels suicidal*
- *CALM (Campaign Against Living Miserably)*

Acknowledgements

Oldham Council Public Health
Oldham Council Business Intelligence Service
Oldham Clinical Commissioning Group
Pennine Acute Trust
Pennine Care Foundation Trust
Greater Manchester Police
Greater Manchester Fire and Rescue
Oldham Probation Service

Oldham Council

Acknowledgements (cont.)

Positive Steps
Tameside, Oldham and Glossop MIND
Rochdale, Oldham and District Samaritans
British Transport Police
MH:2K
First Choice Homes
Contour Homes
Alcohol Dependency Solutions
Survivors Manchester
Regender

Oldham Council

APPENDIX A

Name		**Oldham Council Suicide Prevention Strategy: Suicide Prevention Action Plan**	
Duration:		2017 – 2020	
Relevant strategies:		Mental Health Strategy Schools Mental Health Framework Locality Plan Oldham JSNA GM Crisis Care Concordat	
Board responsible for monitoring plan:		**Health and Wellbeing Partnership Board**	
Plan Author:		**Jennifer McErlain: Project Manager, Public Health**	
Implementation date:	**TBC**	**Review date:**	**TBC**

Oldham Council

Priority Area 1:			Male Suicide		
Objective (if applicable):			Reducing the heightened risk of suicide in men, particularly young and middle-aged men.		
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer/partner:**
1.0	Oldham Council Social Care, Acute Care, Primary Care and Mental Health services to proactively promote and signpost to organisations that are aimed specifically at improving the mental health of men; • Campaign Against Living Miserably (CALM) • Men in Sheds • Andy's Man Club at OCL • Survivors Manchester • Safe and Well Service delivered by the Fire Service	September 2017	December 2019	Number of vulnerable people signposted to secondary mental health providers and support groups	All
1.1	Pre Suicide Prevention Day (10th September 2017) Campaign to promote organisations that are aimed specifically at improving the mental health of men (as above).	September 2017	September 2017	Comms material to be circulated through social media	Council Communications Team

Priority Area 2:			Mental Health of Children and Young People (and in pregnancy)		
Objective (if applicable):			Improve the mental health of children, young people and expectant mothers		
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer/partner:**

2.0	Develop and implement initiatives to support the delivery of the Whole School and College Approach to Mental Health and Emotional Wellbeing in Schools and Colleges	July 2017	July 2018	Commission training for graduated response Commission training for Whole School and College Approach Map services providing support to schools and colleges	Public Health
2.1	Identify and support children/young people/vulnerable families where children are at risk of emotional and behavioural problems	October 2017	December 2019	Implementation of protocols to meet the needs of children living in disadvantaged households	Oldham Children's Social Care

2.2	Provide accessible and engaging interventions for children and young people who offend, in their area and in custodial or secure settings in order to improve their mental health.	October 2017	December 2019	Number of youth offenders accessing interventions	Youth Justice Service (Positive Steps)
2.3	Help seeking information such as leaflets referring to services provided in Section136 Suite in the Royal Oldham Hospital	September 2017	December 2017	Help seeking information provided in Section 136 suites	Pennine Acute

Priority Area 3:			**Tackling High Frequency Locations**		
Objective (if applicable):			Reduce the opportunities people have to commit suicide in Oldham		
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer/partner:**
3.0	Include suicide risk in health and safety considerations by Local Authority Planning departments and Environmental Health Officers and developers when designing high structures that may offer suicide opportunities	January 2018	December 2019	Suicide considerations in standard risk assessment/health and safety tick box template.	Oldham Planning Department
3.1	Maintain the number of Samaritans signs on Greenfield Railway Station Bridge and station area	October 2017	December 2017	Continued presence of signs on Greenfield Railway Bridge	The Samaritans Public Health
3.2	Greenfield Railway Station staff to receive basic suicide	January 2018	July 2018	Number of frontline staff trained by Greater	GMP

	prevention and recognition training			Manchester Police	
3.3	Engage with British Transport Police, Northern Rail and Network rail to identify opportunities to further prevent suicide at their locations.	September 2017	December 2019	Relationship to be built between Oldham Council Public Health and Transport authorities	Public Health Oldham Suicide Prevention Group
3.4	Review Suicide Prevention Standards for Acute Care being developed based upon NICE guidance associated with mental health inpatient settings (e.g. 12 points to a safer service) and see which approaches can be adopted	September 2017	December 2019	Recommendations made based on Suicide Prevention Standards for Acute Care guidance	CCG Pennine Care Pennine Acute GP Clusters
3.5	Risk assessment tool fully utilised within A&E admissions and wards	September 2017	December 2019	Number of patients referred through the risk assessment tool in A&E	Pennine Acute
Priority Area 4:			**Media Engagement**		
Objective (if applicable):			The media to report on suicide and suicide behaviour sensitively, taking into account guidance and support from other stakeholders.		
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer/partner:**
4.0	Ensure that any reporting on suicide; • Provides information about sources of support and helplines when	August 2017	September 2017	All suicides reported on in a sensitive and appropriate way	Oldham Council Communications Team

	reporting suicide • Avoids insensitive and inappropriate graphic illustrations with media reports of suicide • Avoids use of photographs taken from social networking sites without relative consent • Avoids the re-publication of photographs of people who have died by suicide • Reports appropriately where there is evidence of a cluster				
4.1	Share the 'Samaritans' Media Guidelines for Reporting Suicide with Council Communications Team, GMP and NHS media teams and ensure that they are aware of the	August 2017	September 2017	Number of organisations aware of the Samaritans media guidelines.	Public Health Oldham Council Communications Team

	sensitive nature of suicides.				

Oldham Council

4.2	Challenge, where possible, the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide	August 2017	December 2019	Evidence of challenge of harmful or inappropriate material	GMP

Priority Area 5:			**Bereavement Support**		
Objective (if applicable):			Provide better information and support to those bereaved or affected by suicide		
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer/partner:**
5.0	Provide resources for primary care staff to raise awareness of the vulnerability and support needs of family members when someone takes their own life.	January 2018	December 2019	Number of primary care staff who have received training on resources	CCG Pennine Care TOG MIND

5.1	Provide bereaved families with an explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result. Refer families to Oldham Bereavement Support Services.	January 2018	December 2019	Proportion of families who are referred to Oldham Bereavement Support Services.	GMP
5.2	Develop an offer for specific suicide bereavement support services in Oldham. This could involve partnering with out of borough services such as SOBS, or 'fast-tracked' bereavement support services through CCG commissioned services	January 2018 TBC	TBC	GM Mental Health Transformation Bid includes funding for developing bereavement services in each GM locality. Funding not confirmed until earl 2018	CCG Public Health
5.3	Promote Public Health England *Help Is At Hand* document to key partners and make available in Oldham libraries.	January 2018	December 2019	*Help Is At Hand* document readily available in libraries.	Public Health

5.4	Provide accessible, concise information on the processes and standards in a Coroner's enquiry to family members.	January 2018	December 2019	Number of families receiving information	The Coroners Service (based in Rochdale Council)

Oldham Council

Priority Area 6:			Treatment of Depression in Primary Care		
Objective (if applicable):			**Early awareness of the risk of suicide in people with depression**		
Ref:	**Action:**	**Start:**	**End:**	**Measure/outcome:**	**Lead officer/partner:**
6.0	Potential pilot of suicide risk assessment to commence in Primary Care, potentially through EMIS.	September 2018	September 2018	• Identify needs codes • Identify GP practices • Develop template • Establish working group	CCG Public Health Pennine Care Public Health England
6.1	Safe prescribing of painkillers and anti-depressants, plus skilling up primary care practitioners in identification and initial management of risk.	January 2018	December 2019	Primary Care practitioners trained in identification and initial management of risk	Pennine Care Pennine MSK Partnership

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

13

Date: 24 February 2017

Subject: GM Suicide Prevention Strategy

Report of: Andrea Fallon, Chair of the GM Suicide Prevention Executive & Director of Public Health and Wellbeing, Rochdale Borough Council.

Warren Heppolette

PURPOSE OF REPORT:

The purpose of the report is to present to the board the Greater Manchester Suicide Prevention Strategy 2017-2022 as per the commitment made within the delivery plan of the Greater Manchester Mental Health Strategy, and seek endorsement of the Board to move to implementation.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Endorse the GM Suicide Prevention Strategy and support the move toward implementation.
- Support the Suicide Prevention Executive in seeking high level sponsorship for Suicide Prevention in Greater Manchester.
- Support the implementation of the Strategy from 1 March 2017.

CONTACT OFFICERS:

Andrea Fallon
andrea.fallon@rochdale.gov.uk

Warren Heppolette,
warrenheppolette@nhs.net

1.0 BACKGROUND

1.1. In 2014, 277 people took their own life in Greater Manchester. Suicide is the biggest killer of men under 49, and it remains the leading cause of death in our city region for people aged 15 to 29.

1.2. The majority who die by suicide (two thirds) are not in contact with mental health services, so suicide prevention is a shared public health and mental health priority. For every person who dies, another nine individuals will have attempted suicide hence each suicide can be considered a reflection of underlying levels of poor mental health in our population. In addition, each death has a ripple effect within families and communities, resulting in the lives of at least 10 others being seriously affected to the extent that they are likely to find it difficult to work, to form relationships and live to their full potential. It will also increase their own risk of suicide.

1.3. In this wider social context, the economic cost of each suicide is estimated to be £1.5m, thus suicide is a significant social and economic burden for Greater Manchester. Risk factors for suicide include men, individuals aged 35 – 49, a recent history of self-harm, people in the care of mental health services, those with relationship problems and people in contact with the criminal justice system. Some occupational groups are at higher risk such as doctors, nurses, farmers and veterans, and in young people, bullying, family factors, social isolation and academic pressures increase risk.

1.4. This strategy builds on an existing programme of work, and sets out a bold and ambitious five year plan for reducing and ultimately eliminating suicides in Greater Manchester. To do this will require our co-ordinated efforts so that suicide prevention becomes ‘everyone’s business’.

1.5. We have sought direction from the National Confidential Inquiry into Suicidesand Homicides (2016), the National Suicide Prevention Strategy (2012, updated 2017), the Five Year Forward View for Mental Health, and the recently published PHE resource for local Suicide Prevention Planning. In doing so we have developed a plan for action which fits with the national guidance and PHE resource resulting in our actions being organised around six key objectives:

- All ten Boroughs (and Greater Manchester as a whole) will achieve **Suicide Safer Communities Accreditation** (the ‘nine pillars of suicide prevention’) by 2018

- Mental Health Service Providers will collaborate to work toward the **elimination of suicides for in-patient and community mental health care settings** by continuous quality improvement in relation to 10 key ways for improving patient safety

- We will **strengthen the impact and contribution of wider services**
- We will offer **effective support to those** who are affected
- We will **develop and support our workforce** to better assess and support those who may be at risk of suicide
- We will use the **learning from evidence, data and intelligence** to improve our plan and our services.

2.0 AREAS OF INTEREST FOR YEARS 1 AND 2

2.1. We wish to strengthen local political leadership by:

- Gaining a senior level political champion in Greater Manchester by April 2017.
- Gaining a political champion for each borough by October 2017

2.2. We intend to focus on those deaths that may be most preventable such as:

- Individuals in the care of mental health services
- Individuals with depression
- Individuals with a history of self-harm

2.3. We intend to strengthen our intelligence (and use thereof) relating to suicide in Greater Manchester for example by:

- Scoping the potential for a GM approach to using 'real-time data'
- Undertaking a Greater Manchester Audit of Suicide (underway)

2.4. We also intend to strengthen our response to bereavement support for example by:

- Developing a model care pathway for bereavement support in partnership with Public Health England.
- Undertaking a mapping exercise of available support services across GM

3.0 GOVERNANCE

3.1. The delivery of the strategy will be co-ordinated by the GM Suicide Prevention Executive, and will report on progress using a programme management approach to the GM Health and Social Care Partnership Board via the GM Mental Health Implementation Executive.

4.0 RECOMMENDATIONS

4.1. The Strategic Partnership Board is asked to:

- Endorse the GM Suicide Prevention Strategy and support the move toward implementation.
- Support the Suicide Prevention Executive in seeking high level sponsorship for Suicide Prevention in Greater Manchester.
- Support the implementation of the Strategy from March 1 2017.

Greater Manchester

Suicide Prevention Strategy

2017-2022

CONTENTS

Main Editor	Andrea Fallon (Andrea.Fallon@Rochdale.gov.uk) Chair of the GM Suicide Prevention Executive & Director of Public Health and Wellbeing, Rochdale Borough Council
GMCA Officer Lead	Warren Heppolette Executive Lead, Strategy and System Development
Report of	The GM Suicide Prevention Executive
On behalf of	The GM Mental Health Strategy Implementation Executive

1.0 FOREWORD

Each day in the UK, around 13 people take their own life. This is a tragic loss for those who have died, and the devastating effects of each of these deaths are felt far and wide in families, communities, workplaces and schools. Most of all, the impact is felt most acutely for those loved ones who are left behind feeling bereaved, often bewildered and in most cases searching for answers as to what they could have done or said that might have made a difference. The suicide of someone we know has a profound long term impact on our lives, including our ability to work, to enjoy life, and have satisfying relationships. It also raises our own risk of suicide.

There are marked differences in suicide rates according to social and economic circumstances, so suicide is also a marker of how fair our society is. Those who are out of work, in poor housing, and or with a significant health issue (particularly those who are dependent upon drugs and alcohol) are more at risk. Reducing risk requires system change to address the wider determinants of mental health in addition to high quality health and social care in its widest sense. This presents us with a considerable challenge at a time when resources are more stretched than ever.

In February 2015, the 37 NHS organisations and Local Authorities in Greater Manchester signed a landmark devolution agreement with the Government to take charge of health and social care spending in our City region. This has offered a unique opportunity for us to tackle the challenges we face together through our collective efforts. It facilitates the sharing of learning and resources and offers us an unprecedented mandate to break down organisational barriers to ensure clients and residents are at the centre of everything we do. It allows us to work in closer partnership with local people in the design of services, and allows us to support people in taking ownership and control over their own lives so that they can stay well, and take an active part in enhancing the resilience of their communities.

This suicide prevention strategy has been set out in the spirit of the devolution agreement and fits our vision in Greater Manchester for the greatest and fastest improvement in health, wealth and wellbeing of residents. It has been developed in partnership with a wide network of partners, who have collaborated to develop this strategy.

In developing our strategy we have taken inspiration from the ‘best of the rest’ elsewhere, and thus we take opportunity here to acknowledge the excellent work of all our all colleagues working on this agenda across the UK and thank them for sharing their work.

It is clear that nationally our collective goal is that no-one will see taking their own life as a solution, and to this end our commitment in Greater Manchester is that we will do everything in our power to achieve this.

Andrea Fallon, Chair of the Greater Manchester Suicide Prevention Executive

Lead Director of Public Health for Mental Health (on behalf of the ten Directors of Public Health in Greater Manchester)
& Director of Public Health and Wellbeing, Rochdale Borough Council

2.0 EXECUTIVE SUMMARY

The number of deaths to suicide in Greater Manchester is significant, with 277 deaths occurring in 2014 alone. The majority of suicides occur in men, with increased risk seen in those within the lowest socioeconomic groups and living in the most deprived geographical areas. Other at risk groups include those who self-harm, children and young people and those with untreated depression. Individuals who have been bereaved by suicide, those who are isolated, and those who misuse drugs and alcohol are also at increased risk.

Only a third of all suicides occur in individuals who are known to mental health services, thus preventing suicide requires a co-ordinated whole system approach.

This strategy builds on our work to date and sets out a bold and ambitious five year plan for reducing and ultimately eliminating suicides in Greater Manchester. To do this will require our co-ordinated efforts so that suicide prevention becomes 'everyone's business'.

We have sought direction from the national Suicide prevention strategy from 2012, the Five year Forward View for Mental Health, and the recently published PHE resource for local Suicide Prevention Planning. In doing so we have developed a plan for action which fits with the national guidance and PHE resource, and we have organised our actions around six key objectives:

1) All ten Boroughs (and Greater Manchester as a whole) will achieve **Suicide Safer Communities Accreditation** (the 'nine pillars of suicide prevention') by 2018
2) Mental Health Service Providers will collaborate to work toward the **elimination of suicides for in-patient and community mental health care settings** by continuous quality improvement in relation to 10 key ways for improving patient safety
3) We will **strengthen the impact and contribution of wider services**
4) We will offer **effective support to those** who are affected
5) We will **develop and support our workforce** to better assess and support those who may be at risk of suicide
6) We will use the **learning from evidence, data and intelligence** to improve our plan.

3.0 WHAT DO WE WANT TO ACHIEVE?

Our vision is that no-one will see suicide as a solution, and our ambition is therefore that there will be no more suicides in Greater Manchester.

We recognise that from the evidence we have, some suicides might be considered to be the most preventable although we firmly believe that all are avoidable. With this in mind, our strategy sets out our plan to ensure that we harness the support and contribution of all services and agencies so that we can reduce risk, proactively intervene when needed, and effectively respond to those in crisis.

Our primary focus for the first two years of our strategy (2017/18 – 2019/20) will be to meet the challenge set out within the Five Year Forward View for Mental Health ie. to reduce the rate of suicide by 10% by 2020. Thereafter we will seek to stretch this target further.

4.0 WHAT IS THE PURPOSE OF THIS DOCUMENT?

This document sets out our strategy for preventing suicide in Greater Manchester. In this strategy we set out a bold ambition that there will ultimately be no more suicides, with an initial focus on meeting the challenge set out within the Five Year Forward View for Mental Health for at least a 10% reduction by 2020. In order for this to be achieved, every borough in Greater Manchester will need to support this strategy.

Our strategy is intended to stimulate a social movement for change in the way we think and act in relation to suicides and suicide prevention. We aim to enhance the skills of our wider workforce in relation to assessing and managing risks and supporting those who are affected or bereaved, to reduce the stigma attached to talking about suicide and mental health more openly, and to promote suicide safer communities.

5.0 WHY HAVE A SUICIDE PREVENTION STRATEGY?

5.1 Key drivers

Suicide is a major mental health, social, economic, and public health issue. It is a cause of early death and an indicator of underlying poor mental health at population level and represents a devastating loss for individuals, families and communities and carries a huge financial burden. The highest numbers of suicides are found in men aged 35 – 54 years, and in women aged 40-59 years.

By 2020/2021 our Greater Manchester health and social care system faces an estimated financial deficit of £2bn indicating the need for radical transformation. The impacts of mental health on our wider health care system are considerable: we know that poor mental health worsens physical illness and raises total health care costs by at least 45%, for example, an estimated 12% - 18% of all NHS expenditure on long-

term conditions is linked to poor mental health and wellbeing (between £420m and £1.08bn in Greater Manchester alone).

Improving the mental health of our residents is therefore a high priority for Greater Manchester. Our broader plans for how we will do this are set out within the Greater Manchester Mental Health and Wellbeing Strategy[i] and within this, suicide prevention is identified as a year one/two priority for delivery.

Most importantly, this strategy recognises that suicide has a significant toll on others – i.e. estimates suggest that for every person who dies from suicide at least 10 people are directly affected. Also for each case of suicide we know that there are around nine others that will have been attempted. Thus each suicide is an indication of a significant number of individuals who need help and support.

The key national driver for the development of local suicide prevention strategies and action plans was set out within the 2012 strategy for England *Preventing Suicide in England, a cross government strategy to save lives*[1]. The requirement for a comprehensive local suicide strategy is considered to be an effective mechanism in reducing deaths by suicide by supporting the combination of a range of interventions. More latterly, the Five year forward view for Mental Health[2] set a requirement for all local areas to have Suicide Prevention plans in place by 2017.

5.2 The benefits of a Greater Manchester approach to Suicide Prevention

This strategy reflects a call to action to all Greater Manchester agencies and communities to come together to join forces to tackle a significant threat to the health and wellbeing of our residents. We have taken an all-age approach, recognising that risk varies across the life-course and that prevention requires a range of interventions, some of which are tailored to need and some demographic groups

We acknowledge the increased emphasis on self-harm, primary care, prisons and other at risk groups within more recent policy documents in relation to suicide prevention. We have not attempted to present all actions for each priority area here as these are the focus of subject specific comprehensive plans, each led by expert leads from within the Suicide Prevention Executive Group. In preference we have looked at broader priorities and objectives that can be effectively supported by a Greater Manchester approach.

In line with the ethos of other Greater Manchester Plans, we are interested in whole system and asset based approaches as these are most likely to foster effective partnerships between local authorities, primary care, prisons and probation, mental health services, voluntary organisations and local people affected by suicide. Importantly the Greater Manchester devolution arrangement offers us the best opportunity to date in scaling up activities which have been successful in some boroughs to every borough where it makes sense to do so.

[1] Preventing Suicide in England: A cross government strategy to save lives (2012) https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[2] The five year forward view for mental health (2016)

A Greater Manchester approach also presents an opportunity to achieve parity of access for all our residents, through a combination of a framework for action to which all boroughs can pledge their support and the potential for economies of scale when commissioning interventions for the whole of Greater Manchester. It will also allow us to promote the prevention of suicide as everyone's business, with key stakeholders (including the media) joining forces to support workers and residents to reduce the stigma surrounding suicide, and to take action.

5.3 Priorities for Greater Manchester Suicide Prevention

Our plan supports us in focusing on all six areas of the national strategy in the long-term, however our priorities for a whole system approach in the short term are[3]:

a. **Reducing the risk in Men**
b. **Preventing and responding to self-harm**
c. **Children and young people and women during pregnancy and postnatally**
d. **Treating Depression in Primary Care**
e. **Acute Mental Health Care Settings**
f. **Tackling High Frequency Locations**
g. **Reducing Isolation and Loneliness**
h. **Bereavement Support /Postvention**

6.0 THE NATIONAL AND LOCAL PICTURE

6.1 National

The recent publication of the 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[7] (NCISH) shows that suicide is the biggest killer of men under 49 and it remains the leading cause of death in people aged 15-29 [4]. The majority of people (two thirds) who die by suicide are not in contact with mental health services[5] and in England one person dies as a result of suicide every 2 hours.[6]

For every one person who dies from suicide, at least 10 others are directly affected. In 2014, there were 4882 deaths from suicide in England, of which 277 were in Greater Manchester. From 2004 to 2014 there was a 30% fall in suicide rates in men aged 25 to 34. However since 2006, suicide rates in men aged 45-54 have risen by 27%, and in men aged 55-64 rates have risen by 20%. We also know that specific

[3] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England.
[4] Office of National Statistics, What do we die from? (2015)
[5] HM Government Preventing suicide in England A cross-government outcomes strategy to save lives (2012)
[6] Self-harm, suicide and risk: helping people who self-harm (2010) Royal College of Psychiatrists

groups appear to be at higher risk. The following risk factors have become more common as antecedents to suicide:[7]

- Isolation
- Economic adversity
- Alcohol and drug misuse
- Recent self-harm

People in the most deprived areas are ten times more at risk of suicide than those in the most affluent group living in the most affluent area. The strongest predictor of suicide is previous episodes of self-harm with the most common antecedent to suicide being alcohol use.

The most common methods of suicide are hanging and strangulation (47%), self-poisoning (overdose) (21%) and jumping and multiple injuries (mainly jumping from a height or being struck by a train) (11%). Less frequent methods are drowning (4%), gas inhalation (including carbon monoxide poisoning (3%), cutting and stabbing (3%) and firearms (2%).

The report also indicates that in the UK, the highest rates of suicide as a whole are in Northern Ireland, with rates in England and Wales being higher post 2009, and the rate in Scotland appearing to be falling. The only area in England where rates didn't appear to increase after the recession were in London. Across England, this increase translates to an additional 250 deaths each year.

Suicides amongst those who are under the care of mental health services appears to be decreasing overall, although this picture is not uniform – with inpatient suicides falling significantly (by 60%) following the decree by government in 2003 to eliminate ligature points on inpatient mental health wards, although there are still in excess of 75 inpatient deaths each year.

An increase in suicides under the care of crisis teams is clear from the data which is considered to be as a result of pressure on the system ie as a consequence of community crisis teams taking on more complex clients as a result of scarcity of in-patient beds.

The NCISH report indicates that effective crisis teams can have an essential role in reducing suicides - a third of suicides amongst those under the care of mental health services have been discharged from hospital within the preceding 7 days. 30% of suicides in this group occur in the space between discharge and the first outpatient appointment at 7 days plus, reducing this gap to 2-3 days can reduce this to 11%[7].

6.2 Greater Manchester

[7] Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

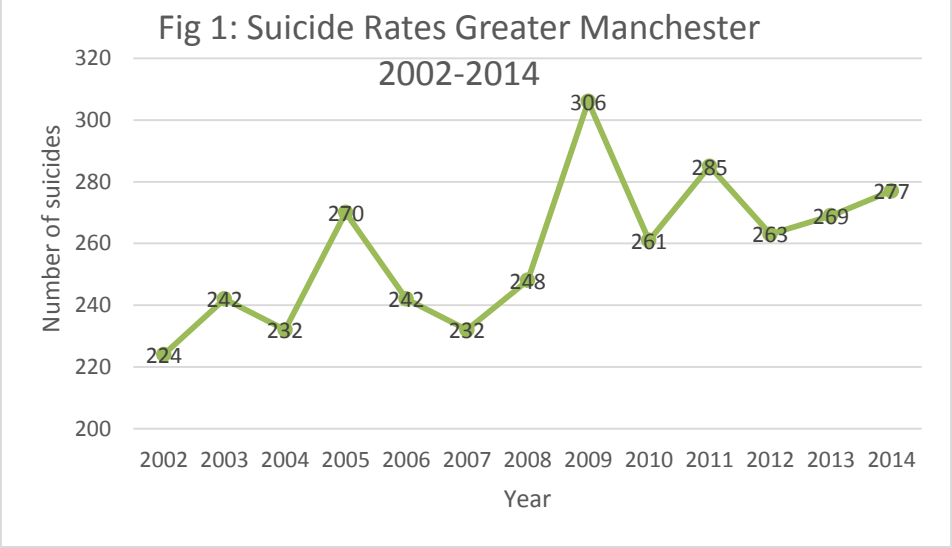
The total population of Greater Manchester is approximately 2.8million people. In 2014 there were 277 [8] deaths by suicide in Greater Manchester, this is 277 too many. Perhaps unsurprisingly the greatest number (48) were seen in the city of Manchester, with the lowest in Trafford (N=13) (table 1)

Table 1 Numbers of suicides by Borough (2014)

Local Authority	Count
Bolton	24
Bury	30
Manchester	48
Oldham	26
Rochdale	31
Salford	27
Stockport	26
Tameside	23
Trafford	13
Wigan	29
Greater Manchester	**277**

Of the 4882 deaths from suicide in England in 2014, suicides in Greater Manchester constituted around 5.7% of these, reflecting the significant local and national burden of mental ill-health within the population.

As for the national picture, overall rates in Greater Manchester have been rising since 2002, with a peak seen in 2009 (Fig 1). The overall rate of suicide for Greater Manchester between 2012 and 2014 was 10.3 (per 100,000 residents)[9] with significant variation between boroughs, and between different population groups.



[8] ONS Suicide registrations by Local Authority
http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
[9] Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

In 2014, individual boroughs in Greater Manchester took part in a sector led-improvement initiative, which set out to bench mark activity against the recommendations of the 2012 strategy and share good practice across the sector. An intended benefit from the process was for boroughs to explore different approaches, and to share data and information.

A key finding was that although all boroughs had undertaken local suicide audits at some point, not all were undertaken routinely either annually or bi-annually, and some may be insufficient to effectively assist with prevention planning. Not having undertaken a recent audit was generally linked to a lack of capacity, but importantly feedback suggested that suicide audits may be better undertaken (from a statistical perspective) on a larger spatial scale, ideally at GM level and to a standardised format so as to enable more meaningful comparison.

6.3 Key risks in relation to suicide

An understanding of the key risks in relation to suicide enables targeted approaches to those most in need of intervention. A number of local suicide audits suggest that Greater Manchester fits the national picture with regard to overarching demographic, social and economic factors which place residents at higher risk of suicide.

Men are three times more likely to die by suicide than women as in the UK[10] and people in the lowest socio-economic group and living in deprived areas appear to be more at risk of suicide than those in the most affluent groups living in the most affluent areas.[11] A more detailed analysis of suicides at GM level is intended through the undertaking of a GM wide audit although this is not without its challenges due to the slightly different methods used across the ten boroughs.

Of interest nationally is that a newly emerging group at high risk appear to be recent migrants, who face multiple features of social adversity, and this group may be of interest for targeted interventions going forward. National evidence suggests that those most at risk are:

- Men
- Individuals aged 35-49
- People with a recent history of self-harm
- People in the care of mental health services
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers[12] and veterans.

The incidence of self-harm as an antecedent to suicide has seen a steep rise, calling for better assessment of those presenting to services. In 2014/15 there were 7,116

[10] http://web.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2014-registrations/
[11] Platt, S. Inequalities and suicidal behaviour; In O'Connor, R.C. et al. International handbook of suicide prevention: research, policy and practice. 2011
[12] Op.cit. HM Government (2012)

hospital admissions due to self-harm[13]. Of these, evidence suggests that patients can often present with a complex history of risk factors and events leading up to admission including:

- Untreated depression
- Unemployment
- Debt
- Relationship breakdown and bereavement including by suicide
- Drug and alcohol misuse
- Social isolation [14]

Key risk factors for the under 25s are:[15]

- Family factors such as mental illness
- Abuse and neglect, Bereavement and experience of suicide
- Bullying, Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Alcohol and illicit drugs
- Mental ill-health, self-harm and suicidal ideas

In contrast, certain protective factors are evident from the data on suicides, which include:

- Effective coping and problem solving skills
- Presence of reasons for living, hopefulness and optimism
- Physical activity and health
- Family connectedness
- Supportive schools and Social support
- Religious participation, Employment
- Lack of exposure to suicidal behaviour
- Traditional social values
- Access to health treatment [16]

It is reasonable to assume therefore that strategies which seek to increase these protective factors at a population level are likely to be of benefit in reducing overall risk.

7.0 STRATEGIC APPROACH

7.1 National Strategy

[13] PHE Public Health Profiles (2015)
[14] PHE Local suicide prevention planning A practice resource (2016)
[15] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Suicide in children and young people. (2016)
[16] Scottish Government Social Research Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review (2008)

The Five Year forward view for Mental Health (2016) sets out the challenge to reduce suicides by 10%, and several strategies around the UK have clearly stated their intent to go much further than this – toward a zero suicide approach. This too is our ambition. We intend to adopt a focused approach to achieving this goal by targeting those deaths which are most preventable by identifying specific at-risk groups, communities or settings for action.

We will use the intelligence gathered via the GM Suicide Audit to inform where our efforts might be best targeted in addition to national priority groups.

This approach is founded on the principle that 'the sum of marginal gains' is likely to be the most effective means of meeting our vision for no more suicides in Greater Manchester and will foster a highly targeted and effective approach.

This strategy acknowledges and builds on a substantial body of work in relation to suicide prevention in Greater Manchester and reflects the learning of a programme of sector led improvement undertaken in 2013. Our overarching objectives are aligned with the six national priorities (2012) and national refresh (2017).

During 2015 and 2016 each of the ten boroughs has been working to develop and deliver a transformational 'Locality Plan' which set out how the ambitions set out within 'Taking Charge of Health and Social Care in Greater Manchester' will be delivered in each borough.

Most of the work aligned to the priorities for suicide prevention are incorporated in the locality plans for each borough. The strategic priorities for Greater Manchester are set out below and this strategy principally focuses on actions that support those objectives which can be delivered or supported by utilising a Greater Manchester approach

7.1.1 National Priorities for Action

The National Suicide Prevention strategy of 2012 set out six priority areas for action:

1. Reduce the risks in key-high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

These six areas for action have been used as a framework for this Strategy, and to develop our overarching aims and objectives and supporting action plan.

The recent national strategy refresh (January 9th 2017) stays true to these themes with an additional emphasis on

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan by 2017, with agreed priorities and actions.

- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately
- Improving responses to suicide
- Expanding the scope of the national strategy to include self-harm prevention in its own right.

7.2 Greater Manchester Mental Health Strategy

7.2.1 The overarching Greater Manchester Mental Health Strategy

This suicide prevention strategy forms part of an overarching strategy for mental health in Greater Manchester. This broader strategy is summarised in appendix 1, and sets out our vision to improve child and adult mental health, narrow the gap in life expectancy and ensure parity of esteem with physical health. Our vision also commits to shifting the focus of care toward prevention, early intervention and resilience and toward delivering a sustainable mental health system. Simplified and strengthened leadership and accountability is at its core, as is the enablement of resilient communities, the engagement of inclusive employers and close partnership working with the third sector.

To achieve these goals we intend to strengthen our mental health system, and we will do this through four key characteristics which run throughout our plans:

- Prevention
- Access
- Integration and
- Sustainability

A number of ‘golden threads’ also run throughout our strategy, including

- Parity of Esteem
- Research deployed to inform best practice
- Using technology to provide new and innovative forms of support
- Leverage the learning from successful programmes (e.g. Troubled families)
- Workforce Development,

This Suicide Prevention strategy stays true to these principles.

8.0 GREATER MANCHESTER PRIORITIES FOR ACTION

Our key priority areas for action for preventing suicide in Greater Manchester are as described in the recent Public Health England resource for suicide prevention[17]. Following the completion of the GM audit this may be enhanced to reflect findings.

Priorities	More specifically …
1) Reducing the risk in men	In particular middle aged men, with a focus on economic disadvantage such as debt and or unemployment, social isolation and drugs and alcohol misuse. A focus on developing treatment and/or support settings that are more acceptable and accessible by men
2) Preventing and responding to self-harm	A range of services are needed for adults and young people in crisis, and psychological assessment for self-harm patients. Acknowledgement that support for young people will be distinct from that of adults.
3) Mental Health of Children and Young People (and in pregnancy)	Joint working between health, social care, schools and youth services, and includes risk during pregnancy and those who have given birth during the last year. In particular we intend to focus on the increased suicide risk between 15 to 19 year olds.
4) Treatment of depression in Primary Care	Safe prescribing of painkillers and anti-depressants, *(plus skilling up primary care practitioners in identification and initial management of risk)*
5) Acute Mental Health Care	Safer wards and safer discharge (including follow up), adequate bed numbers and no out of area admissions.
6) Tackling High Frequency Locations	Including working with local media organisations and groups to prevent imitative suicides
7) Reducing isolation and loneliness	For example, through community based support, good transport links and by working with the third sector with a particular focus on men and older people
8) Bereavement Support and Media engagement.	The provision of better information and support for those bereaved or affected by suicide and supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

9.0 WHAT WE WILL DO: OUR OBJECTIVES

An overarching and ambitious action plan has been developed to support the delivery of this strategy which following stakeholder feedback is being further

[17] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England

developed into issue specific work plans. These actions have been structured around six strategic objectives which cross reference our priorities for action (section 8.0) and the national strategy objectives. Below is a summary of our strategic objectives and associated 'pledges' that this strategy makes for 2017-2022.

Strategic Objective 1

All ten Boroughs (and Greater Manchester as a whole) will achieve **Suicide Safer Communities Accreditation** (the 'nine pillars of suicide prevention)' by 2018 i.e.

1) A leadership/steering committee
2) A robust background summary of the local area to support goal setting
3) Suicide Prevention Awareness raising
4) Mental Health and Wellness promotion
5) Training for community members, lay persons and professionals
6) Suicide intervention and ongoing clinical support services.
7) Suicide bereavement support and resources
8) Evaluation measures including data collection and evaluation system
9) Capacity building/sustainability within communities

Strategic Objective 2

Mental Health Service Providers will collaborate to work toward the **elimination of suicides in in-patient and community mental health care settings** by continuous quality improvement in relation to the 10 ways to improve patient safety[18] :

1) Safer wards (eg prescribing, eliminating ligature points)
2) Early follow up on discharge (within 2-3 days)
3) No out of area admissions
4) 24 hour crisis teams (sign up to the crisis care concordat)
5) Family involvement in 'learning lessons'
6) Guidance on depression
7) Personalised risk management
8) Outreach teams
9) Low staff turnover
10) Dual Diagnosis services (i.e. Alcohol and Drugs)

Strategic Objective 3

We will **strengthen the impact of wider services by**

[18] Appleby,L et al (2016) Making Mental Health Care Safer: Key findings from the National Confidential Inquiry into Suicides and Homicides. Manchester University.

1) Refreshing the mapping exercise undertaken as part of the sector led improvement programme to inform a directory of services (via an app/website)
2) Developing a GM standard for suicide prevention in secondary care
3) Secure high level GM political support for suicide prevention, with support from local political mental health champions
4) Working with colleagues in schools to raise awareness of emotional wellbeing amongst young people.
5) Working closely with colleagues in maternity services, health visiting and mother and baby units to identify opportunities to improve outcomes for new or expectant mothers with mental health issues.
6) Working with the community and voluntary sector by supporting collaboration such as a voluntary sector Health and Wellbeing Alliance in each borough.
7) Work with prisons and the probation service to address self-harm and suicide amongst offenders
8) Work with substance misuse services to ensure timely access to treatment.
9) Seeking support for the GM strategy and local action plans at each Health and Wellbeing Board and within each locality plan.
10) Seek to strengthen the management of depression in primary care
11) Learn from and strengthen the approaches to suicide reduction and post-vention developed by Network Rail, GMP, Highways Agency and other colleagues as first responders to incidents.
12) Identifying high risk locations and putting plans in place to reduce risks.
13) Being open, receptive and supportive of social movements that improve public awareness of suicide prevention through campaigns or social media platforms

Strategic Objective 4

We will offer **Effective support to those** who are affected

1) In partnership with Public Health England, we will look at the potential for a social marketing initiative that will stimulate a social movement for change with regard to eliminating the stigma associated with suicide and self-harm.
2) We will scope current arrangements across GM in relation to post-vention interventions, eg schools, communities and outreach to family and friends, in addition to bereavement support
3) We will review and continually improve access to IAPT to meet the national targets for those in need of support.
4) We will review local Suicide liaison service provision across GM.
5) We will review local self-harm care pathways against NICE guidance (CG133)
6) We will continue to strengthen our crisis care arrangements so that there is parity of access to 24/7 support for all-age groups especially children.
7) We will develop a Greater Manchester Suicide Bereavement Pathway including population based initiatives, group based and 1-1 interventions.
8) We will scope the potential for additional commissioning of suicide bereavement support to supplement local arrangements
9) We will scope the potential for a GM approach to the use of ‘Real-Time Data’ in maximising our response to suicides.
10) We will develop our processes across GM to foster a culture of learning from suicide attempts and the avoidance of a blame culture.

Strategic Objective 5

We will **develop and support our workforce** to better assess and support those who may be at risk of suicide

1) Promote mental health in our workplaces and amongst our staff, especially those in higher risk occupations, and promote approaches that reduce stigma.
2) Expanding access to a locally developed training programme which supports a greater understanding of the five ways to wellbeing (Stockport/Manchester/Bolton) across GM
3) Increasing knowledge skills and confidence for primary care practitioners and pharmacies, and in management of risks in primary care (eg medicines)
4) We will seek to standardise our care pathways to strengthen consistency across provider organisations.

Strategic Objective 6

We will use the **learning from evidence, data and intelligence** to improve our understanding, our communications, our strategy and our services

1) We will undertake a GM audit of suicides every 2 years and share learning across boroughs to identify high frequency locations/groups/means etc.
2) We will work with local faith group leaders to share knowledge and understanding of suicide in relation to culture and faith.
3) We will seek to standardise post-incident reviews
4) We will work with colleagues in the media regarding appropriate reporting of suicide and maximise opportunities to signpost and raise awareness.
5) We will scope the potential for a minimum/optimal standard for risk assessment tools in primary care
6) We will use the audit process to identify high risk locations and or new and emerging means of suicide and put in place plans to reduce related risks.
7) We will hold an annual suicide prevention conference for Greater Manchester to share learning, good practice and strengthen links between agencies
8) We will consult with community and voluntary sector colleagues to identify the distinct needs of specific groups such as LGBT, Asylum seekers, those with a Long-term condition, perinatal care, drugs and alcohol clients and individuals in contact with the justice system to set out plans for improving outcomes in these groups
9) We will review the learning from elsewhere to design a campaign to target men in particular, such as that employed in Kent which focused on barbers.

10.0 WHAT ARE WE BUILDING ON?

Many examples of good practice exist in Greater Manchester with the potential to scale up across the conurbation:

11.0 MONITORING PROGRESS AND IMPACT

Monitoring and evaluation

We will monitor progress against each of our actions as set out within the action plan above, which will be refreshed each year using a programme management approach.

We will also evaluate the impact of the strategy by monitoring the following:

1. Local suicide rates, attempts and rates of admission for self-harm
2. Help-seeking behaviour such as the use of telephone helplines
3. Improvements in waiting times, access and completion rates for treatment of depression.
4. The numbers recorded as experiencing suicidal ideation
5. The use of standard questionnaires to monitor depression and anxiety
6. Monitor the views and experiences of service users
7. Monitor the views of professionals
8. Reduction in the number of GPs who are exempt from the QOF indicator relating to depression (depending on Primary Care Strategy)

Formal reporting on each work stream is be expected by the GM Mental Health Implementation Executive each month.

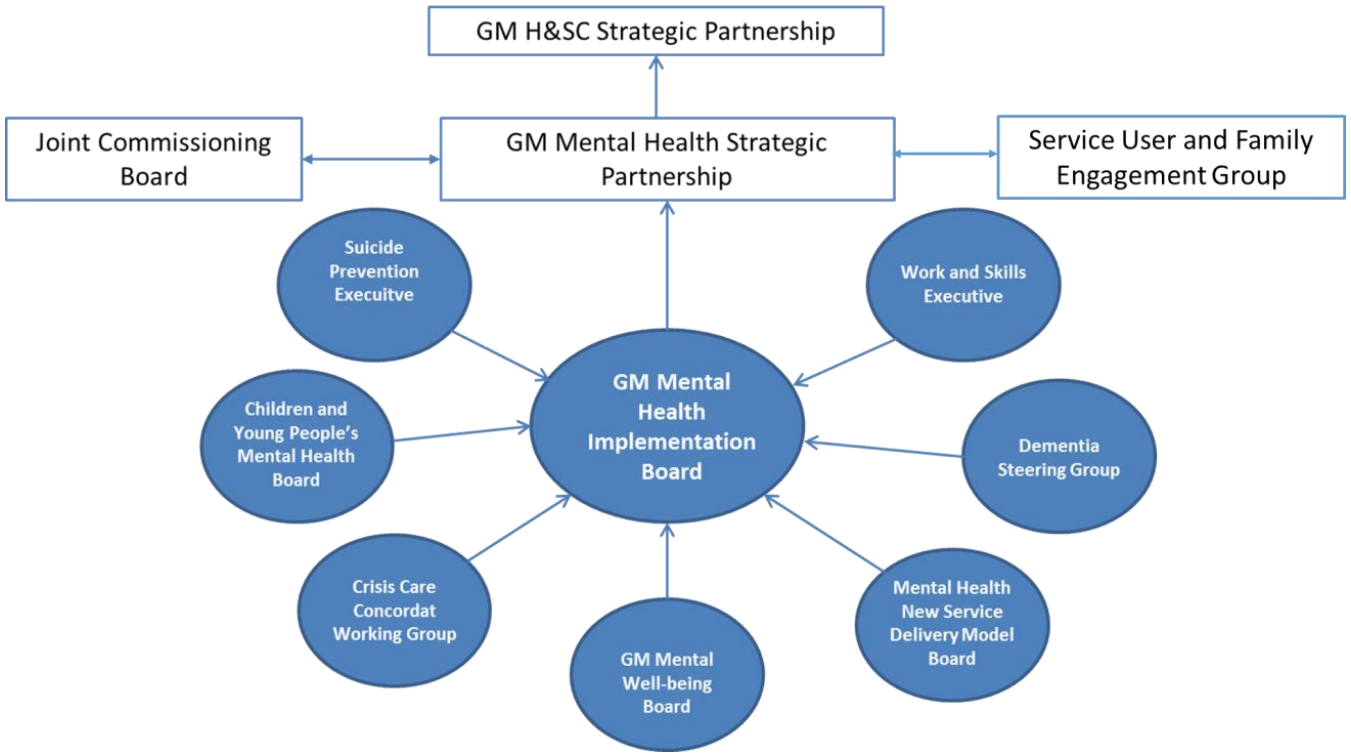
12.0 GOVERNANCE INFRASTRUCTURE

The strategy will be governed by the Greater Manchester Suicide Prevention Executive which will receive monthly updates on progress against each work stream. The suicide prevention work stream is closely aligned to the mental health and wellbeing programme. The strategy will be presented to each Health and Wellbeing Board for comment and support.

Stakeholder feedback will be sought from each of the ten boroughs, and through relevant events where key partners will be able to input into its ongoing development.

A programme management approach will be utilised to focus on delivery and measurement of impact during 2017/8 and 2018/9 which will form the basis of the work of the Suicide Prevention Executive.

A full equality impact assessment has been undertaken in respect of the strategy, and the 'place' of the GM Suicide Prevention Executive within the overall governance framework for implementation of the broader strategic GM Mental Health Strategy for Greater Manchester is set out below



Appendix 1 – Greater Manchester Mental Health Strategy.

Compelling Vision

Strategic Plan on a Page