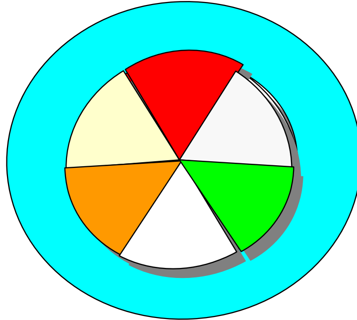
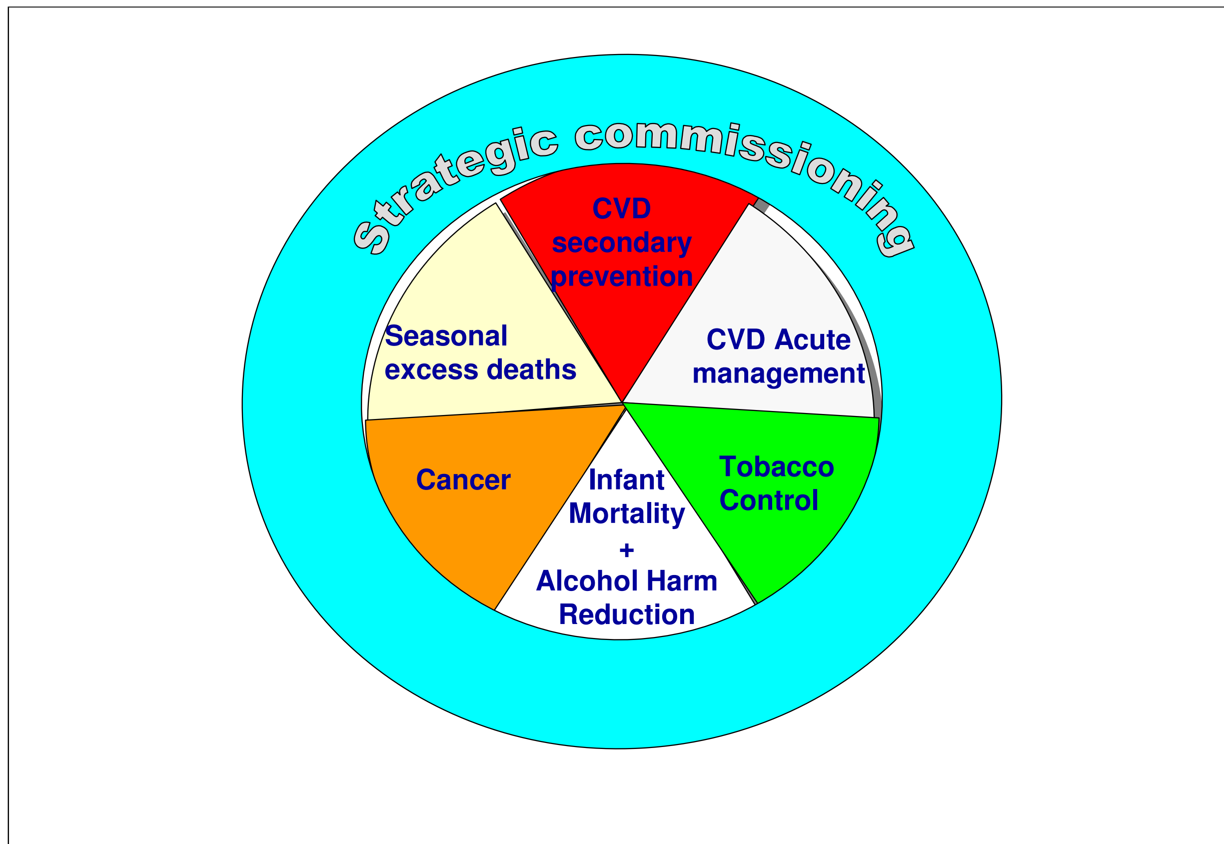
Health Inequalities
National Support Team Feedback

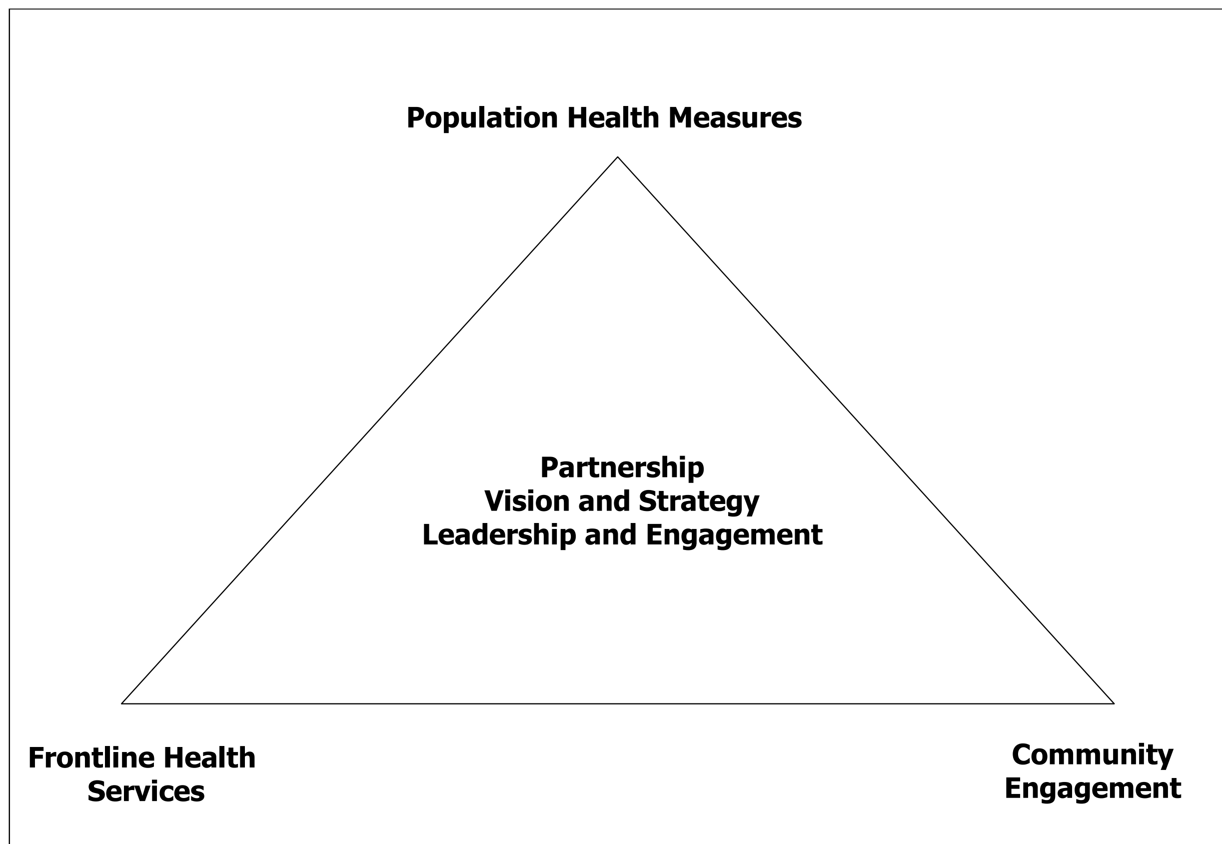


Manchester
March 2009

This presentation was delivered during the final plenary session of the NST visit and has been annotated and slightly amended as a result of feedback we received from attendees at the closing plenary.



The 1 to 1 discussions concentrated on strategic aspects of addressing health inequalities, the results of which are reported in this presentation, while the workshops looked at 7 contributors to the life expectancy gap i.e. Cardio Vascular Disease (CVD) secondary prevention, CVD acute management, tobacco control, cancer, alcohol harm reduction, preventing seasonal excess deaths and infant mortality.



Achieving percentage change at population level can be pursued in three main ways

Population Health Level

Direct input at population level through legislation, regulation, taxation, mass media etc. (eg preventing smoking in enclosed public spaces)

Personal Health Level (Frontline Services)

Applying effective personal health interventions (eg. cholesterol management with statins, affordable warmth) so systematically, and at a scale that improvements add up to population level change

Community Health Level (community engagement)

Engaging, developing and empowering communities effectively and systematically enough that resulting health improving and health seeking behaviours result in percentage change at population level.

Achieving improvement in health inequalities through a combination of these factors will depend on 'the organised efforts of society' at four points in the population health triangle as shown above. The whole must be driven by committed leadership fostering engagement, effective local strategic partnership, and locally owned, coherent vision and strategy. Interventions must be provided effectively with system and scale by frontline services pro-actively pursuing health outcomes

Community development should be addressed in a systematic, rather than ad-hoc approach, targeting engagement and support to the weakest, and least capable of responding alone. A range of processes should connect frontline services into the heart of communities, reaching out to 'seldom seen, seldom heard' groups and individuals.

Strengths

Leadership & Engagement

- Public Sector organisations in Manchester are perceived to have strong leadership which is committed to improving health and reducing health inequalities.
- There are designated health champions amongst elected members of the City Council.
- Manchester City Council (MCC) is a 3 star authority and is seen to have benefited from a long period of continuity of leadership
- The PCT was recently assessed by the World Class Commissioning (WCC) Panel as green/amber and scored largely grade 2 across the range of competencies.
- Public Health is perceived to have emerged from the period of transition as a very strong influence on the local health economy. Health improvement is now upper most amongst the priorities of the commissioning authorities and there are strong levels of engagement with all partners including a strong emphasis on provider organisations.
- The Acute Trusts and Manchester Community Health (MCH) have developed strong internal focus on public health, including some reorganisation to place the responsibility for this portfolio at a senior level. “Need to match the public health focus of commissioners”.

Leadership & Engagement

- The arrangements for clinical engagement across the City will necessarily be varied and complex. The PCT has invested resources in development of Practice Based Commissioning (PBC), but the structures, processes and outcomes have evolved differently in each of the three hubs. World Class Commissioning Panel identified the strengths of the model adopted in South Manchester, which is able to demonstrate tangible achievements most clearly at present.
- The arrangements for primary and secondary care clinicians to engage around areas of common concern, e.g. patient care pathways, prescribing guidance are also different in each of the three hubs. There are good examples from each area, although this does not necessarily lead to consistent and equitable outcomes City-wide.

PCT – Primary Care Trust

Leadership & Engagement

- There is an exemplary approach to leading through corporate citizenship across public sector partners, through schemes such as;
  - Cross Sector employment group for the city which includes a specific focus on the recruitment of BME people to reflect the demographic make-up of local communities
  - Each of the Acute Trusts has strong programmes reflecting targeted employment, skills development through the academy, staff health and sustainability
  - The City Council in partnership with NHS Manchester has a "Built Environment Group" that seeks to marry up Public Sector capital programmes to benefit local residents.

BME – Black and Minority Ethnic Community

Partnerships: Structures and Processes

- The Manchester Partnership demonstrates excellence through a cohesive approach to tackling health inequalities.
- There is a long standing commitment to partnership across the City. The re-establishment of one PCT across the City is seen to have reduced transaction costs substantially and the current arrangements are seen as strong, trusting, productive and fit for purpose.
- The NHS is well represented across the PCT strategic structure, in key positions to make a significant contribution.
  - PCT Chief Executive chairs the Public Service Board (PSB), which is also attended by the DPH.
  - The PCT Chair sits on the Manchester Board.
  - The PCT is represented at a senior level on all of the thematic boards.
  - The NHS Provider Trusts are well represented on some of the thematic Boards.

Partnerships: Structures and Processes

- There are regular separate board-to-board meetings between the PCT and the Council. The PCT Board also meets regularly with each of the NHS Provider Trusts.
- There are a range of cross-representations between organisations, in particular:
  - The PCT Chief Executive sits on the senior management team of the Council, which is a rare example of the culmination of partnership working.
  - The Deputy Council Chief Executive attends PCT senior management team.
  - Senior Social Service representatives attend PCT PEC.

PEC – Professional Executive Committee

Partnerships: Structures and Processes

- The Joint Health Unit (JHU) provides an important intelligent interface between the NHS and the City Council, bridging:
  - Access for the NHS into what they otherwise might perceive as ‘silo’ directorates in the City Council.
  - Access for Local Authority to the plethora of NHS bodies across and beyond the City boundaries.
  - Between the two environments the Unit is seen as an honest broker. The JHU is seen to be genuinely jointly owned by health and local authority and, jointly resourced, it is well embedded in and respected by both partners.
  - The Unit has an excellent reputation for programme management and financial competency, with a track record of looking after resources well.
  - Provides the focus for joint analysis and appraisal, including for development of the Joint Strategic Needs Assessment.
  - It is a vehicle for joint commissioning/joint provision of Public Health and wider determinant programmes, e.g. Valuing Older People Group.
  - The Unit has provided a continuity of focus for Public Health leadership during the health service reorganisations of the past seven years.

Partnerships: Structures and Processes

- Although the DPH post is not formally joint between the PCT and the City Council, the HINST believes that the unique arrangements in Manchester more than compensate for that. The strength of health resource and influence brought into the Council by the Joint Health Unit, the presence of the PCT Chief Executive on its senior management team, and the strength of health representation on the partnership structures allow the DPH to retain professional independence in providing Public Health advice to both.
- It is acknowledged that the City of Manchester is a part of a complex multi-tiered set of partnerships. This brings with it a range of obligations and benefits which must be balanced in deciding priority of attention and committed resource.
- The partnerships at Greater Manchester level, including the Association of Greater Manchester PCTs are pursuing closer joint working and have been given decision making powers by member organisations. Strong programmes emerging from these arrangements include the Greater Manchester Health Commission with a focus on on Health Inequalities, Tobacco Control, Affordable Warmth and Worklessness.

DPH – Director of Public Health

HINST – Health Inequalities National Support Team

Partnerships: Structures and Processes

- Within the focus of the Manchester City Region seven commissions have been established. The Greater Manchester Health Commission has been given the remit to impact assess the work of the other commissions to ensure progress leads to reduction of the inequalities.

Vision and Strategy

- Manchester is at the core of the City region and is the principal economic driver in the North of England. The City region is the best performer outside London.
- In the past fifteen years world class sports facilities, expanding service industries, and thriving universities have brought new money and jobs to Manchester.
- The Partnership has a clear strategy that the wealth that is coming into the City should be shared amongst its residents, who should have lifted aspirations for their future.
- The Improving Health in Manchester Programme informed by a robust partnership and public engagement process has been welcomed by Manchester Partnership and steers the health priorities within the Commissioning Strategic Plan.

Vision and Strategy

- The current iteration of the Local Area Agreement (LAA) was developed from an excellent evidence-base, including the State of the City reports from the Local Authority augmented by material from the Joint Health Unit.
- The partnership engagement around the development of the second LAA was strong, which provided a firm base for negotiation and dialogue with regional and national government offices.
- There is a strong health and health inequalities component to the agreement, with it including the main PSA targets, on life expectancy, CVD and cancer mortality amongst other mainstream lifestyle targets, e.g. alcohol and childhood obesity.
- The five-year Commissioning Strategic Plan and the Operational Plan to 2009/10 are well structured, accessible and sophisticated in their approach. They are established on the basis of good analysis and use of available evidence.
- Health improvement and health inequalities are uppermost amongst the priorities addressed, and account for for five out of the eleven main stated outcomes.

PSA - Public Service Agreement

CVD - Cardio-Vascular Disease

Vision and Strategy

- There are five Strategic Regeneration Frameworks and a separate plan for the City Centre and each of them has a clear focus on the contribution of coordinated regeneration activity to support health improvement and reductions in health inequalities.
- The acute and community providers have developed public health plans to demonstrate how they can improve the health of the local population. A number of these are exemplary and this level of response to the public health challenge from providers has not been seen anywhere else.
- Reports to the PCT Board all require a statement of impact on health inequalities. The same is also true of the business case process, which requires statements of:
  - Public engagement
  - Access and inclusion
  - Health inequalities
  - Health gain.

Vision and Strategy

- Manchester is one of the UK's designated Healthy Cities and draws well on the evidence base of the European Network and the technical expertise offered by the WHO Health and Urban Governance programme. Rather than treating this as a separate programme it is integrated well into other mainstream approaches, which is facilitated by its resource being managed within the Joint Health Unit.

WHO – World Health Organisation

Targets, Trends and Needs Assessment

- Despite limited public health analytical capacity in the City there has been a high quality of analysis which has formed the basis of a range of mainstream documents including the Joint Strategic Needs Assessment (JSNA), CSP and the 'Compendium of Statistics' and the Director of Public Health's Annual Report
- The JSNA was particularly well received locally and received plaudits within the Region.
- The JSNA is currently being developed further to include analysis by PBC Hub and extension down to ward level
- There has been particularly good analysis of mortality rates and other indicators to highlight inequalities within the City. Particularly innovative measures have included death rates by *Mosaic* group and the use of a 'relative index of disparity' for Manchester wards

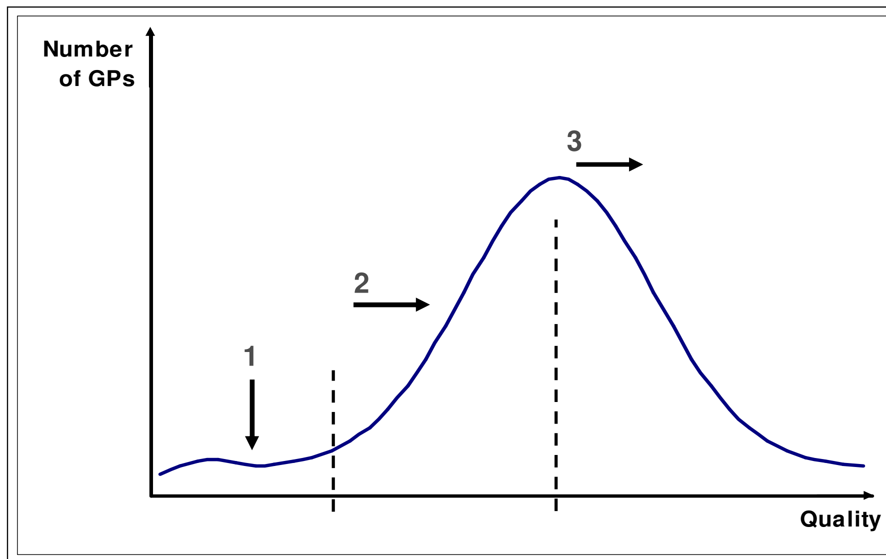
CSP – Commissioning Strategic Plan

PBC – Practice Base Commissioning

Targets, Trends and Needs Assessment

- The PCT is investing an expansion of public health analytical support, and is reconfiguring utilisation of the extra capacity by locating a post within the Performance Management Directorate at NHS Manchester. This move will enable an interpretation of population health information more centrally within the business of the PCT to support delivery on population health programmes on a real time basis. This will also allow population health influence to be brought to bear on the work of other analysts.
- Within the Health Intelligence function of the Joint Health Unit, despite minimal resources, a strong network infrastructure has been developed and an important legacy of quality and reliability has been established, e.g. drawing together inputs from the separate information resources within the Local Authority
- The JHU has also been resourced to carry out the analytical components of Health Equity Audits on behalf of the Partnership
- The JHU has established some links with Manchester University – e.g. developing population impact measures
- The PBC ‘Escalator Framework’ which links drawing down of devolved budget with performance in target areas has been designed to include public health indicators, so as to incentivise work in this area

Distribution of GP Performance



Action required:

- 1. Remove handful of practices that are incompetent and irremediable
- 2. Target underperforming practices for ‘high challenge, high support’ from PCT
- 3. ‘Raise the bar’ with higher expectation of all practices through ‘integrated governance’ and incremental incentives
- Where no progress, consider partial or complete competitive commissioning

Frontline Services

- There has been a programme of activity to generate improvements in quality in primary care in each of the three City hub areas. Historically, the approaches have varied, and there are some persistent differences.
- There has been a robust approach taken to practitioners giving cause for concern, and a track record of successfully moving on the small number whose performance has not responded to other measures
- The NST has been impressed by the conceptual framework represented by the Manchester Standard. This well thought out and evidence based approach, being taken forward as an important part of the CSP, brings a unique population approach to the issues of patient safety and quality improvement, and seeks to draw the whole system together to address them, including joint commissioned services as well as those in the NHS.
- In its first iteration, the project seeks to map current quality measures across the system, and to fully utilise these more effectively as quality profiles, while identifying gaps which might be filled.
- Some of the proposed components of the Standard eg adoption of the Never Events approach, show early promise, and have attracted attention nationally

CSP – Commissioning Strategic Plan

Frontline Services

- There is good and effective medicines management and prescribing support team which has well developed relationships with all practices and improving links with the PBC clusters. There have been some successes in improving cost effective and effective prescribing practice across the City
- The engagement and development of Community Pharmacy across the City appears excellent. There is very good access, and most facilities have consulting rooms now. There are 8 very significant enhanced services with very good uptake, and the current CVD screening pilot in 35 targeted areas has been going well, and should make a major contribution even before roll-out. Links with public health in support of annual campaigns are strong
- The PCT has signed up to the national initiative, Race for Health, promoting the health of people from black and ethnic minorities – giving insight into the outcomes for BME patients on disease registers

Frontline Services

- There are some good working relationships between primary and acute care providers – including clinical assurance boards and clinically led groups developing patient pathways
- Manchester Community Health hosts the the Condition Management Programme with Job Centre Plus to improve people's pathways to work by helping them manage the impact of long term-conditions on their employability
- It hosts one of the national pilots for the 'Family Nurse Partnership' scheme – which is designed to support young single mothers with intensive casework and avoid the perpetuation of chaotic families
- Frontline staff are developing some practical solutions to overcome the problems of working across boundaries
- The 'Points for Life' scheme is an innovative way to promote healthy lifestyles that has emerged from partnership working across the public and private sectors
- The 'Resident Wages' project will map the services provided in the three pilot localities, as a basis for developing more integrated support for families and individuals with multiple needs

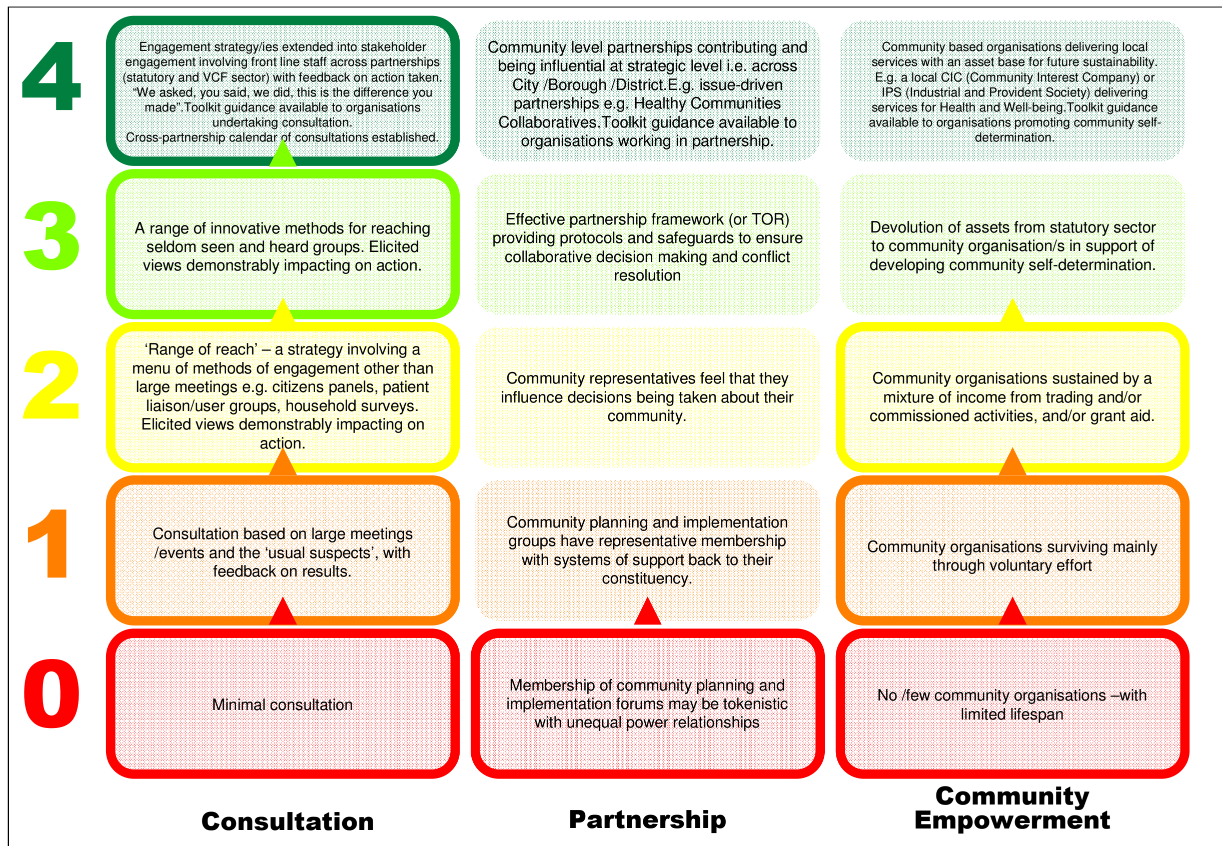
Community Engagement

The NST has developed a community engagement good practice framework which identifies those elements that are necessary to achieve a systematic, comprehensive and effective strategic approach to community engagement. This includes the following elements :

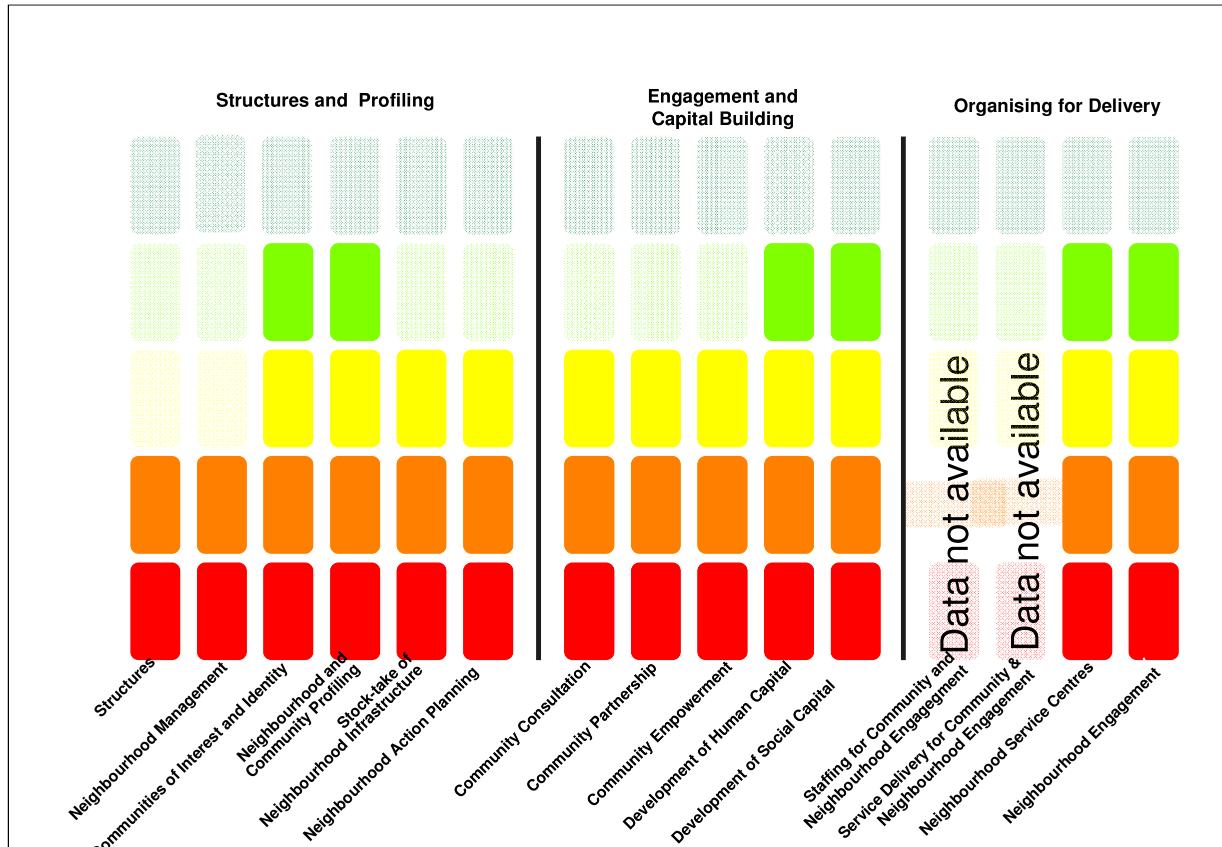
- **Structures and Profiling:**
  - Neighbourhood Structures
  - Neighbourhood Management
  - Communities of Identity and Interest
  - Neighbourhood and Community Profiling
  - Neighbourhood Action Planning
- **Community Engagement and Building Social Capital**
  - Development of Human Capital
  - Development of Social Capital
  - Community consultation
  - Community partnership
  - Community empowerment
- **Service Delivery and Strategic Support**
  - Staffing for community and neighbourhood engagement
  - Service delivery for community and neighbourhood engagement
  - Neighbourhood Service Centres e.g. Primary Care, Healthy Living Centre or LIFT, BSF or Extended School, Employment and Training Access Point
  - Service organisation for community and neighbourhood engagement

Local Improvement Finance Trust – LIFT

Building Schools for the Future


4
Engagement strategy/ies extended into stakeholder engagement involving front line staff across partnerships (statutory and VCF sector) with feedback on action taken. "We asked, you said, we did, this is the difference you made".Toolkit guidance available to organisations undertaking consultation.
Cross-partnership calendar of consultations established.
Community level partnerships contributing and being influential at strategic level i.e. across City /Borough /District.E.g. issue-driven partnerships e.g. Healthy Communities Collaboratives.Toolkit guidance available to organisations working in partnership.
Community based organisations delivering local services with an asset base for future sustainability. E.g. a local CIC (Community Interest Company) or IPS (Industrial and Provident Society) delivering services for Health and Well-being.Toolkit guidance available to organisations promoting community self-determination.
3
A range of innovative methods for reaching seldom seen and heard groups. Elicited views demonstrably impacting on action.
Effective partnership framework (or TOR) providing protocols and safeguards to ensure collaborative decision making and conflict resolution
Devolution of assets from statutory sector to community organisation/s in support of developing community self-determination.
2
'Range of reach' – a strategy involving a menu of methods of engagement other than large meetings e.g. citizens panels, patient liaison/user groups, household surveys. Elicited views demonstrably impacting on action.
Community representatives feel that they influence decisions being taken about their community.
Community organisations sustained by a mixture of income from trading and/or commissioned activities, and/or grant aid.
1
Consultation based on large meetings /events and the 'usual suspects', with feedback on results.
Community planning and implementation groups have representative membership with systems of support back to their constituency.
Community organisations surviving mainly through voluntary effort
0
Minimal consultation
Membership of community planning and implementation forums may be tokenistic with unequal power relationships
No /few community organisations –with limited lifespan
Consultation
Partnership
Community Empowerment

National Support Team Visit re Health Inequalities - March 2009



Community Engagement

Communities of identity and interest

MCC has an Equalities team; every service has an Equalities champion, and uptake of services is analysed and fed back to the Manchester Partnership. Corporate Performance in the Council has produced profiles of service usage against population.

Every PCT business case has an Equality Impact Assessment [60 completed] -effecting changes in policy development, business case approval, service redesign and tender specification, and supported by training for staff (including all directors).

The PCT identifies with 16 ‘Communities of Interest’ mirroring the equality strands, working with, e.g.:

•(BME) Manchester Health and Race Forum

•(LGBT) the Lesbian and Gay foundation

Neighbourhood and community profiling

The MCC State of the City Report includes ward profiles, with health profiles as part of this –produced by the JHU.

The next JSNA will develop information and incorporate community views into a locality framework based on the 3 PBC localities.

MCC – Manchester City Council

BME – Black and Minority Ethnic

LGBT – Lesbian Gay Bisexual Transgender

Community Engagement

Development of human capital

There is a range of good examples including:

–'Training up' Older Peoples Partnership Board members to become 'expert' partners – including, for example, job shadowing.

–Resident Wages Project –actively seeking engagement (Police and other agencies) with disengaged households in Collyhurst, and Benchill–with an employability agenda.

Development of social capital

There is a culture of developing social capital, with examples including:

– Inter-generational work under the Valuing Older Peoples Partnership

– Cohesion work between Afro-Caribbean and Somali communities

– Manchester University and MMU students developing a befriending service in the east of the City

– Johnnie Johnson Housing Trust facilitating cultural swap days to facilitate Chinese elders to move into flats on the city centre fringe

– Mela festivals in Rusholme.

Following the success of Healthy Living Network pilots e.g. Zest in the NE of the city – these are now to be rolled out across 14 sites

MMU – Manchester Metropolitan University

Community Engagement

Neighbourhood service centres e.g. Primary Care, HLC or LIFT centre, BSF/Extended School, Employment and Training Access Point

Joint Service Centres are open and in planning, including Adult Learning, NHS, libraries, Manchester College (FE), e.g. for Miles Platting, Longsight (2010), the Forum at Wythenshawe (with more of a focus on employability).

There is an engagement outreach team for Adult Education Centres.

Service organisation for community and neighbourhood engagement

There are information and good practice sharing networks –

•The Community Engagement Champions Network, including all council departments, the PCT and VCFS,

•The Valuing Older People Co-ordinating Group, including MCC and Health – professionals, trainers, and Healthy Living Network.

Community Engagement

Service organisation for community and neighbourhood engagement
Continued…

The Community Engagement strategy, at its 3rd revision, and Community Engagement Toolkit, are adopted by the LSP and shared across the Partnership – and accompanied by staff/agency training.

Organisationally, within MCC, the Community Engagement Strategy sits under the Sustainable Community Strategy, and within the PCT, under the Corporate Affairs Directorate, which holds responsibility for WCC.

Within MCC, community engagement is a crosscutting theme, originally driven by political support and a past history of democratic working.

Within the PCT, community engagement is driven by external imperatives, also a number of reference groups –the Public Engagement Steering Group, the LINk, and Manchester Alliance for Community Care.

In terms of an outcomes monitoring framework, the Draft Manchester Community Engagement Agreement to be shared by MCC across the LSP incorporates an Impact Measurement Framework, accompanied by a set of 7 Community Engagement Indicators – a mixture of resident perceptions and quantifiable indicators.

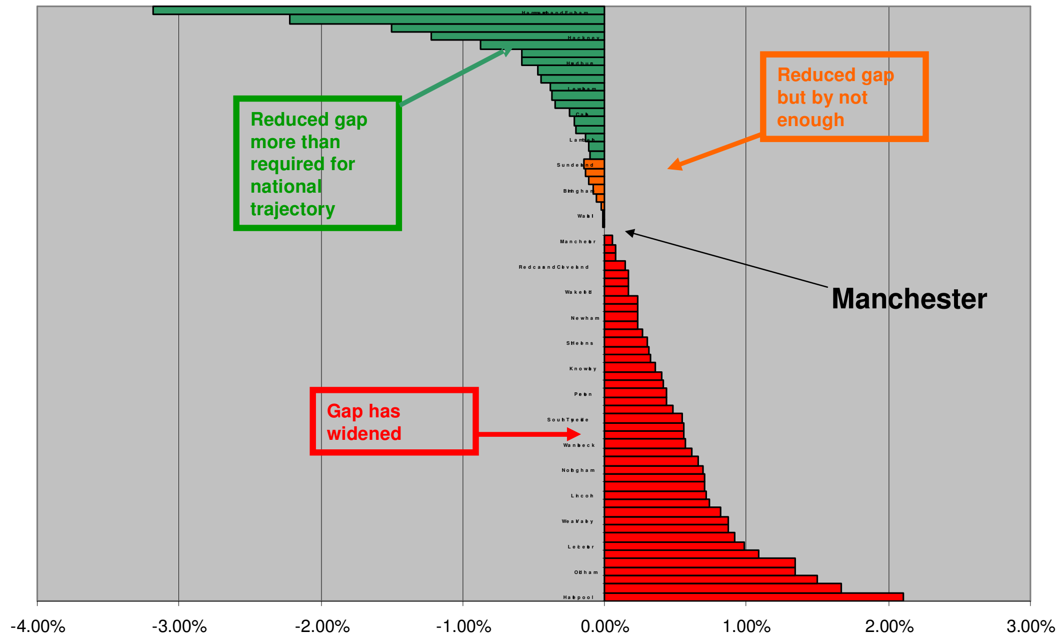
NHS engagement with the community

•The ‘Talking Health’ programme has provided a menu of opportunities for ongoing consultation with local people – a range of surveys, and ‘myNHSmanchester’ membership scheme (effectively a Citizens Panel for health, currently with 3500 members, and capable of segmentation).

•The NHS Manchester Health and Lifestyle Strategy outlines an approach to expand the existing successful Healthy Living Network pilots in the north and south of the City to City-wide provision. This will act at a community level to promote community empowerment and engagement in health and will establish community led services and projects that help promote a wide range of healthy lifestyles. Additionally, Health Trainers will work at an individual level to motivate and support specific lifestyle changes.

Recommendations

Females: % point change in gap in life expectancy at birth between Spearhead Group areas and England, 1995-97 to 2005-07



This chart shows the Manchester's position for % Change in Life Expectancy gap at birth between the Spearhead Group Areas and England (1996-7 to 2004-6) for women.

Males: % point change in gap in life expectancy at birth between Spearhead Group areas and England, 1995-97 to 2005-07

Manchester

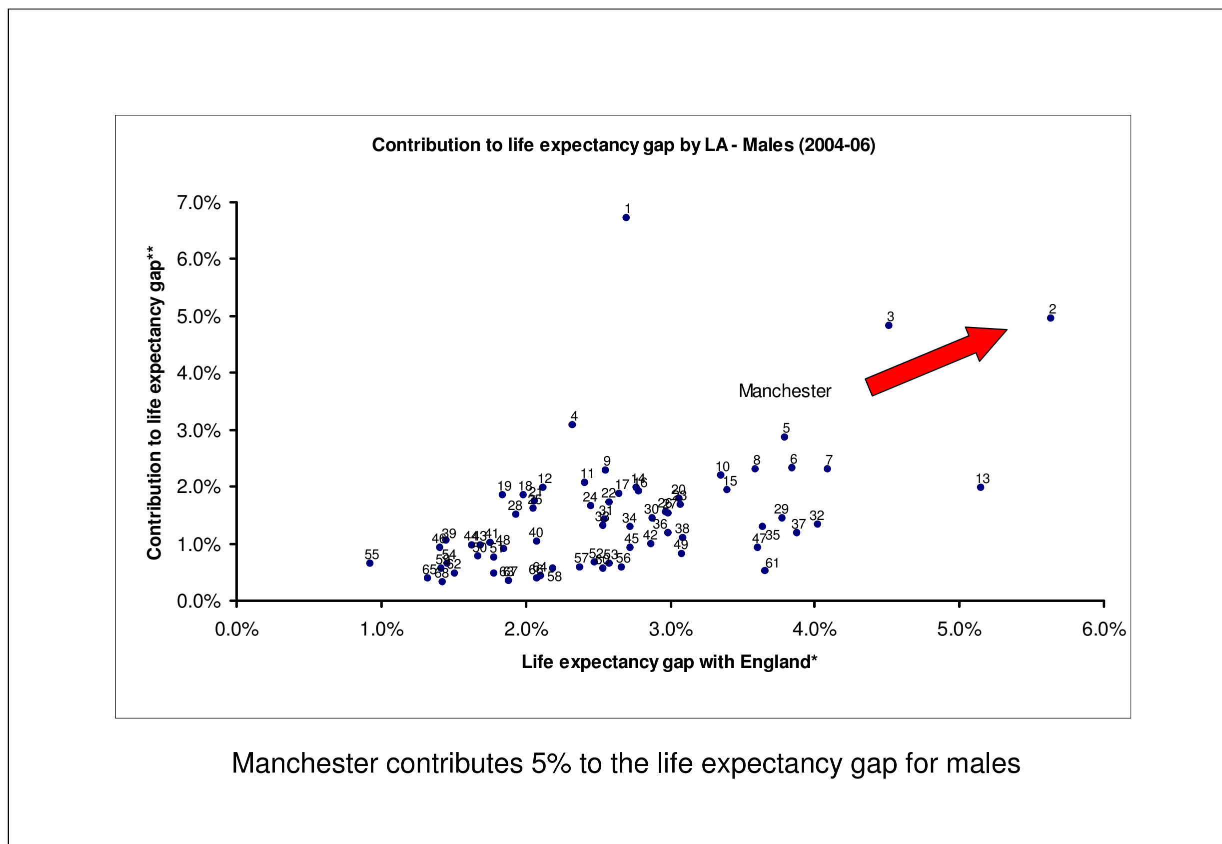
Reduced gap more than required for national trajectory

Reduced gap but by not enough

Gap has widened

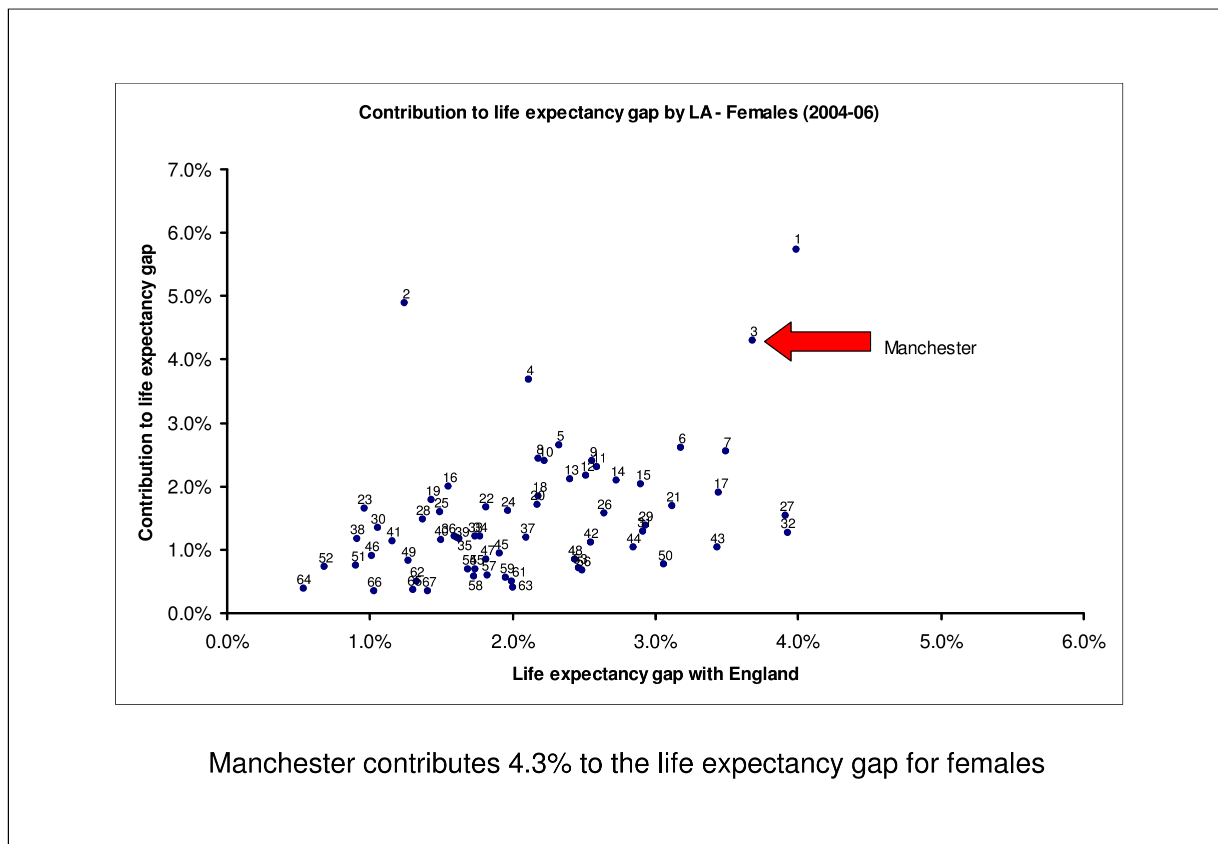
-5.00% -4.00% -3.00% -2.00% -1.00% 0.00% 1.00% 2.00% 3.00%

This chart shows the Manchester's position for % Change in Life Expectancy gap at birth between the Spearhead Group Areas and England (1996-7 to 2004-6) for men.



Manchester contributes 5% to the life expectancy gap for males

This figure demonstrates that Manchester contributes 5% to the overall Life Expectancy Gap for males and is the second largest contributor for this gap out of all Spearhead areas.



Manchester contributes 4.3% to the life expectancy gap for females

This figure demonstrates that Manchester contributes 4.3% to the overall Life Expectancy Gap for females and is the third largest contributor for this gap out of all Spearhead areas.

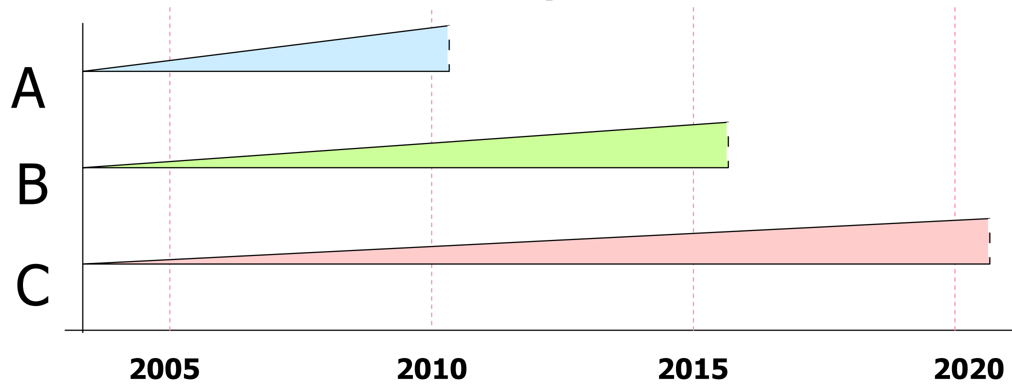
Vision and Strategy

Alongside your vision to be ambitious for the regeneration and development of Manchester as a place we think you should be ambitious for the health of your residents also. Rather than just meeting the minimum requirements of national targets, we would recommend that you aim for attainable but more testing local targets to narrow the gap in a substantial way.

COPD – Chronic Obstructive Pulmonary Disorder

Vision and Strategy

- The vision for improving health and reducing health inequalities is described through strategies that encompass three terms of planning, each with different focus but which need to be tied together by a 'Golden Thread' linking immediate delivery plans, through lifestyle and behaviour issues, medium term plans with long term sustainable regeneration strategies. There will also be common elements which will contribute to successful delivery e.g. addressing system, scale and sustainability



Vision and Strategy

A) Short Term Delivery

- The Commissioning Strategic Plan establishes the need for joint action to increase life expectancy and address health inequalities. There will be a complex array of interventions which can contribute to the achievement of the overall targets. Some of the main contributors have been established from the national review of evidence and subsequent guidance. However there are a number of significant causes of excess mortality not addressed e.g. seasonal excess deaths, COPD.
- For each of the causes of death included, some indicative actions are described but these do not constitute a comprehensive suite of delivery plans that together can demonstrate achievement of 2010 target and going further to improve the very poor life expectancy in Manchester.
- The HINST endorse the proposal to produce these as a component of the Thematic Action Plan for the Adult Wellbeing and Health Board.
- This section of the Thematic Action Plan would include delivery plans for each of the significant contributors to the health inequalities life expectancy gap, that can be addressed by 2010/11, as a milestone on the way to 2013 targets

COPD – Chronic Obstructive Pulmonary Disorder

Vision and Strategy

- The plans should have the following characteristics:
  - They should be rapidly assembled as working documents
  - They should include countdown milestones to 2010/11 within the 5 year framework
  - They should have detailed SMART objectives
  - They should be tested against the 'Christmas Tree' diagnostic
  - They should lay out and quantify the specific contributions by the PCT and PBC hubs, City Council (CC) and other partners such as the Acute and Mental Health Trusts.
  - The individual component parts should have designated leads
  - There should be clear outcome measures which can be built into commissioning intentions for health and social care and reporting mechanisms to inform each of the partners of their progress
  - Where appropriate, components should be included in other major partnership documents, e.g. refreshed Sustainable Community Strategy
- All interventions should be:
  - systematically applied;
  - industrially scaled;
  - sustainable;

Vision and Strategy

- The NST would strongly endorse the proposed approach using programme management principles in driving forward effective delivery of the Operational Plan.
- The NST would recommend a joint communications strategy be developed which would include an information plan to support the Health Inequalities delivery plans. Information should be made available in user friendly ‘marketing’ formats for a range of audiences including seldom heard groups, staff and independent clinicians

Vision and Strategy

B) Medium Term Delivery

- The components of medium term plans, particularly around lifestyle behaviour change, are present in the Commissioning Strategic Plan (CSP) and LAA. It may be appropriate to follow a similar approach within the Thematic Action Plan to delivery planning to ensure that a system scale and sustainability are also addressed for these to ensure impact at population level.
- The achievements of these plans will be dependent upon the protection and development of some programmes, e.g. social marketing, which may be vulnerable to cost pressures arising from unplanned activity. The establishment of detailed and modelled delivery plans will enable stronger business cases to be prepared for such interventions.

C) Long Term Delivery

- The raft of strategic plans present a coherent approach to economic regeneration, leading to sustained health improvement and the reduction in health inequalities. However, this linkage is not currently set out clearly in some key strategy and policy documents e.g. Sustainable Community Plan, MCC Corporate Plan. Similarly, a coherent and consistent ‘Golden Thread’ that draws this theme between the strategies is not clear to those who have not been involved in developing them.

Leadership & Engagement

- The HINST endorses the plans to develop a Gateway Initiative to limit the unplanned growth in acute sector expenditure, which is now urgently needed to implement, upscale and safeguard programmes to improve health and reduce inequalities, which should reduce unplanned demand over time.
- Strategies for prevention and early diagnosis will need, as much as possible, to include the results of modelling to establish predicted impact on elective and emergency pressures within the acute sector. These may not be strictly evidence based, but will need to involve plausible and coherent plans with assumptions that can be tested, and milestones for tangible delivery
- Whilst there is commitment across the PCT directorates to tackling inequalities, there needs to be clearer designation of how that translates into the necessary contribution from each of them to achieve the 2010 PSA targets.

Leadership & Engagement

- There is a perception that there may have been a mismatch in expectation and understanding of the Public Health contribution to PBC working. It is recommended that, before establishing how such support is provided within the implementation phase of the CSP, a Learning Set is established to bring together representatives from the Public Health directorate and the JHU together with representatives from general practice. This would allow mutual learning in a safe environment and development of approaches that are fit for purpose.The NST could help to facilitate this.

- The PCT has adopted a culture of matrix working, which appears to work well at the level of senior leadership. However, the NST was made aware that this approach may create some confusion at “foot soldier level”. Some of this confusion may resolve when the PCT staff consolidate on to a single site. However, it is recommended that addressing the pros and cons of a matrix approach with staff would be a good use of the forthcoming organisational development programme.

Partnership: Structures and Processes

Voluntary Sector

- The lack of a CVS-equivalent infrastructure agency in Manchester must be a source of concern to Partners, although it is understood this is the subject of a contract which is out to tender. The NST recommends a Partnership-wide review of the relationship of the statutory with the VCFS sector, including:
  - The economic role of the local VCFS, including the greater extent to which funding of local organisations stays within the local economy,
  - The uniqueness of role of the local VCFS in accessing ‘seldom seen and heard’ community groups, including those least likely to access health services, and whose health prospects are the poorest,
  - The risk to survival for local smaller VCFS organisations in the absence of regimes of core grant funding -over and above small grants funding,

Partnership: Structures and Processes

- The extent to which mutual understanding can be developed between commissioners and local VCFS organisations e.g. through joint learning sets, leading to mutually agreed frameworks for commissioning,
- The need to 'market develop' the local VCFS to provide an adequate supply of providers to meet the needs of local commissioning,
- The extent to which the local VCFS is supported to 'grow into' commissioning, e.g. through subcontracting, consortium bidding, and statutory/voluntary sector partnerships,
- The need for VCFS infrastructure organisations to provide a menu of support to local VCFS organisations to help them develop into organisations which can operate as valuable partners by providing services which the statutory sector cannot,
- The need for the statutory sector to support VCFS infrastructure organisations so that they in turn can help local VCFS organisations as set out above.

Targets, Trends and Needs Assessments

- Targets for increasing life expectancy need to be broken down within the Thematic Action Plan to quantify:
  - The contribution to be made from each programme to the overall life expectancy targets, which will allow scaling of the resource needed
  - The contribution from partners in each locality/district that will enable each to manage their contribution
  - Intermediate milestones that will enable an overview of progress and performance management

We will respond to the dialogue we've had through the visit about the production of modelled contributions for individual programmes which might contribute to life expectancy targets by arranging a Northwest workshop, together with the regional tier advised by this partnership.

PBC – Practice Based Commissioning

NW PHO – North West Public Health Observatyory

QMAS –Quality Management and Analysis System

Targets, Trends and Needs Assessments

- Currently there is perceived to be some confusion over the numbers and trends related to achievement of the 2010 PSA targets. The PCT is advised to consolidate understanding of the targets to clarify:
  - Do the PCT trajectories include the stretch component of the PSA inequalities targets for Spearheads to enable it to close the gap on the national average?
  - Has this been adjusted to accommodate the over-performance of the national average?
  - Will achievement of this target for cardiovascular disease (under 75) and cancer (under 75), although achieving their own separate targets, provide sufficient contribution to the achievement of the life expectancy and all age or cause mortality targets for 2010?
  - And as a further development, will the trajectories be acceptable as a contribution to additional reduction towards more ambitious local mortality targets to reduce the gap greater than 10%?

If not, the trajectories may need to be re-modelled accordingly and the overall implementation plan adjusted.

Targets, Trends and Needs Assessments

- Of major importance will be opportunities opened up for a greater capacity of Public Health analyst function within the PCT which would strengthen the ability to:
  - Help bring public health interpretation to needs assessment and population elements routinely provided into primary care and hospital commissioning
  - Enable the establishment of routine indicators, trajectories and milestones to track progress on public health programmes
  - Provide a focus for work to model size and scale of programmes needed to achieve targets
  - Provide a focus for negotiating more locally relevant contribution, and drawing in network activity from GM PCTs/NWPHO/NW Cancer Registry
  - Add value to analysis in other sectors of the PCT e.g. QMAS, prescribing, Heath Informatics Service (HIS) and social marketing analysis

GM – Greater Manchester

NWPHO – North West Public Health Observatory

QMAS – Quality Management and Analysis System

Fig 7a - Prescribing Costs per Diabetic Pt (Apr 06-Mar 07) v Percentage of diabetic patients whose HbA1C has been 7.4 or less in the last 15 months (Apr 06-Mar 07)

Higher % pts at target - Low prescribing

Higher % pts at target - High prescribing

Lower % pts at target - Low prescribing

Lower % pts at target - High prescribing

% target met

NIC (£) per diabetic patient

By plotting the QOF outcomes, by practice, for diabetes indicators against the prescribing cost for that practice for diabetes medication, it is possible to identify practices which can be supported to improve.

Targets, Trends and Needs Assessments

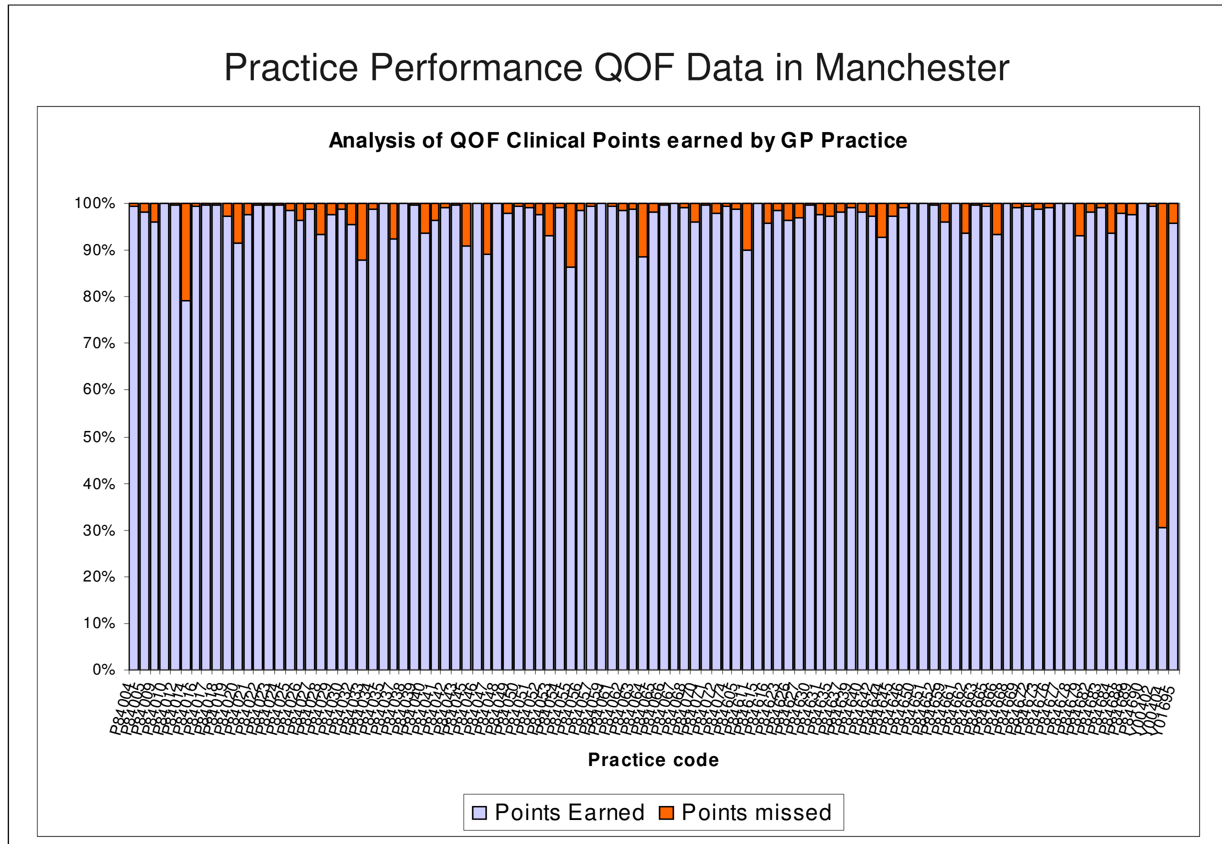
- There was a perception that components of LAA performance management could be more robust, and that the JHU would be well placed to support its development, particularly in relation to component reporting to the Adult Wellbeing and Health Board.

Frontline Services

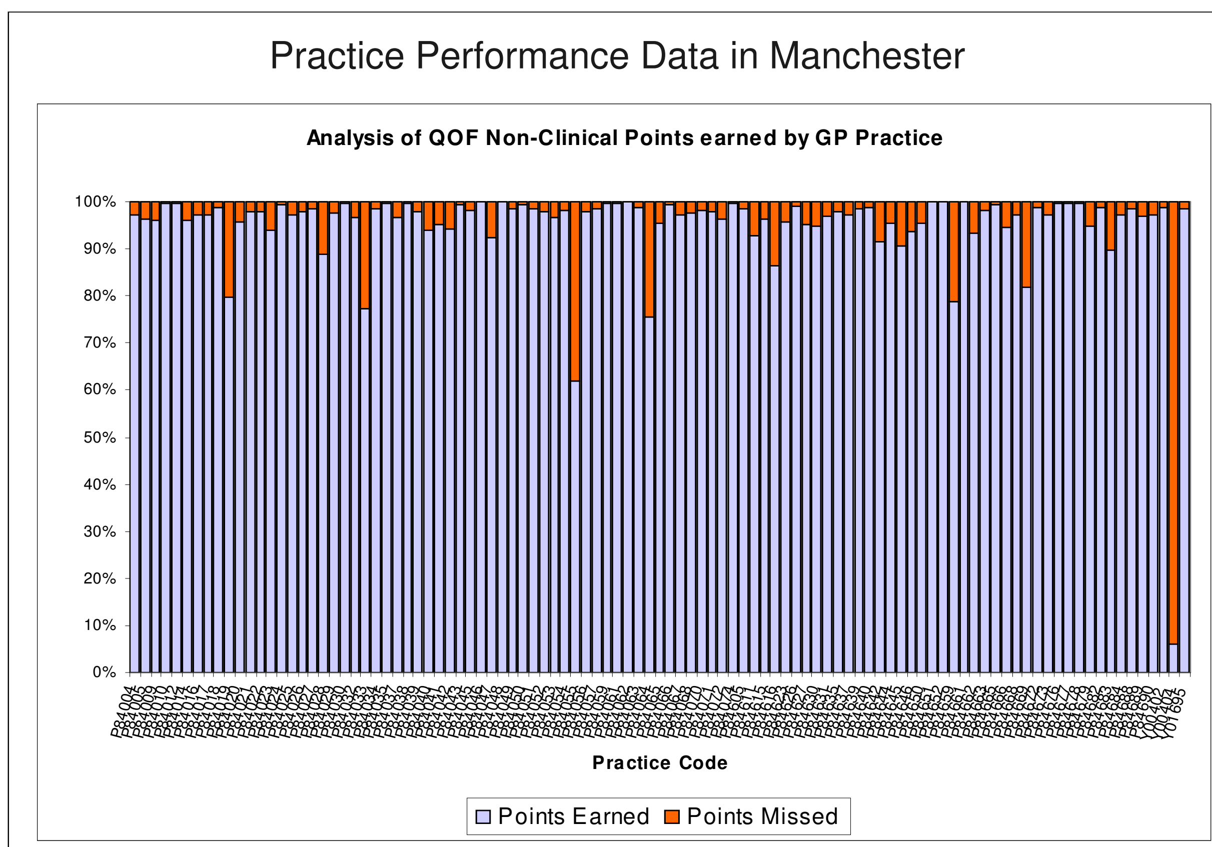
Delivery of the 2010 PSA target will depend to a significant extent on consistent high quality primary care services.

Currently Primary Care on average is moderately effective in those areas that the PCT has targeted – such as CHD – which has been the focus of systematic attention over a number of years. However, there are still substantial degrees of variation across practices, and across the hubs

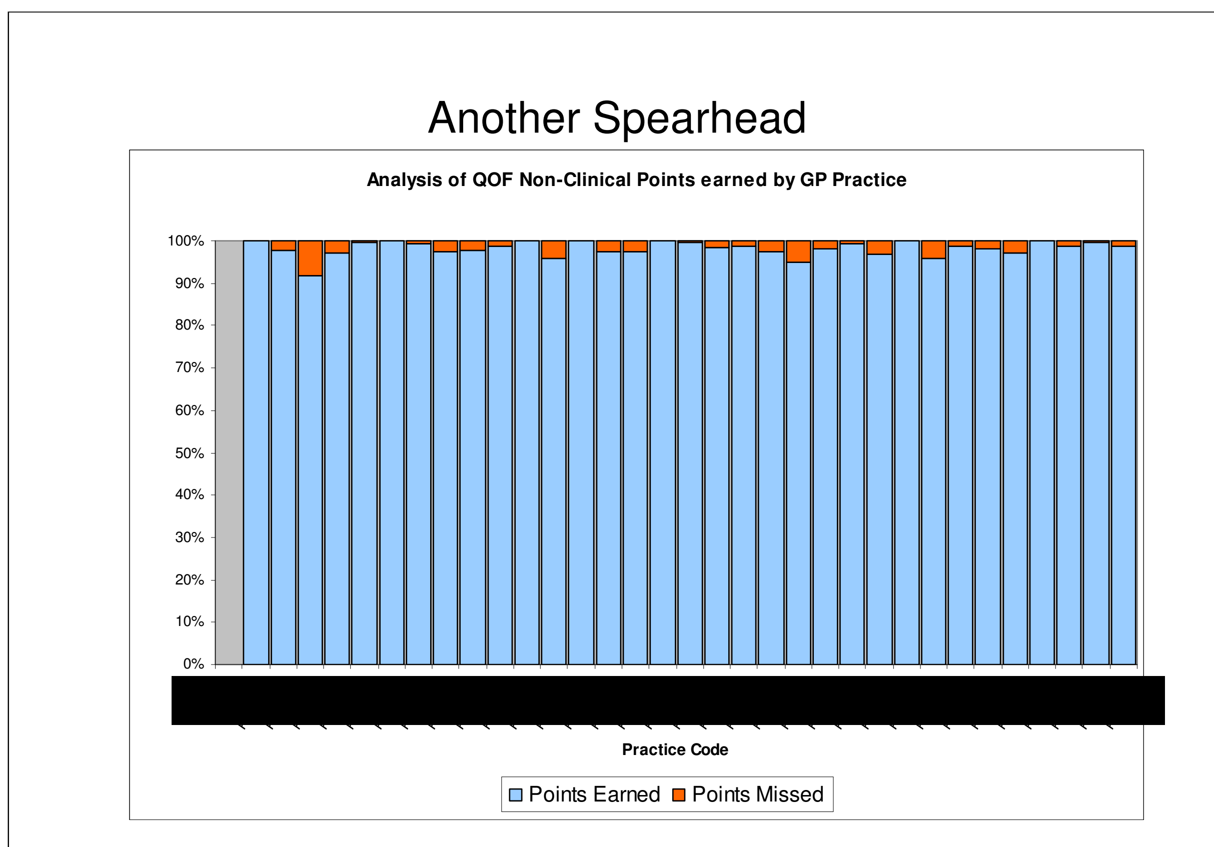
In order to narrow the gap the PCT will have to work to better understand and target variations and establish mechanisms locally to exceed baseline standards such as those laid down in the national QOF programme.



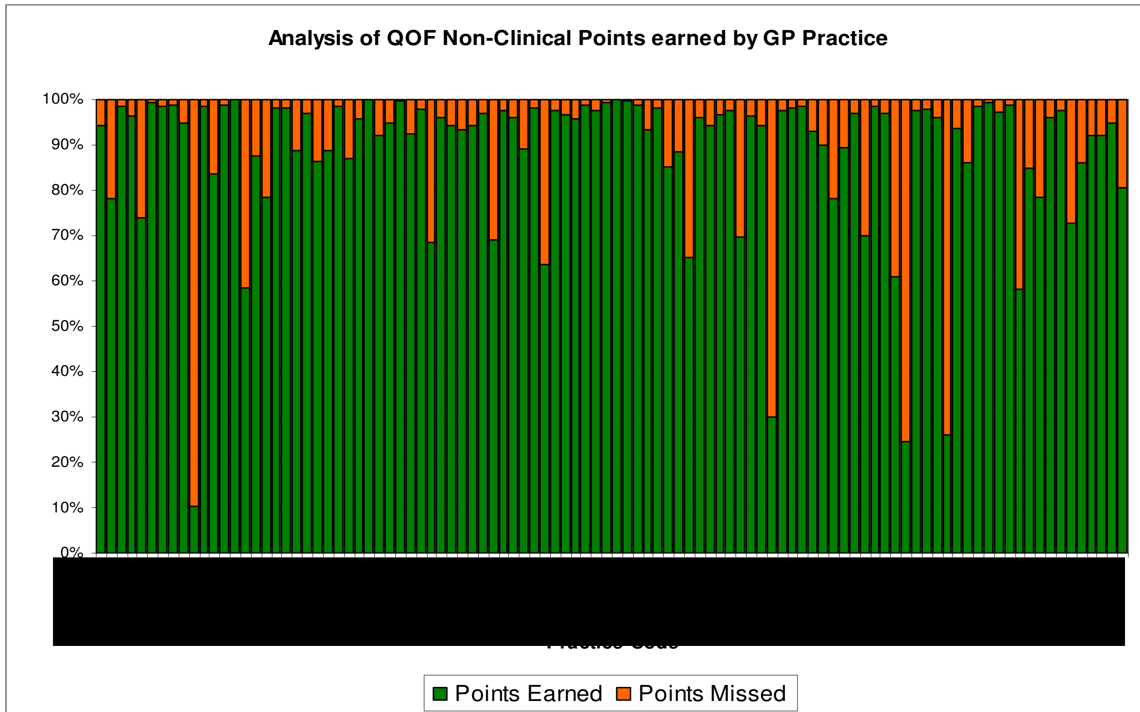
With the exception of one practice, the majority of General Practices across Manchester are performing well in achieving clinical points under the Quality Outcomes framework (QOF). Maximum points only requires around 70% achievement.



This illustrates that the majority of Manchester General Practices are achieving non-clinical points for indicators under the Quality Outcomes Framework (QOF). Two practices are not hitting the target. Maximum points under the QOF only requires around 70% achievement.

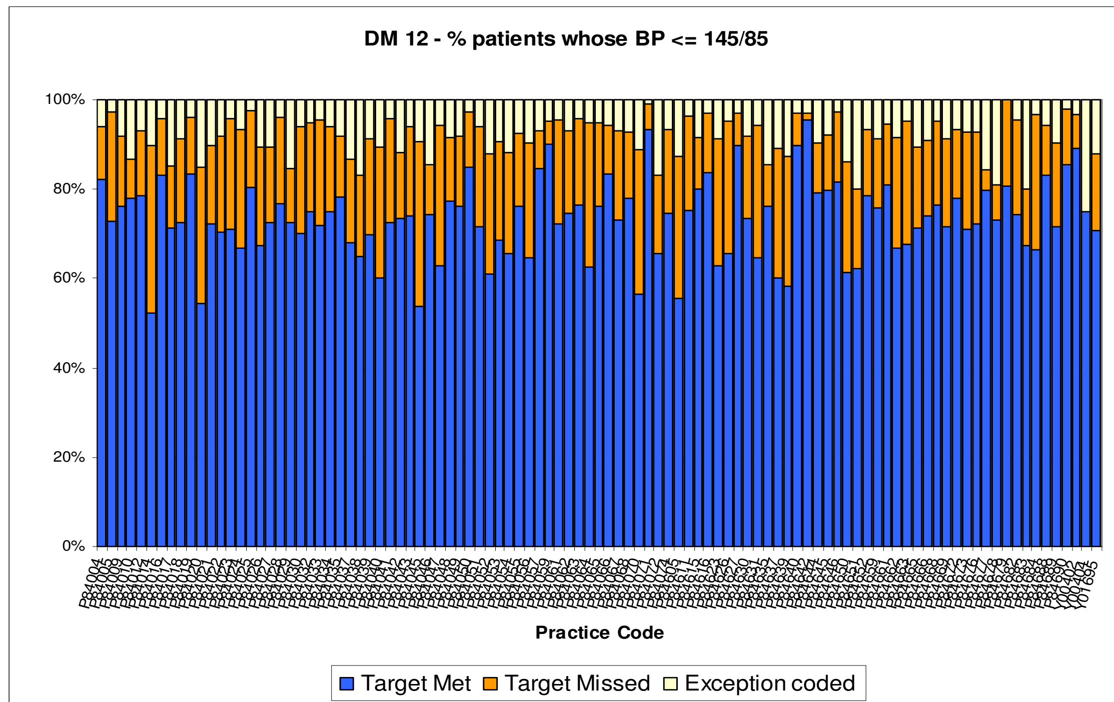


This is another spearhead PCT demonstrating a much higher level of non clinical points achieved across all practices



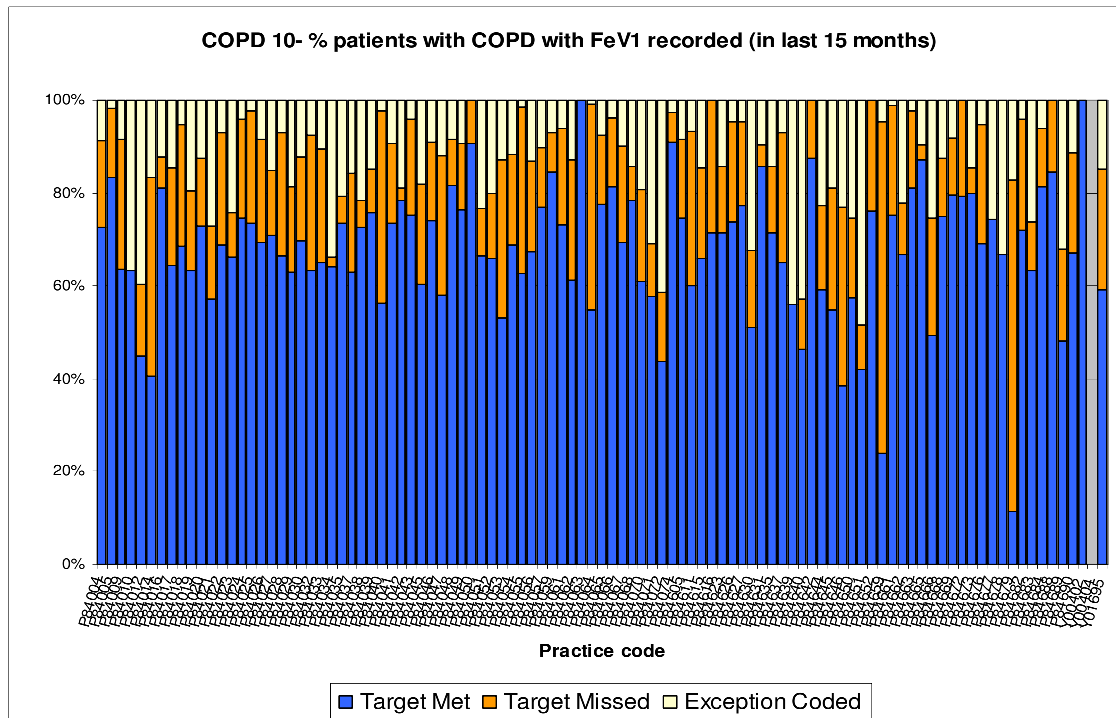
This illustrates another Spearhead area with much more variation in achieving its non-clinical QOF points. This is an indication that this Spearhead area does not have systematic practice development support in place.

Analysis of diabetes outcome indicators in Manchester



This illustrates that there is variation in control of blood pressure for patients with diabetes and variation in exception reporting between practices.

Analysis of COPD outcome indicators in Manchester



This illustrates that there is wide variation in successful management of patients with COPD in General Practice in Manchester and notable variation in levels of exception reporting between Practices.

Frontline Health Services

- Interpretation of current performance of GP practices against QOF outcomes would be enhanced by the development of a ‘taxonomy’ of practices, using readily available data to help cluster practice populations like-with-like. This would then accommodate interpretation in the light of issues such as high levels of churn, specific BME cohorts, and significant student populations. It would also assist in use of the Manchester Standard. The NST can signpost good practice which could be modified for local use
- Such analysis will enable contributory population factors to be laid alongside components of poorer practice performance. These may then be handled differently in ways that can be applied commonly to practices within the same taxonomy cluster. It will then be possible to compare practice performance with those in similar situations, identifying high flyers and poorer performers
- Performance management of primary care could be enhanced through better use of analytical intelligence and benchmarking and further development of user friendly feedback information on performance
- The Manchester Standard is scheduled to develop over a five year period, and the initial emphasis is likely to be on safety. It will be necessary in the meantime, therefore, to pursue a range of interim and targeted quality improvement initiatives to contribute to the 2010 PSA mortality targets

Frontline Services

- **Managing poor performance will require systematic application of interventions from the PCT, in conjunction with PBC clusters.**
- Adopting a more challenging performance management culture around areas of persistently poor performance. This needs to be multi-disciplinary with components including clinical/integrated governance, prescribing support, primary care contracting and lay input.
- The PCT needs to pool the capacity and expertise to provide a more holistic approach to performance development support where this is deemed to be necessary. Support packages will be needed to address specific areas of weakness, e.g. nursing support, practice management support, medicines management. PCT provider services could be commissioned to provide some of these 'wrap around' supports
- Rather than compensating for poor performance, development support needs to be cast as a 'recovery plan' as part of transition. PCT directorates should pool intelligence in a 'case conference' around each underperforming practice, and should coordinate development resources to support the recovery plan run by the practice itself.
- Such plans may be better brokered by the clinical leadership in the PBC clusters - peer support – and might be linked to the PBC escalator system to obtain greater leverage
- Where appropriate, the focus for recovery should be outcome focussed e.g. using QOF clinical outcomes for diabetes such as blood sugar or blood pressure management

PBC – Practice Based Commissioning

QOF – Quality and Outcomes Framework

Frontline Services

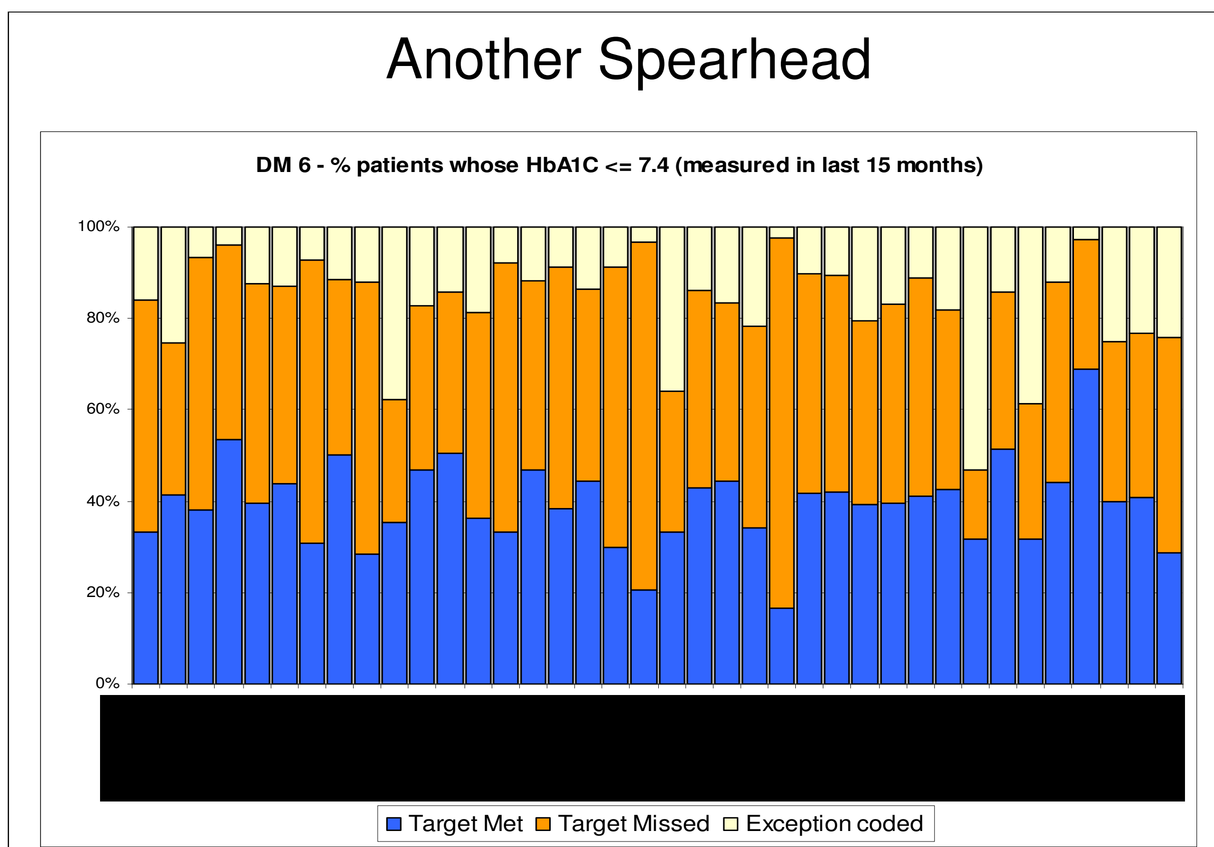
'Raise the bar' for everyone: 70% achievement (e.g. QOF maximum, breast cancer screen uptake) means 30% failure, often leaving behind the most vulnerable. The PCT should be ambitious, and explore mechanisms to incentivise delivery to people previously excluded, or excluding themselves

- Systematise the production of good quality, well presented information at practice level on important delivery areas – e.g. CVD, diabetes. Build on the concept to improve poorer performers to levels of effectiveness and cost effectiveness of the best, whose performance should be celebrated
- Use contracts with new entrants, e.g. the new Darzi practices, to also stimulate greater expectation
- Explore further components of a more exacting exemptions strategy in practices with higher levels of exceptions, through a study of patient characteristics in current excepted groups.

Frontline Services

- Review the use of local incentives to raise the ceiling of achievement on targets. Best practice observed by the NST has involved an 'exponential' scale of extra payments to reduce exemptions and to recognise the disproportionate cost of achieving equitable outcomes for people in more deprived and complex situations.
- The NST is aware of a range of approaches for achieving this:
  - Quality Improvement Framework (QIF), introducing an additional range of incentivised targets
  - QOF 'plus', raising the target of existing standards
  - Supplementary quality contract, with a block incentive, and a requirement to demonstrate a high baseline of service provision first in order to qualify

  All are accompanied by availability of development support as part of improvement plans
- There is a perception that good partnership working along pathways of care is currently dependent upon individual relationships and can result in patchy and un-prioritised progress. In order to make clinical pathways have their impact it will be important for there to be ongoing monitoring of their effectiveness and use, and for ongoing work to ensure that there is equitable use made of these evidence based systems by all practitioners.



This is another spearhead showing worse results

Frontline Services

- The opportunity should be taken to bring together whole systems of care to support specific conditions. Primary, intermediate and secondary care should be commissioned to address common outcomes e.g. diabetes HbA1c across the registered population
- In order to reduce inequalities in capability, practice by practice, in particular specialty areas, PCTs have commissioned-in variable support from secondary care. Where practices cannot consistently provide the whole package of care, specialist staff will compensate. Working alongside primary care staff in practices, they can have a developmental role, and practices can be incentivised to gradually take on greater proportions of the care.
- For example in some PCTs, the diabetes specialist service grades all practices L1 –L5 depending on a detailed assessment of historical performance. The specialist service then provided differential levels of support to patients. Training on-site is offered, and practices periodically reassessed. As GPs will have to buy in the services they are not accredited to deliver, there are incentives for practices to develop their competencies. Similar approaches could apply to other long term conditions e.g. COPD

Frontline Services

- There is an opportunity to mobilise partnerships further to promote healthier living – e.g. by training workers in the partnership and those organisations they commission services from so that every contact becomes a potential health contact – all staff health promoters. Provider services are demonstrating their interest in pursuing this role through the development of their own Health Improvement and Health Inequality strategies

- The NST recommends systematising and scaling up some of the good work in this area, through the development of a **Health Gain Schedule** for all provider services, making at least tobacco, alcohol and weight management everybody's business. This should involve:
  - key screening questions for frontline staff to use
  - brief intervention training and updates
  - referral pathways
  - an activity monitoring system

- A similar Health and Wellbeing Schedule could also be used by Local Authority commissioners with respect to their providers in relation to the contribution that can be made by front line staff.

SLA – service level agreement

Community Engagement

<u>Neighbourhood structures</u> (for communities of place)

Beyond the 2006-08 edition, there is an intention for a ‘Sense of Place’ workstream to produce a map of natural neighbourhoods. The NST endorses this approach, given that ‘natural neighbourhoods’ create a framework for collecting local information, and for neighbourhood engagement service delivery. A structure of natural neighbourhoods can be particularly important to:

- Ensure that the geography of service provision does not ignore the perceptual boundaries that have meaning for local residents. This can prevent serious errors in locating community facilities close to a perceptual boundary that residents will not cross.
- Help service providers to gear their services to local need, i.e. calibrating the intensity of service to the intensity of deprivation, and gearing the mix of services to local need.
- Create the ‘building blocks’ for service provision catchment areas –minimising the incidence of overlapping catchment boundaries.

Community Engagement

– If there is to be coordinated action to reduce health inequalities at a local level the Partnership will first need to decide how programmes will relate to the wide range of current organisational locality structures – e.g. (3) PBCs, (6) Regeneration / ALMOs, (a different 6) Childrens Services, (12) Adult Social Care Re-ablement Teams, or (14) District Healthy Living Areas . Over time it would help to rationalise these into coterminous units.

ALMO – Arms Length Management Organisation

Community Engagement

Neighbourhood management

With an average of over 10000 population per ward, and a Ward Co-ordination establishment of 1 ward co-ordinator @ 1 day per week, 1 full time Support Officer, and 1 Street Environment Manager; viewed from a Neigbourhood Management perspective, there are limitations on what this level of resourcing can achieve in drawing together a range of service provision (including Health) into meaningful dialogue with residents. The NST would recommend that the resourcing of the Ward Co-ordination/Management approach be reviewed at Manchester Partnership level with a view to developing an equal partnership/equal responsibility approach across Neighbourhood Policing, Environment, Health, Employment, Education and training, and Housing.

Communities of identity and interest

There may be scope for the development of a cross-Partnership shared approach - especially between MCC and the PCT - on monitoring equality of service use. This approach could be further enhanced by increasing its range, e.g. extending coverage to primary care

Community Engagement

Neighbourhood service centres e.g. Primary Care, HLC or LIFT centre, BSF/Extended School, Employment and Training Access Point

Working alongside the Joint Service Centre programme, there may be scope for the LIFT centres to–

–Address the gap between consultation and building completion (resulting in a fall-off of interest from consultees) by keeping the involvement ongoing e.g. by ‘Friends of…’ groups

–Enhancing health service provision within LIFT centres with co-located partner services.

Behaviour and Action

Developed

Infrastructure

Un-developed

Won't do Can do	Will do Can do
Won't do Can't do	Will do Can't do

Low **Motivation** High

This illustrates a relationship between individual motivation to access services and the level of development of the infrastructure of the services themselves to facilitate access. The aim is to ensure a developed infrastructure (through social marketing) and to work with communities to improve motivation e.g. through community development.

Community Engagement

Social marketing

- Social marketing principles continue to be an important tool as World Class Commissioning develops. The NST would recommend that partners build upon existing segmentation analysis by overlaying this onto neighbourhood profiles to augment understanding of preferences and probable responses of different segments of the population
- Furthermore the NST would recommend that partners develop a range of tailored 'customer access strategies' building on the understanding of segmental preferences to change the front end of services. This should be used as the basis of developing a Customer Access Strategy with relevance to a wide range of services. The NST could provide examples
- Social marketing is more than undertaking segmentation analysis of population characteristics or communicating messages. In addition to the planned and current social marketing training for commissioners and middle management, the NST would recommend that training is also offered to front line staff to enable them to engage with communities to gain and gather these market insights to inform commissioning and to undertake insight driven approaches to motivating behaviour change among local people

  The NST could provide further support on this
- The NST would encourage moving towards a single bespoke approach to social marketing developed across the partnership

NHS Engagement with Communities

- With the introduction of the acute sector reconfiguration, movement of services into local centres, and the expansion of primary care facilities e.g. through LIFT projects, Joint Service Centres and Darzi Centres, there is an opportunity to develop a supportive infrastructure to provide two way links into yet-to-be reached sections of the community. Neighbourhood Management Structures are well placed to take this work forward through the following approaches:
  - An understanding of natural neighbourhoods and the perceptual boundaries that have meaning to residents, including boundaries between different ethnic neighbourhoods.
  - An understanding of how far a new centre will 'reach' into its own hinterland, including how far residents will come to the centre for services, and the extent to which any outreach services developed from the centre; (not only distance but 'reach' into communities of interest)

VCF – voluntary community and faith sector

NHS Engagement

- Map of the ‘hinterland’ to show:
  - —Formal statutory resources (community nursing, social care, tenancy support)
  - —Street workforce (health trainers)
  - —Facilities (Childrens’ Centres, Fire Stations)
- Risk assessment with local intelligence on social inclusion, chaotic families, disruptive influence reporting
- VCF inputs and resources Utilisation of the community maps, with social segmentation and customer access preferences
- Ensure sufficient capacity for dedicated staffing for the catchment (neighbourhood)
- Re-design programme for coordinated, efficient and effective use of local resources to provide two-way infra-structure, drawing in local community to connectivity and delivery