AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Voting Members : Penny Martin, Supt Suzanne Downey, Val Hussain, Geoff Little, Lesley Jones, Councillor Andrea Simpson (Chair), Sajid Hashmi, Dr Jeffrey Schryer, Keith Walker, Councillor Eamonn O'Brien, Councillor Roger Brown, Councillor Debbie Quinn, Will Blandamer, Sheila Durr, Adrian Crook, Kath Wynne Jones, Ruth Passman, Tyrone Roberts and Councillor Tamoor Tariq

Non-Voting Members :

Dear Member/Colleague

Health and Wellbeing Board

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

Date:	Thursday, 21 October 2021
Place:	Council Chamber - Town Hall
Time:	6.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board are asked to consider whether they have an interest in any of the matters on the Agenda, and if so, to formally declare that interest.

3 MATTERS ARISING

4 MINUTES OF PREVIOUS MEETING *(Pages 5 - 12)*

The minutes from the meeting held on 15 July 2021 are attached for approval.

5 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which the Board is responsible.

Approximately 30 minutes will be set aside for Public Question Time, if required.

6 HEALTH RELATED BEHAVIOUR - SUBSTANCE MISUSE (20 MINS) *(Pages 13 - 24)*

Jon Hobday, Consultant in Public Health to present information on substance misuse. Report attached.

7 HEALTH AND CARE - ELECTIVE CARE TRANSFORMATION PROGRAMME AND BURY CARE ORGANISATION ORTHOPAEDIC IMPROVEMENT PROGRAMME UPDATE (20 MINS) *(Pages 25 - 36)*

Ian Mello, Director of Commissioning, NHS Bury CCG to present information on the Elective Care Transformation Programme and Bury Care Organisation Orthopaedic Improvement Programme. Report and appendix attached.

8 COMMUNITY AND PERSON CENTRED APPROACHES - THE WAY WE ENGAGE PEOPLE AND COMMUNITIES IN A PLACE (20 MINS) *(Pages 37 - 42)*

Chris Woodhouse, Strategic Partnerships Manager to present information on community and person-centred approaches. Presentation attached.

9 POPULATION HEALTH DELIVERY PARTNERSHIP *(Pages 43 - 44)*

Lesley Jones, Director of Public Health to update the Board. Attached is a draft mandate for the Population Health Delivery Partnership to be considered by the Board.

10 DEVELOPING BURY AS A POPULATION HEALTH SYSTEM (20 MINS) *(Pages 45 - 52)*

Lesley Jones, Director of Public Health to present information on developing Bury as a Population Health System. Document attached.

11 OUTCOME AND PERFORMANCE UPDATE (20 MINS) *(Pages 53 - 56)*

Lesley Jones, Director of Public Health to give an update on the Outcome and Performance Framework. Document attached.

12 COVID-19 UPDATE

Lesley Jones, Director of Public Health to give a verbal Covid-19 update.

13 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Agenda Item 4

Minutes of: Health and Wellbeing Board

Date of Meeting: 15 July 2021

Present: Councillor A Simpson (in the Chair)
Councillors E O'Brien, Councillor T Tariq and R Brown

Lesley Jones - Director of Public Health, Will Blandamer - Executive Director of Strategic Commissioning, Adrian Crook – Director, Adult Social Services and Community Commissioning, Sajid Hashmi - Chief Officer Bury VCFA, Tyrone Roberts - Director of Nursing, Sharon McCambridge - Chief Executive of Six Town Housing, Sue Downey - Greater Manchester Police, Ruth Passman – Chair of Healthwatch

Also in attendance: Tracey Flynn - Unit Manager, Economic Development Team, Jayne Garner, Head of Integration
Ingeus, Kez Hayat – Programme Manager for Mental Health (Adults), Jon Hobday – Consultant in Public Health, Joanne Smith – Development Manager, Public Health, Bury Council

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: Penny Martin - Representative of NCA, Dr J Schryer and Kath Wynne-Jones - representative of the LCO

HWB.349 APOLOGIES FOR ABSENCE

Apologies for absence are noted above.

HWB.350 DECLARATIONS OF INTEREST

Councillor Simpson declared a personal interest in all matters under consideration as both her and her son are employees of the NHS.

HWB.351 MATTERS ARISING

There were no matters arising.

HWB.352 MINUTES OF PREVIOUS MEETING

It was agreed:

1. That the minutes of the meeting held on 14th April 2021 be approved as a correct and accurate record.

HWB.353 PUBLIC QUESTION TIME

There were no public questions.

HWB.354 GREATER MANCHESTER HEALTH INEQUALITIES COMMISSION AND

MARMOT BUILD BACK FAIRER REPORT - IMPLICATIONS FOR THE HWBB

Lesley Jones, Director of Public Health presented the key messages from the GM Independent Review on Inequalities and the GM Marmot Report and explained the implications that this has for the Health and Wellbeing Board.

Greater Manchester has had the benefit of excellent reports on inequalities from the Marmot Team and the Independent Commission for Inequalities. Both teams provided powerful and stark evidence on how inequalities have worsened as a result of Covid-19.

The key points from the reports for the Health and Wellbeing Board to note are:-

- The GM Independent Commission described Covid-19 and the Black Lives Matter movement as a wake-up call around inequalities.
- Sir Michael Marmot expressed concerns about the declines in life expectancy that their research unveiled.
- Both teams highlighted the collective spirit of collaborations and the strengths of partnerships across GM.
- There is a commitment to build responses to the findings and recommendations of both reports into the refresh of the Greater Manchester Strategy.

The Inequalities Commission provided a helpful framework within their report to help understand the different dimensions of inequalities; this framework is a good way of understanding different types of inequalities and how they intercept with each other. A reflection of this framework can be built into the Health and Wellbeing Board's Outcomes Framework.

The two fundamental elements that were underpinning both reports were power and resources.

There were over 100 recommendations over both reports which have emphasis on setting targets around inequalities, the importance of good work and good pay and the importance of a good start in life.

The Bury 'Let's Do It Strategy' has an ambition and vision to tackle inequalities and focuses on the key themes that have emerged from both reports.

Lesley Jones shared ideas on what the Health and Wellbeing Board should be focusing on and the key questions the Board should be asking.

Tyrone Roberts explained about a positive piece of work that the Norther Care Alliance is doing around inequalities in recruitment.

Ruth Passman explained how the work of Healthwatch links into the work of the Health and Wellbeing Board. Healthwatch has recently published their annual report which highlights the work that has been completed. Ruth Passman gave examples of how Healthwatch are tackling inequalities around the vaccination programme. Healthwatch has pledge to develop health champions with Bury Council.

Will Blandamer questioned if there were any findings that came out of the reports that the Health and Wellbeing Board should be focusing on.

Lesley Jones suggested that the Health and Wellbeing Board should embed the notion of implementation decay, and to recognise that some people require bespoke and tailored support to meet their needs which is resource intensive. The Board will need to accept there will need to be more resources put into addressing inequalities. Lesley Jones suggested that the Board should focus on the issue of power and ensure that people are given the resources to develop power.

Sharon McCambridge suggested that the Board should look at community safety and to have a focus on the Community Safety Strategy to effectively target areas that are suffering more in inequalities.

Councillor Simpson explained that the Board needs to have good intelligence with the Joint Strategic Needs Assessment (JSNA) to be able to complete targeted intervention. Councillor Simpson's concerns were around the difference in life expectancy between Trafford and Manchester and allocating resources in a fair way.

Councillor Simpson explained it was important to have community champions who understand what the issues are within their communities and who have real lived experiences and ensure they are involved in the decision making in their communities.

Lesley Jones explained that there are lots of work streams actively looking to involve people with lived experience.

It was agreed:

1. That the GM Independent Review on Inequalities and the GM Marmot report be noted.
2. That the Board build a reflection of the Inequalities Commission Framework into the Outcomes Framework.
3. The Board focuses on implantation decay and the issue of power and resources.
4. The Board to look at linking the Community Safety Strategy to health and wellbeing.

HWB.355 QUADRANT UPDATE

a WIDER DETERMINANTS - WORK, HEALTH AND SKILLS

Tracey Flynn, Unit Manager, Economic Development Team presented information on the work that the Economic Development Team are involved in and the benefits that being in work has on people's health.

There is clear evidence to suggest that unemployment is generally harmful to health, and leads to:

- Higher mortality;

- Poorer general health, long-standing illness, limiting longstanding illness;
- Poorer mental health, psychological distress, minor psychological/ psychiatric morbidity;
- Increased alcohol and tobacco consumption, decreased physical activity;
- Higher rates of medical consultation, medication consumption and hospital admission; and
- Increased risk of fatal or non-fatal cardiovascular disease and events, and all-cause mortality, by between 1.5 and 2.5 times.
- Building a local integration system to link good employment, healthy workplaces, an employer influenced skills system, business engagement and inward investment.

Bury Council are building a local integration system to link good employment, healthy workplaces, an employer influenced skills system, business engagement and inward investment.

Sharon McCambridge questioned if there was enough connectivity going on through the Steps to Success Programme.

Tracy Flynn explained that there is engagement in the Steps to Success Programme, most of the tenants and residents are on the Working Well Programme and other programmes.

Sajid Hashmi explained that there is a link between work and health, as a significant number of people who are referred to social prescribing are mental health related to not having work.

Councillor Brown gave positive feedback to The Economic Development Team for the great work that they have been doing.

Adrian Crook advised that there is an employment support service for people with disabilities and suggested that it would be great to find more work opportunities for residents with learning or physical disabilities.

Jayne Garner, Head of Integration at Ingeus presented information on the Working Well, Work and Health Programme in Bury.

The programme provides support for unemployed people with health conditions or disabilities. It helps individuals who have been out of work for a long time, and/ or those needing specialist support.

In Bury, 891 people have started the programme and 351 people have been moved into work. Bury is the highest performing borough for rates of people starting work.

- The programme offers a holistic assessment of needs, which supports to identify barriers.
- Mental and physical health support.
- Personal and social barriers such as isolation, debt and housing are addressed.
- The programme works with a range of partners to address needs.

The evidence shows that community referrals to specialist support at the right time accelerates the progression towards work, and the GM model is built on an integrated approach.

Lesley Jones questioned if the Working Well Programme use the Bury Directory.

Jayne Garner explained that the integration team does use the Bury Directory, although feels there is more work for them to do, around connecting to The Bury Directory.

Lesley Jones questioned if the Working Well Programme could be embedded into the neighbourhood working model in Bury.

Jayne Garner explained that they can co-locate where possible within the community and they try to be as accessible as possible, there are some things that they need to keep on-site which are beneficial to the customers journey such as the health team, who deliver face to face workshops and on-site computers to use.

It was agreed:

1. Tracey Flynn and Jayne Garner be thanked for the update.

b **HEALTH RELATED BEHAVIOUR - BURY MOVING - A PHYSICAL ACTIVITY STRATEGY**

Jon Hobday, Consultant in Public Health presented information on the Bury Moving, Physical Activity Strategy.

The presentation explained the benefits of being physical active. Data from the latest Active Lives survey shows that the levels of activity in Bury is higher than in Greater Manchester. It was explained that over the last 12 months across Bury, there has been a decline in activity levels. There was 73.3% of adults who are active or fairly active. In Bury the levels of inactivity have remained relatively stable since 2015; across Greater Manchester the levels of inactivity have increased.

The following inequalities data in physical activities were explained:-

- Gender Gap
- Socio-economic Gap
- Disability Gap
- Age Gap

Evidence suggests that to reduce inequalities in physical activity there needs to be a focus on:

- Enablers, barriers and identifying opportunity
- Community consultation, engagement, and partnership work
- Holistic approaches for protected characteristics and intersectionality

Jon Hobday explained the work that Bury is doing to reduce inequality and to

support people in the community to become more active.

Councillor Simpson questioned if the leisure part of the website needs to be updated. Councillor Simpson suggested that local walks and beginner classes at the Leisure Centre could be added to the website for people who are not physically active. It was suggested that community champions could work with people to find out what inspires people to be active.

Tyrone Roberts suggested that the Physical Activity Strategy could link into the Outcomes Framework specifically related to Community Services at Fairfield Hospital and linking to BEATS. Tyrone Roberts explained that he is keen to support any work and help get the message across to patients and staff.

Will Blandamer questioned if partners in Bury are clear what our expectations are, about the way to promote physical activity to public, private and voluntary organisations.

Jon Hobday explained engaging partners to promote physical activity is something that he can build.

Sharon Cambridge suggested that Six Town Housing could promote physical activity as they can reach out to communities through various community channels.

Lesley Jones advised that colleagues had done some good MSC research on how they embed the 'every contact counts approach' within their service. They built relationships with the Live Well Service and BEATS. The team have been able to demonstrate that embedding this approach, gives a better clinical outcome. It was suggested that this way of working could be progressed into practice more widely.

Lesley Jones is looking at setting up a Population Health Programme Board to bring people together to help to create and embed the cultures of practice that support the public health agenda. The Population Health Programme Board can take forward the suggestions from this meeting.

It was agreed:

1. Jon Hobday be thanked for the update.
2. Lesley Jones to pass on suggestions to improve physical activity to the Population Health Programme Board.
3. Jon Hobday to engage partners to promote physical activity.

c **PERSON CENTRE APPROACHES - THE BURY DIRECTORY**

Joanne Smith, Development Manager in Public Health & Bury Council presented information on The Bury Directory.

Joanne Smith explained the purpose of The Bury Directory and the benefits. Joanne explained how The Bury Directory had been working collaboratively with several agencies to improve health and wellbeing outcomes for local

communities. Future plans for The Bury Directory were shared with the Board. The Bury Directory is inclusive and addresses inequalities.

- The Bury Directory is open to all ages.
- Google Translate offers over 100 languages and the ability to print off information in selected language.
- Information and advice pages regarding domestic violence, services and clinics are promoted.
- Places of worship are available on the directory and advice pages on various religions.
- The website text is as simple as possible to understand is accessible for screen readers.
- There is information on The Bury Directory regarding LGBT+ support groups, helplines and forums.

The Bury Directory is looking at ways to target priority cohorts better.

The Bury Directory is a prevention agenda, it is an enabler for self-management and long-term conditions and assists in the prevention of developing future costly conditions.

Councillor Simpson stated that The Bury Directory is a great resource. Councillor Simpson suggested that General Practices should be encouraged to use it.

Will Blandamer asked colleagues to promote and provide feedback on The Bury Directory. The more people that use The Bury Directory the better it will become at cataloguing and understanding the community capacity.

It was agreed:

1. That Joanne Smith be thanked for the update.
2. That Board members promote The Bury Directory.

d **HEALTH AND SOCIAL CARE - TACKLING MENTAL HEALTH INEQUALITIES**

Kez Hayat, Mental Health Programme Manager gave an overview of Bury's Mental Health Transformation Programme Plan 2021-2022.

The Transformation Programme for mental health encompasses the key aspects of a Mental Health Foundation report that was published to tackle social inequalities to reduce mental health and highlights the main factors that is linked to poor mental health. It highlights that 1 in 3 people will experience poor mental health which equates to roughly 62,000 people in Bury. There are social, economic, culture and environmental drivers that need to be focused on to reduce the prevalence of mental health.

The following 5 key components to the transformation programme were explained:

- Population Mental Wellbeing (Coping & Thriving)

- Primary & Community MH Transformation
- Improving access to support in a crisis
- Improving care for those with highest needs
- Other key developments

It was agreed:

1. That Kez Hayat be thanked for the update.
2. To invite Kez Hayat to a future Health and Wellbeing Board meeting to discuss mental health inequalities in detail.

HWB.356 OUTCOME AND PERFORMANCE UPDATE

This item was deferred until the next meeting.

HWB.357 COVID-19 UPDATE

This item was deferred until the next meeting.

HWB.358 URGENT BUSINESS

Sajid Hashmi acknowledged the positive work that Liz Thompson, Chief Officer at Creative Living Centre had done, as an advocate for mental health within the community.

COUNCILLOR A SIMPSON
Chair

(Note: The meeting started at 6.00 pm and ended at 8.05 pm)

Classification Open / Closed	Item No.

Meeting:	Bury Health and Wellbeing Board
Meeting date:	21st October 2021
Title of report:	Health related behaviour: Substance misuse (Drugs & Alcohol)
Report by:	Sarah Turton (Public Health Practitioner) and Jon Hobday (Consultant in Public Health)
Decision Type:	**For information**
Ward(s) to which report relates	**All wards**

1.0 Executive Summary

1.1 People with untreated drug and alcohol dependencies have a disproportionate impact on our communities, nationally, regionally and locally. Parental substance misuse affects children, their lives, and prospects. Drugs and alcohol affect the homeless and their chances of recovery, as well as causing an increase in homicides, crime, deaths, and unemployment. Inequalities is also a large issue, as drug and alcohol use is usually higher in deprived communities. Due to how cross cutting substance misuse is with other areas, no one organisation can address this issue and collaborative and partnership working is key within this sector.

1.2 Recent investment into this sector, as well as the newly published Dame Carol Black Review of drugs, have cast light on substance misuse and increased the awareness of the need for drugs, alcohol and inequalities to be addressed further and current practices reviewed. Within Bury, we are currently reviewing our Substance Misuse Action Plan and continuing with the important work we do in this field, focusing on prevention, recovery and a holistic approach to tackling issues within this area.

2.0 Recommendation(s)

2.1 That the Bury Health and Wellbeing Board continue to support the ongoing work around drugs and alcohol and reducing inequalities.

3.0 Key Considerations:

3.1 Introduction / Background

3.1.1 The harm caused by drugs and alcohol affects individuals, families, communities, and places pressure on many public services. Therefore, it is extremely important to address this public health field and work towards decreasing this harm within Bury, using a holistic, collaborative approach.

3.1.2 In January 2021, the government announced a new package of funding to tackle drug related crime. This included an additional £80 million for drug treatment in the form of universally available grants. This comprised of funding to support the collaborative commissioning of medically managed inpatient detox programmes, helping to stabilise or stop drug (or alcohol) use in those with the most complex health needs.

3.1.3 Drug and alcohol treatment reduces the burden on local authority services in many ways. Dame Carol Black's independent review estimated the costs of drug use to social care at £630 million a year and noted that treatment for dependent drug users can reduce the cost of drug related social care by 31 per cent. [1] Public Health England estimate that most people are not being treated for their addiction – about half of opiate and crack users and only one in five dependent drinkers. Being in treatment reduces offending behaviour, drug and alcohol related deaths, and the spread of blood borne diseases.

Below is a link to a publication from the Local Government Association (LGA), aimed at elected members:
[1] Must Know: Treatment and recovery for people with drug or alcohol problems | Local Government Association

3.2 Our position in Bury

3.2.1 In Bury, we saw an increase in drug related deaths due to drug poisoning in 2018, with 27 deaths recorded. However, in 2019, 13 deaths were recorded and 8 in 2020, showing a decrease over this timeframe. The same pattern can be seen with the number of deaths related to drug misuse, with 23 deaths recorded in 2018, 12 in 2019 and 5 in 2020.

The age-standardised mortality rate for deaths relating to drug poisoning stood at 8.8 per 100,000 for 2018-20, which was a decrease from 10.6 per 100,000 recorded in 2017-19. For 2018-20, the Northwest rate was higher than Bury, at 10.4 per 100,000. However,

Bury is above the national average in this category with the rate being 7.6 per 100,000 for England during this time period.

Similarly, reductions were seen in Bury regarding the age-standardised mortality rate for deaths relating to drug misuse, from 8.6 per 100,00 in 2017-19 to 7.3 per 100,000 in 2018-20. However, in the period of 2018-20, Bury (7.3 per 100,000) was higher than both the regional and national rates, with the Northwest at 7.1 per 100,000 and England at 5.0 per 100,000.

3.2.2 Looking at the data around people currently in treatment for alcohol and drugs in Bury, there seems to have been a general decrease from previous years, except for opiate service users. In terms of people receiving treatment for opiates, this has increased in 2019/20 (475) from 2018/19 (465). In contrast, when looking at non-opiate (125 in 2017/18 and 85 in 2019/20), alcohol (315 in 20017/18 and 275 in 2019/20) and non-opiate plus alcohol (125 in 2018/19 and 110 in 2019/20) service users, numbers have decreased.

Nationally, a reduction in people in substance misuse treatment services has been seen over the past few years, with a significant drop in service users in treatment relating to alcohol. There has also been a noticeable decrease in the number of men and women in treatment regarding alcohol. A PHE Inquiry into the fall in treatment numbers indicated that perceptions of services as drug services, a lack of alcohol specialist expertise and alcohol specific interventions as probable barriers. [2]

In terms of treatment outcomes, successful completions in 2019-20 (47%) have reduced slightly from 2018-19 (51%) and the number of people who dropped out or left stayed relatively stable (from 33% to 34%). This slight drop in successful completions appears to be due to the male cohort, with the female figures remaining the same for successful completions between 2018-19 (52%) and 2019-20 (52%). While the overall proportions of individuals dropping out of service remained stable, when comparing by gender the number of females that dropped out or left decreased during this time period (from 41% to 33%), in contrast the males increased (from 31% to 34%). Regarding overall successful completions for 2019-20, Bury was the same as the national average (47%) and below the regional average (51%).

3.2.3 With regard to people who are not currently accessing treatment, data from the Public Health Dashboard shows that the proportion of dependent drinkers not in treatment as of 2018/19 in Bury stands at 78.8%. This is slightly below the regional and national averages, with the North West at 81.7% and England at 82.4%. On the other hand, the proportion of opiates and/or crack cocaine users not in treatment are slightly above the regional and national averages for 2018/19, with Bury standing at 54.6%, the North West at 47.9% and England at 52.1%. [3] Further research is needed to fully understand these cohorts of people not currently accessing treatment and the reasons behind this. In the meantime, raising awareness of the current support that is available and trying to reach these harder to engage populations is key.

3.3 Dame Carol Black Review of drugs - phase 2 report:

The report suggested that significant changes need to be made in four areas, including: radical reform of leadership, funding, and commissioning, rebuilding of services, an increased focus on prevention and early intervention and improvements to research and how science informs policy, commissioning, and practice. [4]

Dame Carol Black suggested funding is to be allocated to local authorities based on a needs assessment and then protected. The review concluded, based on current evidence of prevalence, that an additional £552 million is needed from DHSC by year 5 on top of the baseline annual expenditure of £680million from the public health grant, for drug treatment and recovery services. An additional £15 million by year 5 is needed for employment support.

In terms of commissioning, the review recommends a National Commissioning Quality Standard to be set up, to help specify the full range of treatment services that should be available in each local area. Commissioners should work collaboratively with providers and have longer commissioning cycles of at least 5 years, to encourage stability and quality improvements.

The review also emphasised the importance of rebuilding and improving services and their links to substance misuse services, such as: workforce, treatment, recovery support, criminal justice system, employment, housing, mental health, and physical healthcare. As well as the importance of prevention and early intervention; thinking about schools and age-appropriate services.

Overall, there were 32 recommendations set out by the Dame Carol Black, based on the main categories mentioned above. An initial government response has been issued; however, we are still awaiting the formal response from the government, which should provide more information and further direction. The spending review, which will hopefully be released soon, will also aid with further direction on this report.

3.4 What we do in Bury currently

3.4.1 In Bury, we have commissioned services for alcohol, drugs, with 'Achieve Bury' (Greater Manchester Mental Health Trust) providing our substance misuse service. As Part of the service 'Achieve Bury' provide they subcontract 'Early Break' to provide the family and children and young people elements of the service and 'Big Life' to provide the assertive outreach and prison in reach components of their work. Bury's commissioners work in close partnership with our providers, regularly reviewing performance, strategy, and our system approach.

Prevention is a key part of reducing harm from drugs and alcohol and both our Adult (Achieve) and Young People (Early Break) substance misuse services carry out an abundance of work around this. Early Break have good links with local schools and can deliver sessions to students and staff around drugs and alcohol. Early Break also have an

Outreach team, who engage with young people wherever they are in the community i.e., parks, youth clubs, streets or events. Part of this role is to safeguard young people, raise awareness of substance misuse issues, and offer any support needed to help them make positive decisions, thus minimising risks to their physical and emotional health and wellbeing. Achieve offer a range of training and awareness sessions to external organisations such as primary care and educational settings. The Big Life Group work alongside Achieve to support service users to rebuild their lives and work towards an optimistic future. The Big Life group have an assertive outreach team where peers and volunteers identify and target at risk individuals and engage with vulnerable people, as well as those who are poor engagers, with a robust missed appointment pathway in place. The Big Life team attend various neighbourhood meetings to enable targeted work where needed, as well as multi-disciplinary meetings to enable a holistic approach to drug and alcohol treatment. In terms of prevention work, The Big Life group carry out drug and alcohol awareness sessions and drop-in sessions at various organisations and community venues including Manna House (food bank) and ABEN (A Bed Every Night). Work is also in progress to expand these sessions in to other community venues and organisations.

Lived experience is an important aspect of drug and alcohol treatment services and plays a pivotal role. It was also referenced in Dame Carols Black's report, where she recommends that 'Services should include people with lived experience of drug dependence working as recovery champions and recovery coaches.'[4] Achieve incorporates lived experience into their treatment and recovery model by having both volunteer and paid opportunities, including peer mentor schemes, available for people with lived experience. There is a robust volunteer workforce development pathway in place, to support and encourage volunteers to develop workforce readiness skills. Furthermore, service user and carer feedback are reported on as part of performance every month. Having people with lived experience is beneficial, as it a form of visible recovery that current service users can see and relate to.

Recovery work is just as important as the treatment itself when it comes to drugs and alcohol and our substance misuse services incorporate this into their treatment models. Achieve's community development team do a lot of work around recovery. They have a social recovery group called Kaleidoscope, as well as focused groups around areas such as education, training and employment (ETE). Achieve also support and link with mutual aid groups, such as Alcoholics Anonymous (AA), and have recovery fund grants available to service users to aid with many aspects of recovery. Early Break offer the 'Holding Families' programme, which provides whole family support for children and family members affected by parental substance misuse, working with parents and carers at any stage of their recovery from drugs and alcohol use. Furthermore, Early Break also offer the 'Holding Families+' programme, working with children and families of alcohol and substance dependent parents who are in prison.

3.4.2 The Bury Substance Misuse Action Plan is currently being refreshed, based around the Greater Manchester Drug & Alcohol Strategy, which includes 6 key priorities:

1. Prevention and early intervention
2. Reducing drug and alcohol related harm
3. Building recovery in communities
4. Reducing drug and alcohol related crime and disorder
5. Managing accessibility and availability to drugs and alcohol
6. Establishing diverse, vibrant and safe night-time economies

This process involves ongoing engagement between treatment providers, GMP, GMFRS, DWP, community safety, primary care representatives, licensing, and housing, to name a few. Once the action plan is finalised, it will be launched, and action points tracked and continuously reviewed. In addition, our service providers do a lot of work with people who have lived experience. We are currently looking at ways that lived experience could be further incorporated into the action plan and our approach to recovery, as this is essential in supporting individuals through treatment and back into housing and employment.

3.4.3 From a system perspective Bury Council works collaboratively with Greater Manchester (GM) and regularly discusses collaborative work and bids. In addition, Bury have a Substance Misuse Partnership Delivery Group meeting every month. This brings together many of the services and teams involved (directly and indirectly) with substance misuse within Bury. This is where we focus on our system response and work to reduce inequalities.

3.4.4 Furthermore, we are doing work around Alcohol-Exposed Pregnancies (AEP) and Foetal Alcohol Spectrum Disorder (FASD). A recent prevalence study [5] conducted within GM found that FASD may affect 1-3.6% of children, with a crude prevalence rate of 1.8% identified. Therefore, using the finding of a 1.8% prevalence rate, based on live births, potentially 40 children are born every year in Bury with FASD and there are potentially 3438 people with FASD (undiagnosed and diagnosed) based on our population. Therefore, we have been working to increase awareness of FASD and the harms that drinking alcohol during pregnancy can cause. This has involved a communications strategy to raise awareness, which included, social media ads, liaising with relevant teams and services to spread the message and an advertisement in our local magazine (Your Local Bury). In addition, we are working with services, such as probation, to provide FASD training to staff members, so that they can have discussions around alcohol during pregnancy and FASD, and signpost people to the relevant services if needed.

A link to the FASD Health Needs assessment, where the GM AEP programme is cited as good practice, is below:

[6] Fetal alcohol spectrum disorder: health needs assessment - GOV.UK (www.gov.uk)

3.4.5 At Bury Council we ensure we are part of all the relevant campaigns to help raise awareness of issues around drugs and alcohol. For example, we have various communications scheduled for FASD Awareness Day on the 9th September and are in the process of organising a communication plan for Stoptober, Go sober for October, as well as Alcohol Awareness Week in November.

The Bury Directory is a large resource which contains information pages and referral details linked to our substance misuse treatment providers and lifestyle service (Live Well), as well as many mutual aid groups, which anyone (professional or general public) can access.

3.4.6 The work that is underway around drugs and alcohols contributes to the Public Service Reform agenda and the neighbourhood working model, as well as the 'Let's do it' Strategy for 2030. The vision for 2030 has been developed and tested with our communities. Local people have said this vision will achieve a better future for the children of the borough and a better quality of life. The work ongoing around substance misuse will contribute to these achievements, both directly and indirectly. There are also links with the Community Safety Partnership Agenda, with drug related offending listed as one of their priorities for the next 3 years. Furthermore, links can be seen to the 'Thriving in Bury' mental health strategy, due to the prevalence of dual diagnosis.

3.5 What we are doing to reduce inequalities

3.5.1 When it comes to drugs and alcohol, certain groups and populations are often disproportionately affected, and therefore inequalities need to be addressed within these areas.

Local data shows how inequalities play a role within these fields. For the year 2019/20, when looking at service users who began treatment for drugs or alcohol, 195 were unemployed / economically inactive and 115 were long-term sick / disabled, compared to 140 being in regular employment. The numbers being higher for unemployed, versus employed, is a trend that has been constant since 2009/10.

In addition to this, in terms of ethnicity, the figures for the year 2019/20 are listed below:

- White: 955
- Mixed / multiple ethnic group: 20
- Asian / Asian British: 30
- Black/African/Caribbean/Black British: 10
- Other ethnic group: 10

The trend regarding people of white ethnicity in treatment being substantially higher than other ethnicities has been a continuous trend since 2009/10, which may suggest other ethnicities may be underrepresented within drug and alcohol treatment services.

Since 2009/10, there has always been more males starting drug and alcohol treatment within Bury, with the figures for 2019/20 showing 700 males accessed our adult drug and alcohol treatment service, compared to 240 females.

There have been links made between having a mental health condition and misusing drugs and alcohol (dual diagnosis), and some people that are dependent on alcohol or drugs often have underlying mental health illnesses. [7]

Opiate and crack use is also strongly linked to deprivation. In England, we saw 58% of people in treatment for crack and 57% of those in treatment for opiates living in areas ranked in the 30% most deprived areas (2018-19). Similarly, to the opiate and crack prevalence rates, the higher prevalence rates of alcohol dependency are concentrated in the north of England. Nearly half of alcohol only clients in treatment (47%) were living in areas ranked in the 30% most deprived areas (2018-19). [3]

In light of these inequalities, we are reviewing our provision and doing engagement work to better understand why certain groups are underrepresented in services. We will then look to shape services appropriately to make them as accessible and appealing to those groups who are less likely to engage e.g., BAME community, those in the most deprived community, women and those with mental health issues.

3.5.2 We are currently reviewing our Shared Care model, which previously saw substance misuse workers seeing clients within GP practices. We are looking at producing more of a community approach by looking at community venues in deprived areas with high need, which would have easy access and feel comfortable for the clients. The new model aims to provide care for all drug and alcohol patients and reduce inequalities.

A key focus of our action plans will be how we effectivity reduce inequalities in those that misuse substances and the impact of substance misuse.

4.0 Conclusion

By the end of the year, we hope to have finalised the refreshed Bury Substance Misuse Action Plan for release. In addition, we plan to continue with the work mentioned above and aim to improve provision around drugs and alcohol, whilst reducing inequalities.

Community impact/links with Community Strategy

- Let's Do It strategy
- Bury Substance Misuse Action Plan

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to -

(a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

(b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

(c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

Legal Implications:

To be completed by the Council's Monitoring Officer

Financial Implications:

To be completed by the Council's Section 151 Officer

Report Author and Contact Details:

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Background papers:

1. Local.gov.uk. 2021. Must Know: Treatment and recovery for people with drug or alcohol problems. [online] Available at: https://www.local.gov.uk/publications/must-know-treatment-and-recovery-people-drug-or-alcohol-problems
2. Nihr.ac.uk. 2021. Policy Research Programme - Unmet need for substance misuse treatment Research Specification. [online] Available at: https://www.nihr.ac.uk/documents/policy-research-programme-unmet-need-for-substance-misuse-treatment-research-specification/27632
3. GOV.UK. 2021. Adult substance misuse treatment statistics 2018 to 2019: report. [online] Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2018-to-2019/adult-substance-misuse-treatment-statistics-2018-to-2019-report
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5. McCarthy, R., Mukherjee, R. A. S., Fleming, K. M., Green, J., Clayton-Smith, J., Price, A. D., Allely, C. S., & Cook, P. A. (2021). Prevalence of fetal alcohol spectrum disorder in Greater Manchester, UK: An active case ascertainment study. Alcoholism: Clinical and Experimental Research, 00, 1– 11. https://doi.org/10.1111/acer.14705
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Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning
LGA	Local Government Association
GM	Greater Manchester
GMP	Greater Manchester Police
GMFRS	Greater Manchester Fire and Rescue Service
DWP	Department of Work and Pensions
AEP	Alcohol-Exposed Pregnancies
FASD	Foetal Alcohol Spectrum Disorders
PHE	Public Health England
ETE	Education, training and employment

AA	Alcoholics Anonymous
ABEN	A Bed Every Night

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Agenda Item 7

NHS
Bury
Clinical Commissioning Group

Meeting: Health and Wellbeing Board

Meeting Date	21 October 2021	**Action**	Receive
Item No.		**Confidential**	No
Title	Bury Elective Care Transformation Programme and Bury Care Organisation Orthopaedic Improvement Programme Update		
Presented By	Ian Mello, Director of Commissioning, Bury CCG Penny Martin, Director of Operations, Bury Care Organisation, NCA		
Author	Catherine Tickle, Commissioning Programme Manager, Bury CCG		
Clinical Lead	Howard Hughes, Clinical Lead Elective Care, Bury CCG		

Executive Summary

This paper provides the Health and Wellbeing Board (HWBBB) with an update on the Northern Care Alliance (NCA) and Bury CCG Elective Care Transformation Programme, following the presentation to the Board in April 2021.

The paper also provides the Board with an overview of an interrelated Orthopaedics improvement programme of work, which the CCG has jointly initiated with the Bury Care Organisation (BCO) within Northern Care Alliance (NCA). The speciality level improvement work interrelates with the overarching wider NCA elective recovery agenda/strategy. The BCO Orthopaedic Improvement Group sits as a subgroup under the Elective Care Transformation Programme Group.

The programme of work with BCO colleagues aims to support the recovery of the Orthopaedics speciality. It also has a distinct focus on inequalities and gaining a greater understanding of the needs of individual with orthopaedic conditions. It has brought together partners within Bury, including patients, to drive forward a programme of change interventions, where through a Bury system approach, changes to existing pathways and processes will be 'tested.' The programme aims to improve patients access and experience of 'care,' including self-care, and to support the recovery of this specialty.

It is intended that the learning from these 'tests of change' will be reported into the Elective Care Transformation Programme Group, to inform the wider transformation work at a NCA trust level and look for opportunities to roll out a similar programme of 'improvement' work in other specialities delivered by NCA for Bury patients. Alignment with the overarching Elective Transformation Programme will also support the scaling up of successful initiatives across the other localities within the NCA footprint. In turn this will then report into the emerging Elective Care and Cancer Care Programme Board referenced in section 8 of this paper.

Through their engagement at the Elective Care workshops, where several of the improvement areas were identified, Horizon Primary Care Network (PCN) is supporting this programme of work. Using the practices within the PCN as a test bed it will enable the development of a 'blueprint' that can be rolled out across the other PCNs in Bury at pace. We are hopeful that other PCN colleagues will join this work in future.

Recognising the impact of the pandemic on waiting times, supporting patients to 'Wait Well' is a key element of both work programmes and an update on the work of a Bury Waiting Well Task Group leading this initiative is included in the paper. The paper also reports on work undertaken to capture patients

experience of elective pathways and waiting for appointments/treatment to aid the systems understanding and inform the transformation and improvement of pathways/services. The learning experienced as an integrated system team will be captured to progress and develop Bury's collective system wide understanding of the nature and impact of inequality for individuals; their families and how this shape the outcomes affecting their daily lives.
Recommendation • To note the content of the paper and the work to date. • Receive further updates as required.

Links to CCG Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality	Yes	☐	No	☐	N/A	☒

Implications						
Impact Assessment been completed?						
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG's risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**

Bury Elective Care Transformation Programme and
Bury Care Organisation Orthopaedic Improvement Programme Update

1. Introduction

1.1 Following the presentation to the Health and Wellbeing Board (HWBB) in April 2021 on the Northern Care Alliance (NCA) and CCG Elective Care Transformation Programme, several developments have taken place, including a programme of improvement work in Orthopaedics with Bury Care Organisation (BCO).

1.2 The BCO programme of work sits as a subgroup, reporting into the wider Elective Care Transformation Group, supported by a range of system partners, primarily focused on developing a greater understanding of the inequalities facing patients with orthopaedic conditions.

1.3 Gaining a greater level of understanding of what is driving these inequalities will help to identify changes that can be made to the current models of care, to improve outcomes for patients and support recovery of this speciality.

1.4 In time and using orthopaedics are a 'blueprint,' this learning can be applied to other specialities delivered by NCA facilitated through the Elective Care Transformation Programme.

1.5 Orthopaedics has been selected as a 'test bed' as the service is delivered in whole through the BCO, giving Bury Commissioners greater scope to work with the Operational Director and wider Orthopaedics Team to implement change at pace.

1.6 Orthopaedics is also a high-volume speciality that has been significantly impacted by the pandemic, resulting in large number of patients waiting for surgical interventions for extensive periods of time.

1.7 To contextualise the current service position, it is important to note that at the end of June 2021, there were 22076 Bury patients waiting to commence treatment across all specialties and providers and of these, 2821 (13%) were in orthopaedics, making this the second highest waiting list for Bury patients with only gastroenterology being slightly higher.

1.8 At 246 in June, orthopaedics also has one of the largest number of patients who have waited more than 52 weeks to commence their treatment, though this marks a notable improvement from 383 in February. 82% of Bury's orthopaedic waiting list is held within the NCA whilst 6% are waiting at Wrightington, Wigan & Leigh (WWL) with the remainder split across several other providers and with whom engagement will be required going forward.

1.9 A multiagency Task Group, including patient representation, has been established to address gaps in support and information for patients waiting. Partners across Bury are co-producing a local 'Waiting Well' offer, which sits as part of an overarching GM led Waiting Well Programme of work.

1.10 In addition to the new areas of work and 'tests of change' outlined in this paper, the improvement work programme will also include the technical efficiencies work being undertaken by BCO in Orthopaedics to support elective recovery.

2. Purpose of the Paper

2.1 This paper is presented for information, to update HWBB members on the Elective Care Transformation Programme in section 4 and provide an overview of the Orthopaedic Improvement Programme of work in section 5.

3. NCA Elective Care Recovery Strategy

3.1 NCA is in the process of finalising a strategy for the recovery of elective care services, which has been taken through the Bury system governance for locality input. The aim of the NCA recovery strategy is to deliver the NHS constitutional standards for patient access by 2025 ensuring patient safety, excellence, and improvement in all known inequalities.

3.2 This will be achieved through focus in the following 5 key areas: pathway re-design, safety & experience of patients waiting, clinical & operational leadership, automation & standardisation of processes and engagement of trust staff, partners & patients.

3.3 The work of the Bury Elective Care Transformation Programme and BCO Orthopaedic Improvement Programme will support delivery of the NCA recovery strategy, along with future work in other specialties.

4. Elective Care Transformation Programme Update

Last 10 Patient Review

4.1 Through the work of the Elective Care Transformation Group, NCA partners have carried out an exercise to map the journey of the last 10 patients on the arthritic knee pathway, in collaboration with clinical colleagues. This included interviews with patients to discuss their experience of waiting on the pathway.

4.2 The Last 10 Patient approach is a proven methodology to understand what is happening in a patient journey. The approach identifies variations in pathway, causes of variations and highlights potential solutions to improve pathways and outcomes for patients.

4.3 The review has highlighted high levels of variation. This variation is being reviewed with clinical colleagues to inform pathway developments/re-design. An MDT is being convened with partners from all sectors across the Bury system to review the findings from the patient journeys and patient feedback to identify areas for improvement through integration and collaboration.

4.4 Several themes emerged from the patient experience calls, with the main area being communication and patients not feeling informed, or empowered, whilst waiting for the next stage of their journey. The patient feedback has been reported into the Waiting Well Task Group to inform the development of the locality 'offer' for patients waiting and local pathways.

4.5 A second phase of the review has commenced to look at the journey and experiences of 10 patients prior to acute referral, to identify their journey in primary/community care. The two will enable 'end to end' pathway reviews.

4.6 The outcomes of the Last 10 Patient Reviews and MDT will inform the development of 'tests of change' to improve the journey and pathways for patients. The 'tests of change' will be delivered through existing task groups, or via newly established groups, that will report into the Elective Care Transformation Group.

Patient Involvement and Participation Group

4.7 The Bury Patient Involvement and Participation (PIP) Group, established to support the delivery of the Elective Care Transformation Programme, meets monthly to ensure a patient perspective is brought into the work and facilitates coproduction of initiatives across the Bury system. The group is chaired by Bury Health Watch and has representation from VCFA, AQUA, NCA, CCG and LA.

4.8 The group, whilst in its infancy, has agreed Terms of Reference and works to the following co-production principles:

- Equality – everyone has assets
- Co-production starts from the idea that no one, group, or person is more important than any other group or person. So, everyone is equal, and everyone has assets to bring to the process.
- Diversity - diversity and inclusion are important values in co-production.
- Accessibility - As well as physical access, making sure that information is accessible and that it is provided in appropriate formats is a key part of making sure that everyone can take part in co-production. Some of the language used can be problematic because it can involve jargon that is inaccessible.
- Reciprocity - Reciprocity' is a key concept in co-production. It has been defined as ensuring that people receive something back for putting something in. The idea has been linked to 'mutuality' and all parties involved having responsibilities and expectations.

4.9 The PIP group is currently working to develop an action plan that will align with supporting the Elective Care Transformation Programme and Orthopaedic Improvement work.

4.10 Most recently the group have coordinated a programme of engagement work through the Bury Social Prescribing Link Workers and Bury Health Watch to encourage individuals to share their experiences of waiting on the Elective Care pathway, or previous experience of waiting for Elective surgery.

4.11 As with the Last 10 Patient Review, key themes have emerged, to include issues with communication, the impact of waiting on mental wellbeing, a need for honesty and transparency in relation to waiting times and support for patients waiting.

4.12 The finding from the engagement exercises will inform the development of the transformation and improvement programmes, initially within Orthopaedic.

5. Bury Care Organisation Orthopaedic Improvement Programme

5.1 The improvement programme of work with BCO will support the wider transformational programme with NCA to achieve the desired 'end state,' as outlined below and shared in the presentation that came to the Board in April:

- Patients 'waiting well,' supported whilst on the waiting list to optimise their likely outcomes from surgery and any other form of treatment.

- Patients prioritised in accordance with clinical need, urgency, likely degree of benefit and consideration for the wider impact on an individual's socioeconomic factors that may drive further inequalities from waiting for treatment.
- A holistic approach taken to waiting list management to reduce inequality in access.
- Parity of esteem achieved across pathways to support improvement in both physical and mental health outcomes for patients.
- GPs and other stakeholder informed of expected waiting times for individual patients and the support available to patient whilst they wait.
- Integration across pathways to allow the patient to be seen by the right professional, at the right time in the most appropriate place, including within the neighbourhoods.
- All opportunities for non-surgical intervention explored, including those relating to social circumstances/social prescribing.
- Re-engineered pathways that deliver better patient outcomes that may not result in an elective or planned procedure.
- Enhanced pathways into non medicalised support to address socioeconomic factors, lifestyle, primary and secondary prevention and maximise Burys community assets.
- A tried and tested model of co-production that can be scaled to support transformation on a wider footprint and inform an overarching Bury Co-production Strategy.

5.2 All the above aligns with the current Greater Manchester Elective Care Recovery and Reform Boards strategic direction, of which NCA is a major partner in alongside other GM based providers.

5.3 To deliver the Orthopaedic Improvement Programme a task group has been established led by the Director of Secondary Care Commissioning at Bury CCG and Director of Operations at BCO. The group is made up of colleagues from Public Health, BI, Primary Care, Clinicians, PCN, NCA and Community. Members of this group also sit on the Elective Care Transformation Programme Group to ensure alignment of the two programmes.

5.4 As with the overarching Elective Care Transformation Programme, co-production and reducing inequalities is the 'golden thread' running through the Orthopaedic improvement work.

5.5 Understanding the local population deeply, their individual and collective needs, their experiences and understanding of services and their ideas for positive sustainable change, is paramount to the success of the programme.

5.6 The work is supported by Public Health at the Local Authority, through the Public Health Consultant and the Patient Experience Lead at the NCA. It also has links into the Greater Manchester (GM) Elective Health Inequalities Task and Finish Group.

Programme Aim and Strategic Context

5.7 The Driver Diagram in appendix 1 agreed through Bury system governance sets out the overall aim of the orthopaedic improvement work to; *'Deliver effective system demand and waiting list management by March 2022.'*

5.8 The key drivers to support delivery of the project aim, aligns with the priorities and expectations set out in the NHS Long Term Plan and GM Elective Care Priorities around referral optimisation, supporting patients waiting and managing capacity and demand.

5.9 The outputs of a series of locality workshops 'Elective Care Matters', co-delivered by CCG and NCA colleagues as part of the transformation programme, generated several 'ideas' for potential areas of work that could be considered 'quick wins.'

5.10 These ideas fall within 'business as usual,' with a focus on improvement, as opposed to larger scale transformation and lend themselves to tests of change in Orthopaedics. These have been included in the driver diagram.

5.11 Existing GM and nationally driven initiates, such as Waiting Well and Primary Care Networks, that can be accelerated in the locality through a focused 'test of change' in orthopaedics, have also been brought into this programme of work and are reflected in the driver diagram. It is intended that the benefits gained in orthopaedics can then be replicated in other specialities.

5.12 Also reflected in the driver diagram are existing initiates such A&G, PIFU, Care Navigation. Within the locality these have been implemented in part but have greater potential. The test of change in Orthopaedics will provide the platform to develop a 'blueprint' and evidence base to support these key pathway components to be embedded across more specialities in NCA and at other points across the pathway, championed by local clinicians and patients.

Progress to Date

5.13 The change ideas within the driver diagram have been further developed into an action plan with named leads, tasked with driving forward the plan and being accountable to the Elective Transformation Programme Group.

5.14 A Data Analysis Task Group, chaired by the CCG Head of BI alongside NCA BI, acts as an overarching group, providing analysis to inform the development of the 'tests of change' and ultimately to monitor the impact of the initiatives.

5.15 The group is currently undertaking some baseline analysis of waiting lists, priority at referral compared to actual activity, analysis of waiting lists and activity by inequality, and development of a local Bury heat map of current waiters and deprivation.

5.16 The outcome of the analysis will be presented back to the Orthopaedic Improvement Programme Group to inform the 'tests of change' identified in the workplan.

5.17 A key 'test of change' is the revision of the GP referral template to highlight at the point of referral into secondary care orthopaedics any inequalities. The aim is to ensure this is visible to the triaging clinician and equity is factored into decisions and prioritisation of treatment. The referral template will help to 'advocate' for patient, some of whom may not be able to do this for themselves.

5.18 The analysis from the data group will provide the current baseline position and inform the development of a monitoring framework to measure the impact of the 'tests if change.'

5.19 As part of the work to address inequalities in the Orthopaedic Pathway, the Patient Experience Lead from NCA has obtained feedback on the experiences of patients and the impact of waiting on their physical/mental health and social-economic factors.

5.20 Along with the quantitative date from the Data Group, all the qualitative patient experience data will come together to inform an 'end to end' Orthopaedic pathway review.

6. GM and Bury Locality Waiting Well Initiative

6.1 The GM Elective Recovery and Reform Programme is developing a 'Waiting Well' framework; a repository of information for patients with resources available to them while they are waiting for their outpatient appointment and/or procedure. This includes signposting to national and regional resources.

6.2 Bury CCG and local partners, including NCA and VCFA, have been working alongside the GM Programme Manager to support the development of the GM platform, as well as developing a local platform to include a bespoke local offer and pathways to support patients waiting. The local Waiting Well package will be sited on the Bury Directory, with links being made to SharePoint to aid access in Primary Care.

6.3 Bury has been recognised by GM as being ahead in their local plans to implement Waiting Well and was invited to speak at a recent GM led learning event.

6.4 The CCG is coordinating a NES response to Waiting Well with NCA colleagues to ensure a consistent approach to communicate the Waiting Well initiative across staff and patients.

6.5 A Bury Waiting Well Task Group, a subgroup of the PIP Group, is coordinating this work, informed by the patient feedback obtained from the different patient engagement processes outlined in this paper.

6.6 Through the BCO Orthopaedic Improvement Programme, the Waiting Well Task Group is working with colleagues from BCO Orthopaedics Team to develop a bespoke Waiting Well page for orthopaedic patients as a 'test of change.' The learning from the Orthopaedic Improvement work will be cascaded and scaled up to support a more tailored approach to patients waiting across other specialities.

7. Elective Care Governance

7.1 A review of the current governance for the Elective Care Programme, which includes the transformation and improvement work outlined in this paper and the Cancer Programme, is taking place.

7.2 The aim is to bring together a focus on elective care and cancer from the point of view of recovery, transformation, performance, and 'Business as Usual' operational elements, under one Elective Care and Cancer Board that represents the Bury system.

7.3 The board will work to develop a shared vision for Bury, that feeds into the NCA Elective Care Recovery Strategy, Cancer Plans and Bury OCO strategic plans.

7.4 The work of the Elective Care Transformation Group and the BCO Orthopaedic Improvement Group will be accountable to the newly formed board.

8. Recommendations

HWBB to:

- Note the content of the paper and the work undertaken to date.
- Receive further updates as required.

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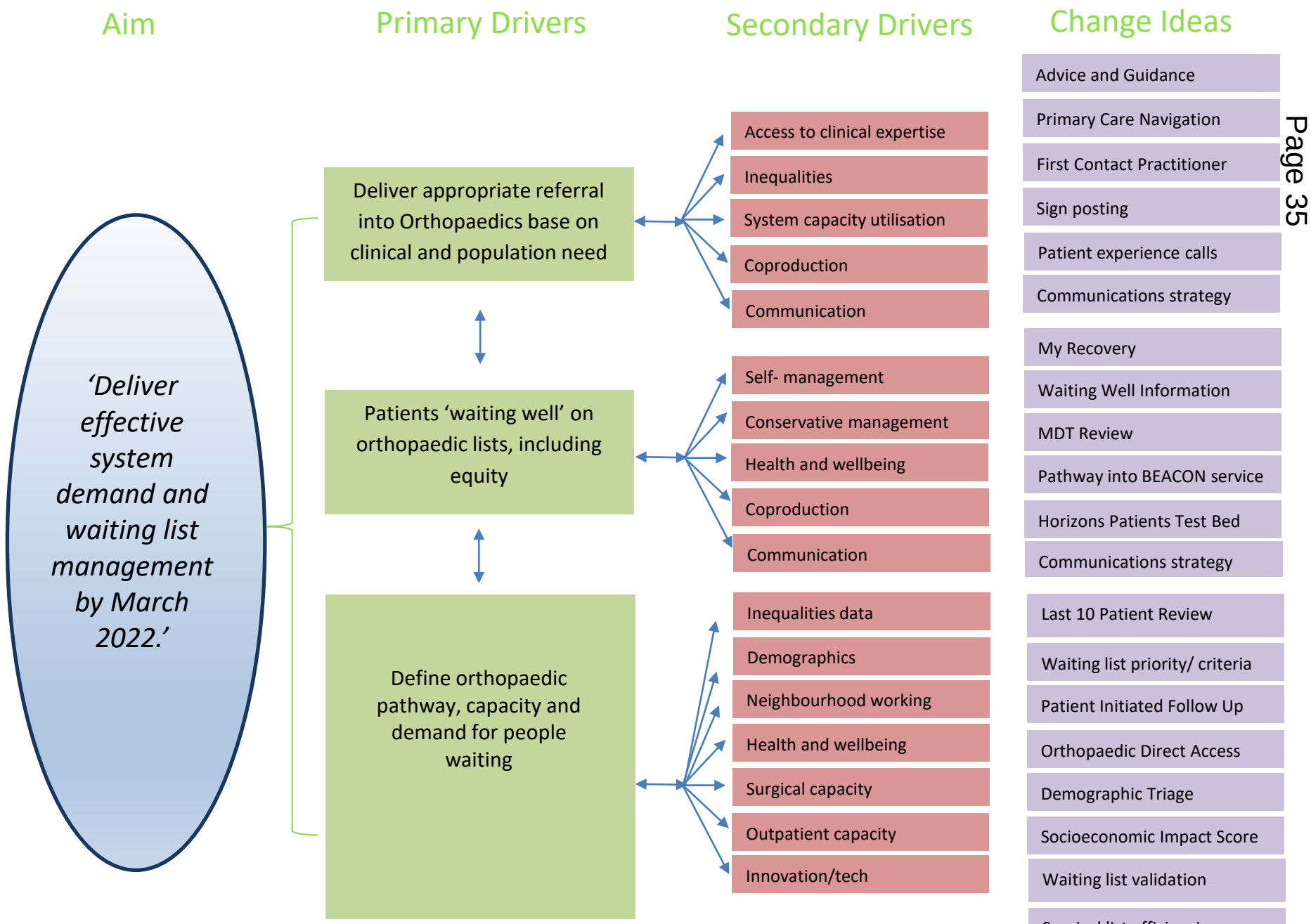

Elective Care Improvement Project: Bury CCG and Bury Care Organisation

(29/07/21) Appendix 1

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The way we engage people and communities in a place

Resources to embed the 'LETS' principles

Person and Community Centred Approaches(PCCA)

- Key pillar within Bury's neighbourhood model
- The consistent and persistent utilisation of person and community centred approaches.
- Underpins the way in which the Bury system collectively engages and interacts with local communities.
- Tailored to need each neighbourhood - select, co-design, develop and evaluate the relevant components of PCCA to apply in place according to demand and opportunity.

Let's do it …. In our neighbourhoods - Communities & public services *Together*

Lets Do It – The Strategy for the Borough to 2030.

*"achieving **faster economic growth than the national average, with lower than national average levels of deprivation"***
"we** will work collectively to give everyone the **encouragement and support** to play their part (and) joining together the delivery of all **public services as one

The way we organise ourselves for case management
Neighbourhood Team/System Working

e.g Housing –
STH; PRS & Homelessness
GMP
Substance misuse

Improving Adults Lives

Children's and Families

Health & Care Integrated Teams

e.g Early Help,
Schools,
Social Care
Youth Justice

e.g primary care, community health services, adult social care , community mental health, social prescribing

The way we engage people & communities in a place
Resources to embed the "LETS" principles

Enterprise
Participatory Budgets
Community Wealth Building

Local
Bury Directory
5 x Community Hubs

Strengths
Personal Budgets
VCFA
Ethnography

Together
Ward Members
Community Champions
Co-design

Community Hubs as place-based co-ordinators & connectors

Led by neighbourhood data profiles & case risk stratification:
- Join up of universal and targeted public services
- Unlocking multi-agency cases of discrete cohorts of risk
- Targeted intervention to prevent spiralling risk/demand

Led by neighbourhood asset maps & community for a:
- A focus on socio, economic, and health inequalities
- Nurturing local assets / resources eg residents groups
- Co-design with & engagement of communities

Local Neighbourhoods

- Neighbourhood / Community asset mapping
- Neighbourhood and Ward profiles to inform activity
- Community Hubs to harness and expand local capacity
- Bury Directory
- Commissioning, funding grants and social investment

Enterprising

- Community Wealth Building
- Sustained social & community enterprise

Delivering Together

- VCFA and networks
- Participatory budgeting
- Community Fora
- Co-design / co-production approaches
- Transparency of record keeping
- One Community
- Social prescribing
- Listening events

Strengths Based Approach

- Community development
- Ethnographic skills training and approaches
- Strengths based assessments
- Person centred conversations
- Personal budgets
- Community Asset Transfer
- Neighbourhood funding and budgets
- Community Champions

Public Service Reform Steering Group

- Provides oversight and delivery of the framework for Bury's person and community centred approach (LETS principles) ensuring it runs through everything we do
- To define what is meant by person and community centred approaches in Bury, promote what is working well and challenge where more can be done
- Mapping progress against each activity – leads, governance, progress to date and key next steps
- Deep dive into activity at each meeting - discussed to date:
  - Bury Directory
  - Participatory budgeting
  - Trauma informed approaches

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Population Health Delivery Partnership
Mandate/Brief

Purpose
To support the development of Bury as a Population Health System and to coordinate delivery of a range of population health strategies and programmes aimed at improving health and reducing inequalities. The Partnership will act as an engine room for the Health & Well-being Board and will also feed into the Integrated Delivery Collaborative Transformation Programme.

Impact
Able to self-assess with supporting evidence as fulfilling characteristics of a 'Population Health System'
Evidence of proactive action to understand and address inequalities and inclusion across all H&C transformation programmes
Evidence of systematic approaches to health improvement, primary and secondary prevention across all health and care transformation programmes, embedded as part of the neighbourhood working model and regeneration programmes
Evidence of 'Heath in all Policies' being embedded as business as usual

Outcomes
Improved life-expectancy and healthy life-expectancy and self-reported well-being and driving indicators
Reduction in inequalities in life expectancy, healthy life expectancy and self -reported well-being and driving indicators

Practicalities
Meetings will take place via Teams in the week following the Health & Wellbeing Board, which meets every 6 weeks, with a first workshop style meeting in September 2021.

Participants
Populaiton Health Board - proposed m

The Partnership will be chaired by the Director of Public Health and include a range of stakeholders form a range of partners who have a critical role to play as system leaders in progressing the population health agenda. (see attached)

Products
The Partnership will utilise the description of the GM Population Health System and System characteristics to develop a programme of delivery to optimise the contribution of the Bury system to improving health and reducing health inequalities.

It will shape and work to support the agenda of the Health & Well-being Board ensuring robust, relevant, and good quality reports are put before the Board with an emphasis on health inequalities, inclusion and co-production.

Process	Principles
The Partnership will undergo an initial development phase to support individual members in their role as system leaders and champions for population health. This will include an introduction to some key public health principles and practice, developing a shared understanding of what it means to be a population health system and the work required in Bury plus common application of concepts such as 'Implementation decay'.	The Partnership will operate as a supportive vehicle for mutal sharing and learning and for ensuring the whole is greater than the sum of its parts with an empahsis on iimproving health and reducing health inequalities. We will work to the values and priciples enshrined in Lets Do it!.

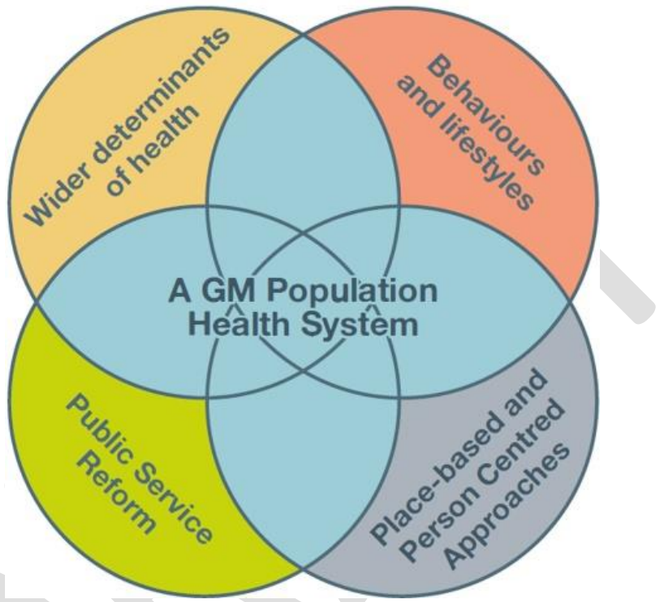
Greater Manchester Population Health System Framework

V2.5 (DRAFT)

There is a shared ambition within Greater Manchester to use our system assets and the opportunities of devolution to significantly improve health and tackle inequalities.

This framework sets out the conditions, characteristic and functions required at different spatial levels for a whole system approach to population health to be in place in Greater Manchester. It builds upon significant previous activity and investment over recent years to establish such an approach and represents an iteration from an existing position of strength. It recognises the importance subsidiarity and of place in determining what is required at difference spatial levels in order to maximise impact.

The model ties directly back into the existing **GM Population Health Model**:



The model builds upon the existing principles for Public Service Reform that exist within Greater Manchester and are as follows:

GM Public Service Reform Principles:

1) A new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production, and joint delivery of services – we need to '*do with*', not '*do to*'

2) An asset-based approach that recognises and builds on the strengths of individuals, families, and communities rather than focusing on their deficits

3) Behaviour change in our communities that builds independence and supports residents to be in control

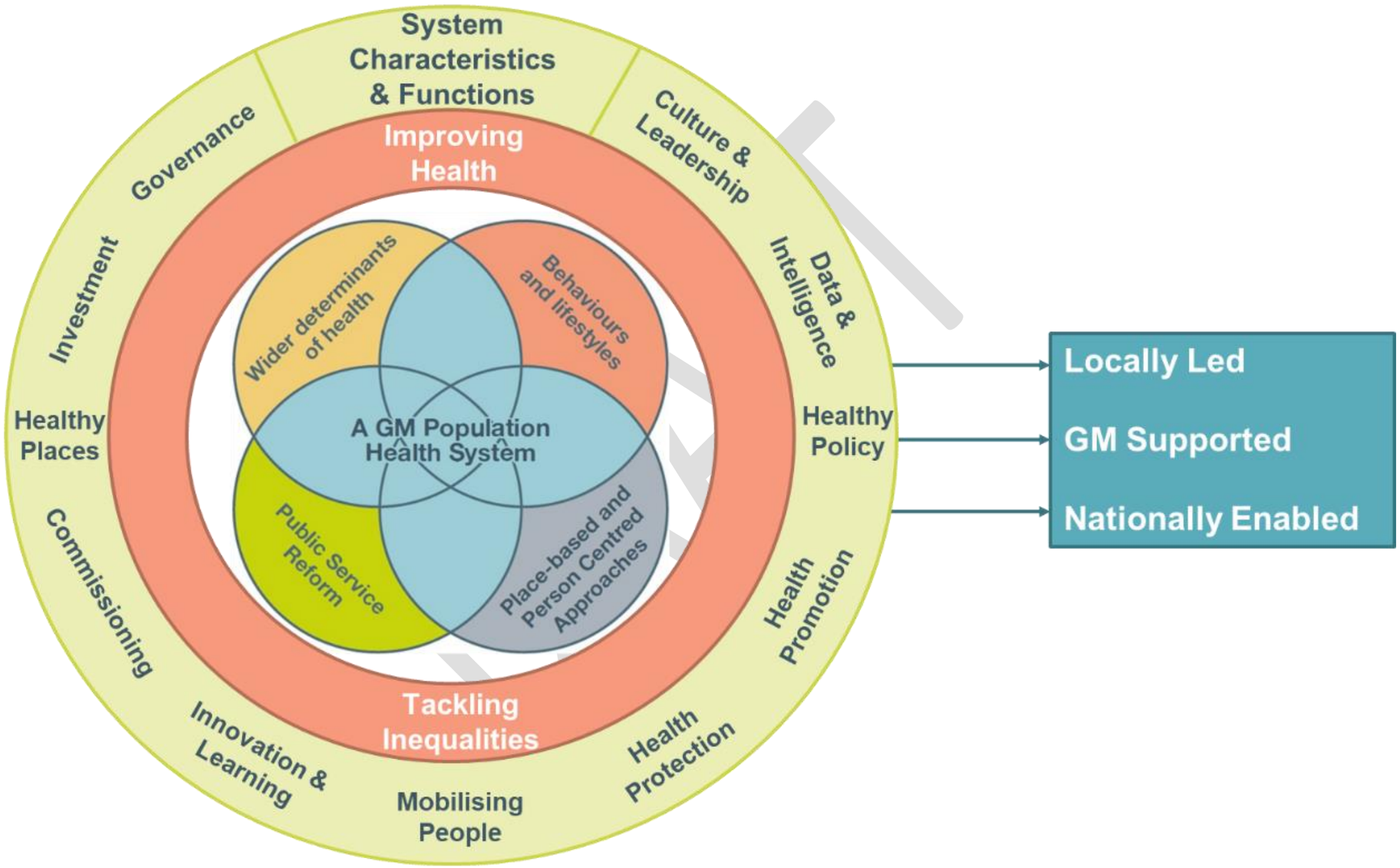
4) A place-based approach that puts individuals, families, and communities at the heart redefined services

5) A stronger prioritisation of wellbeing, prevention, and early intervention

6) An evidence-led understanding of risk and impact to ensure the right intervention happens at the right time

7) An approach that supports the development of new investment and resourcing models, enabling collaboration with a wide range of organisations.

The additional focus on conditions, functions and characteristics enables an iteration of the pre-existing GM model into one that is more wide-ranging and comprehensive, and sets out the key ambitions and considerations for the GM system:



Core System Characteristics	Conditions & Functions required at a locality / neighbourhood level	Current position in Bury	Next Steps
1) Culture: a) Improving health and reducing inequalities are recognised as being integral to all our ambitions and are accepted as being "everybody's business". To translate this recognition into tangible action and outcomes, GM functions as a unified population health system, working towards achieving a set of common goals, and utilising system resources flexibly to maximise impact. b) There is a clear understanding across the system of the fundamental role that the wider, social and commercial determinants of health play in shaping health outcomes.	c) All locality stakeholders recognise that improving health and reducing inequalities are integral to delivering our strategic ambitions and this is reflected in local conversations, behaviours, decision making and the use of resources.	Strong emphasis on improving health outcomes and reducing inequalities in local conversations and narratives across senior leadership across all locality stakeholders. Recognition that Covid has exacerbated poor health and inequalities and there are still gaps in the system. Starting to translate into behaviours, decision-making and resource allocation in some areas. Questions about extent to which this has yet permeated through whole organisations. Still an over emphasis on 'individual responsibility' vs societal population approaches	Work through the new Strategic Workforce Group to embed culture of population health system within OD programme Membership of Population Health Delivery Partnership to act as champions and set expectations within own areas of work. PH Team allocated to support translating intent into deliverables with strategi Let's Do It programmes. Use the Frameworks Institute work to re-shape the narrative and embed in emerging IDC Organisational Development programme .
2) Governance: a) Population health is embedded at the heart of system governance and assurance at all spatial levels and across all organisations, and there are clear decision-making processes in place, particularly for decisions requiring multiple partners or for contentious decisions. b) The VCSE sector has a prominent leadership role within all system governance. c) System assurance is in place to ensure learning and improvement is based on mutual agreement and trust.	d) Locality governance and leadership arrangements exists with a primary focus on improving health and reducing inequalities, and within which the Director of Public Health is recognised as a senior leader alongside other key stakeholders. e) Locality assurance ensures learning and improvement and is based on mutual agreement and trust. f) Effective partnership working exists between the city-regional organisations and constructs (including the GM ICS) and locality public	The Health & Wellbeing Board has been stood up as a 'standing commission' on health inequalities within which the Director of Public Health has a strong leadership role in agenda setting and supporting contributors to focus on contribution to heath outcomes and reducing inequalities through the application of the concept of 'Implementation Decay' and a 'PDSA' approach through which to share learning. Good partnership working across Bury, which had been strengthened through the pandemic; enables learning and mutual assurance as well as highlighting that some parts of the system may be less connected because of other pressures. A population health outcomes framework is underdevelopment feeding into the overarching Let's Do It outcomes framework which will be monitored by the HWBB. GM architecture is currently changing, working relationships between locality and other	Continue to support the HWBB to constructively challenge the extent to which strategies, programmes of work and services are contributing to a reduction in health inequalities Consider best mechanisms for engaging Priamry Care Networks Further develop the outcomes framework with stakeholders. Work with Intelligence team to build into Tableau and include analysis by all dimensions of inequality Work through GM DsPH to shape GM Population Health Board and relationship with Locality

	services (including locality health and care arrangements, Health and Wellbeing Boards and the VCSE).	partners across GM is evolving, with more changes to come. The Director of Public Health links to the GM System via the GM DsPH group	
3) Mobilising and Involving People & Communities: a) Communities and citizens are viewed as equal partners who are enabled to lead change, and there is evidence of this happening in practice. b) There is clear evidence of engagement and co-production happening at scale.	c) A wide range of person and community centred approaches and tools are used to involve people living in neighbourhoods in co-design and delivery. d) There is a vibrant and sustainable VCSE and faith sector working with locality partners to support and enable local people. e) Local public services have strong links into their communities, good insight into their makeup and structures, and the ability to undertake impactful communication and engagement activity about health.	There are increasing examples of good practice. A new Framework has been developed as part of 'Let's Do It' which encapsulates the wide range of approaches into a single framework and high-level plan for further embedding these approaches to create systematic, routine mechanisms for engagement, co-production and mobilisation. The VCFA has been recommissioned with a strengthened role and on a on a more sustainable financial footing. Local public service staff have undertaken Strengths Based and Ethnographic Training and are building strong links with communities through the community hubs and with those with lived experience. Many are also engaged with the 'Building a Community Mindset' programme. A workforce collaborative bid that has been submitted to help support this work.	Oversight of the development work takes place through the Inclusion partnership and PSR Boards. There is mutual membership between these Boards and the Population Health Delivery Partnership. Population Health Delivery Partnership to support and champion application of community engagement and co-production within specific workstreams led by members. The Strategic Workforce Group will oversee the further roll out of training. There is mutual membership between the Strategic Workforce Group and the Population Health Delivery Partnership
4) Leadership: a) All senior leaders in GM recognise the role they play in approving Population Health and this sits at the heart of leadership development and throughout system organisational development programmes.	b) There is bold clinical, professional, managerial, community and political leadership and a willingness to invest personal capital in championing health-promoting policies and taking action to reduce inequalities. c) Locality development programmes for future leaders have a population health and inequalities focus.	Members of the HWBB are investing personal capital in championing health promoting policies and taking action to reduce inequalities. Local professional, managerial, community and political champions are also members of PH Programme Board Not currently aware of development programme for future leaders. Have small number of local staff undertaking level 6 Public Health Apprenticeship, UKPHR practitioner registration process and the PH fellowship programme. RSPH (Royal Society of Public Health) Understanding Health Improvement Course Level 2 delivered locally.	There is a need to identify clinical lead(s) to join the Population Health Delivery Partnership The Population Health Delivery Board will provide opportunities for shared learning Develop a comprehensive Population Health Development Programme through the Strategic Workforce Development Group
5) Sustainable investment in Population Health: a) A sustainable investment strategy for population health is in place which incorporates agreed benchmarks for	b) Investment in improving health and reducing inequalities is seen as a strategic priority, and investment stretches beyond health-specific interventions and into tackling the social determinants of health.	Understood conceptually as important by an increasing number and range of strategic leaders but no clear investment strategy in place and no clear plan to shift balance of spend	Understand and make visible the current balance of spend Develop proposition/targets for resource shift

investment in population health (e.g. funding per capita) and health is seen as a meaningful investment by all key system stakeholders, and there is a widespread acceptance that good health is a pre-requisite of achieving a fair and prosperous society.	c) There is a clear commitment, underpinned by explicit plans, to shift the balance of spend towards prevention and early intervention.		Develop strategy and proposals for investment
6) Data, Intelligence, Research and Evaluation: a) A cross-system approach to using data, intelligence, research, and insight underpins a learning system where progress is measured using agreed health, inequality and equity Indicators (Including 'Marmot indicators'). b) There is system wide agreement about the appropriate spatial level to deploy specialist resources to achieve maximise impact and effectiveness. c) The data required to understand population health and inequalities is available, accessible and of high quality. d) GM can exploit the opportunities presented by its scale as a city region of 2.8 million people, and with strong ties across to world class academia and health innovation, to rigorously evaluate approaches, services and interventions in way which adds considerable value to the local, national and international evidence base e) Qualitative information and insight is valued as a means of understanding communities and shaping decision-making.	f) Capacity and specialist capabilities are in place to ensure that data, intelligence, research, and insight is integral to driving improvements in outcomes and reducing inequalities in a manner which complements the analytical work undertaken at locality level. g) Localities engage with emerging research funding opportunities with a view to building research cultures and strengthening locality and system-wide analytical capability and capacity. h) Local public services have strong links into their communities, good insight into their makeup and structures, and the ability to undertake impactful engagement about health. i) Systems are in place within localities to systematically capture and utilise community insight gained through engagement and research.	Lack of up to date and comprehensive JSNA Limited local data avaialble Immature application of Population health management approaches Agreed set of inequality and equity indicators in development. Inadequate capacity and specialist capabilities in place. Current capacity more focused on business intelligence and performance monitoring than public health analysis. ONS Accredited Researcher training and access to Local Data Spaces but limited capacity to optimise use. Little current engagement in research opportunities Stronger links and insight developing through Neighbourhood profiles, Neighbourhood Working Model, Community Hubs and opportunities to building on Covid community engagement and the Champions programme. Not currently harnessed and shared.	Redevelopment of the JSNA Resumption of local health Surveys Strategic approach to development and application of Population Health Management approaches Further discussion re alignment of resources to support work of HWBB and PH Programme Board. Consider use of transformation monies to support development of Public Health epidemiological and intelligence capacity. Establish 'Population Health Evidence and Research' post to take lead on building relationships with academic and research institutions and optimising opportunities. Build systematic approach to harnessing and sharing community insight.
7) Shaping Healthy Policy & Strategy: a) Population Health and Inequalities considerations are reflected in all policy, strategy, and investment decisions to achieve an explicit system goal to improve health and reduce inequalities. b) The GM system can speak with a single voice on key national policy issues that affect health and health inequalities and is able to harness the relevant public health expertise to undertake meaningful engagement with regional, national, and international stakeholders.	c) All local strategic plans and policies are underpinned by a primary ambition to improve health and reduce inequalities. d) Specialist capacity and capability is available at a locality level to influence, implement and evaluate local policy and strategy to ensure it contributes to improving health and reducing inequalities.	Let's Do It' and Locality Plan underpinned by primary ambition to improve heath and reduce inequalities and beginning to feature in other underpinning strategies. Inequalities targets been set to drive decision making. Capacity gaps exist. Covid Response also detracting from Policy work	Explore role of council corporate core policy 'team' in Health Impact Assessment and assurance of health in all policies Determine priority policy asks and build political and stakeholder (including community) advocacy and a unified voice for change. Build response to capacity gap within PH re-structure

8) Health Protection: a) A whole system model exists within which all key stakeholders work collaboratively to deliver a comprehensive health protection model, underpinned by appropriate expertise and clear roles / responsibilities.	b) A locality Health Protection functionality exists, working alongside GM and UKHSA as part of a whole system response to prevent and tackle health protection threats, including those associated with Covid-19.	Additional capacity and capability developed as part of Covid response and well positioned to assume fuller locality health protection function.	Continue to influence and shape new health protection system and ensure resources directed to where needed in the system.
9) Taking action to improve health: a) Decisive action is taken to prevent identified and agreed health challenges, and to proactively create good health, and the most appropriate spatial level is defined used the GM principles of subsidiarity.	b) There is appropriate and sustainable investment in population health interventions that is best delivered locally, and these are focussed on the outcomes of greatest concern to the locality as well as those that are mandated.	Programme of work in place aligned where necessary with work at GM spatial level. Investment significantly constrained by financial position of Council and CCG	Bring under view of new Population Health Programme Board Link to investment strategy
10) Tackling Inequalities a) Tackling inequalities is a recognised priority across the whole system and there is evidence of effective action taken place to deliver the recommendations of the GM Independent Inequalities Commission and the Marmot Review, underpinned by a comprehensive understanding of the data and intelligence, a knowledge of 'what works', and robust evaluation of impact.	b) In addition to contributing to the delivery of the GM plan to tackle inequalities, localities have a comprehensive understanding of intra-borough inequalities and targeted plans to tackle them in recognition that this is most effectively addressed at a local level. c) All localities utilise a set of agreed indicators (tied to the GM marmot indicators) to assess the local state of play and progress made in tackling inequalities. d) Appropriate methodology is used as part of city-regional decision making to assess the likely impact on equity and inequalities.	Local understanding of inequalities building throughout the system based on neighbourhood profiles and specific pieces of analysis. Evidence of this informing some plans (e.g. Elective care) but not yet fully embedded as a systematic way of working as a whole system. Local indicators in development (taking account of Marmot and GM Inequalities Commission)	Finalise indicators and monitoring Make data and intelligence accessible and visible to those that need it. Continue to spread and embed notions of 'Implementation decay' as an approach to understanding inequalities and the impact of interventions and services. Continue to spread and embed principles of 'equity' and 'proportionate universalism' as an approach to addressing inequalities. Establish routing equality monitoring and equity audits in all performance reports.
11) Commissioning for Health & Outcomes: a) Commissioning is focussed on outcomes with an emphasis on improving health and reducing inequalities, and maximising Social Value sits at the heart of our approach to commissioning.	b) All services and interventions (including those specific to public health) are commissioned in a manner which is data and evidence driven, reflects proportionate universalism and drives outcomes at a neighbourhood level. c) Localities commission in a manner which is cognisant of the GM Social Value Framework, and which seeks to maximise the role of anchor institutions.	A mixed picture – many services still commissioned on an activity basis. Most PH services are based on needs assessments and have adopted 'Outcomes Based Accountability' as basis of commissioning. Local community of practice building to develop role of anchor institutions across public sector. Social value framework exists but not optimised	Ensure a clear population health outcomes framework is developed and widely owned as part of the Triple Aim approach to help provide clarity on what we want to achieve Opportunity to shape way in which 'NCA community services' are 'commissioned'
12) Shaping heathier environments by optimizing the use of regulatory & legislative levers and powers: a) There is a comprehensive understanding of all available powers, an ability to use them proportionately and appropriately to create health-promoting places, and a willingness to	d) There is a comprehensive understanding of available powers and a willingness to use them proportionately and appropriately. e) The role of the statutory Director of Public Health is optimized at a local level, including as a	Current understanding not comprehensive DPH on all key Boards and Partnerships	Build understanding and consider how to apply.

seek new powers if there appears to be value in doing so. b) There is a greater focus on changing the environments that people inhabit whether physical, economic, digital, social, or commercial is key to improving population health. c) There is a recognition that utilising levers such as social protection through legislation and regulation, which have population wide reach and that place minimal demands on individuals, are deemed to be the most likely to narrow than widen health inequalities	recognised senior leader within locality ICS constricts. f) Guidance / evidence should be used to create health-promoting places, and this should be evident in all local plans and strategies. g) Spatial planning at a local level is focussed on changing the environments that people inhabit to ensure that they are conducive to good health.	Climate Change Strategy, Housing Strategy and Township Regeneration plans in place – evidence of health considerations within these. Further work required to maintain focus through delivery – PH capacity gap.	Build response to capacity gap within PH re-structure
13) Promoting Innovation and Learning: a) There is a commitment to learning from each other and from other areas, a systematic methodology for sharing new knowledge, and a culture of innovating and learning through evaluation.	b) Localities actively participate in GM, Regional and National Networks to share learning including though Sector Led Improvement programmes. c) There is a local culture of innovating and learning through evaluation.	There is strong engagement in a range of population health related networks where learning is actively shared. There is a willingness to innovate and learn but there is a lack of structured/ systematic evaluation	Build evaluation skills and application of evaluation methodologies. Seek external opportunities to support innovation & evaluation.

	Potential years of life lost from causes considered amenable to healthcare – adults								Potential years of life lost from causes amenable to healthcare CYP
OUTCOME MEASURES SYSTEM METRICS	**CHD Under 75s Mortality Rate from all cardio vascular disease Under 75 mortality rate from cardiovascular disease considered preventable**	**Stroke (Preventable mortality)**	**Diabetes (Preventable mortality)**	**Cancer Under 75s mortality rate from cancer Under 75 mortality rate from cancer considered preventable from Cancer 1 & 5 year survival from cancers**	**Chronic Respiratory Under 75s Mortality Rate from respiratory disease Under 75 mortality rate from respiratory disease considered preventable**	**CKD (Preventable mortality)**	**Mental Health Premature mortality in adults with severe mental illness Excess mortality rate in adults with severe mental illness Suicide rate Deaths from drug misuse**	**MSK Hip fractures in people aged 65 and over**	**Maternal & Child Health Infant mortality rate Good Level of Development age 2.5 and 5 years**
URGENT CARE Emergency admissions for ambulatory care and urgent care sensitive conditions Avoidable Hospital admissions Readmissions	Emergency MI admissions	Emergency Admissions due to Stroke		% diagnosed on A& E attendance			Mental Health Streaming A&E attendances/Emergency hospital admissions for self-harm	Emergency admission due to falls	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s Accidents & unintentional injury Emergency admissions for children with lower respiratory tract conditions
PLANNED CARE Unmet need for health care Stage of presentation, RTT waits, DNAs,)	Diagnostic waits			Cancers diagnosed at early stage Treatment within 62 days			IAPT access IAPT recovery EIP Waiting Times Inpatient admissions Out of area placements Admission episodes for alcohol related conditions		Waits LAC, CIN, CSC Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under Breast feeding initiation

COMMUNITY **Independent Living among those with Multi-morbidity** **Health related quality of life for people with Long term conditions** **Proportion of people feeling supported to manage their condition** **Employment of People with Long term conditions** **Health related quality of life for carers** **Proportion of older people still home 91 days post discharge**			Diabetes patients achieving NICE recommended targets				Employment of people with mental illness Successful completion drug treatment Successful completion alcohol treatment	Rapid response – response to falls/admission avoidance Hip fracture: proportion of people recovering to previous levels of mobility/walking ability at 30 day and 120 days	Social Prescribing Referrals % of children receiving 6-8 week review Breast feeding at 6-8 weeks New birth visits within 14 days
PRIMARY CARE **Proportion of people feeling supported to manage their condition**	NHS Health Checks Expected vs observed CVD registers % treated to target Referrals to Live Well Services 'Social prescribing' referrals and outcomes	Expected vs Recorded Prevalence (Missing Thousands) % achieving best care indicators Referrals to Live Well Services 'Social prescribing' referrals and outcomes	Expected vs Recorded Prevalence (Missing Thousands) % achieving best care indicators Referrals to Live well Services Preventable sight loss – diabetic disease	Screening uptake Two week waits Referrals to Live well Services 'Social prescribing' referrals and outcomes	Expected vs Recorded Prevalence (Missing Thousands) % achieving best care indicators Referrals to Live Well Services 'Social prescribing' referrals and outcomes	Expected vs Recorded Prevalence (Missing Thousands) % achieving best care indicators Referrals to Live Well Services 'Social prescribing' referrals and outcomes	Dementia diagnosis rate Dementia care plan reviewed within 12 months People with SMI received health check Referrals to Live Well Services 'Social prescribing' referrals and outcomes	Osteoporosis Screening and management Referrals to Live Well Service 'Social prescribing' referrals and outcomes	Childhood Imms LARC Tooth extractions due to decay for children admitted to hospital Child development – communication skills at 2.5 years Personal social skills at 2.5 years

POP HEALTH **Smoking prevalence** **% classed as Overweight or obese** **% Physical Activity levels** **% Flu uptake**	% achieving health goals with Live Well Service	% achieving health goals with Live Well Service	% achieving health goals with Live Well Service	% achieving health goals with Live Well Service	% achieving health goals with Live Well Service	% achieving health goals with Live Well Service	% achieving health goals with Live Well Service Self reported wellbeing	% achieving health goals with Live Well Service % injuries form falls in people aged 65+	Number of referrals into lifestyle services % children aged reception & year 6 classified as overweight or obese % physically active children Smoking prevalence at age 15 Maternal smoking at time of delivery Maternal obesity Alcohol at booking Under 18s conception rate % children DMF teeth

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