

**GREATER MANCHESTER HEALTH AND SOCIAL CARE  
STRATEGIC PARTNERSHIP BOARD**

**8**

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Subject: Transformation Theme 1 – Public Health System Reform

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**PURPOSE OF REPORT:**

The Greater Manchester Population Health Plan serves as a key driver to re-orientate the wider system towards prevention and a focus on population health and wellbeing. The delivery of the Population Health Plan requires the support of a population health system which is organised to deliver at pace and scale.

A review of the current public health system has been underway since November 2016 with the aim of developing an evidence based set of propositions for creating a unified population health system for Greater Manchester. An emerging set of propositions have been tested with colleagues across the system and have been further developed by AGMA Wider Leadership Team in early February 2017 and endorsed by the Strategic Partnership Board Executive 16 March 2017.

This paper sets out the findings from the review, as well as puts forward a suite of proposals for the creation of a unified population health system for GM which will ensure the necessary effective delivery of the Population Health Plan. The paper consists of an executive summary and also a fuller document.

**RECOMMENDATIONS:**

The Strategic Partnership Board is asked to:

- Approve of the proposals outlined in the paper.
- Acknowledge that a detailed mobilisation plan and transition plan will be developed to support the delivery of the proposals.

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## **1.0 INTRODUCTION**

- 1.1. In GM, we have a shared commitment to the most ambitious approach in England to place public health at the heart of public service reform and economic growth. Rebalancing our economy also requires rebalancing our public services. Since the implementation of the NHS and Social Care Act in 2013, public health leadership has become somewhat fragmented with capacity and functions dispersed across local authorities, Public Health England (PHE), NHS England (NHSE) and more recently into the Greater Manchester Health & Social Care Partnership (GMHSCP) under the devolution arrangements. While there have been some real positives from these changes, for example, integration of public health functions into wider local services, there has also been some fragmentation of health protection, intelligence architecture and commissioning functions, and also some duplication and overlap, which limits the capacity to effect significant change across Greater Manchester (GM).
- 1.2. In July 2015, partner organisations across GM signed a Memorandum of Understanding (MoU) with PHE, with an ambition to create a Unified Public Health System. This would be an opportunity to support and add value to local working by reducing the fragmented nature of public health leadership in GM and drive the necessary emphasis on prevention of ill-health and integration of services, which will be central to improving outcomes in a landscape of diminishing resources. The GM Taking Charge Together Plan (December 2015) further committed to this by prioritising the prevention agenda, and recognising the need to embed lasting and relevant changes to how GM organises itself for the best outcomes for and wellbeing of GM's population.
- 1.3. Work has progressed since 2015 to change the premise from unifying a 'public health system' to creating a unified 'population health system'. Public health is about using the expertise of a specialist workforce to embed knowledge, skills and expertise across systems in a place based model. Population health is a wider cross-cutting perspective which is everybody's responsibility, involving collaboration across a range of sectors and partnerships (such as health, social care, other public services, voluntary sector, businesses and wider communities).
- 1.4. The GM Population Health Plan January 2017 set out GM's approach to delivering a radical upgrade in population health. 'System Reform' – creating a unified population health system - is one of the key programmes of work within the Plan, recognising that an ambition of the magnitude of the delivery of the Population Health Plan requires the support of a population health system which is organised to deliver at pace and scale and in the context of a devolved system, one that is better able to achieve improved health outcomes for the citizens of GM.
- 1.5. Broad stakeholder involvement and engagement work has taken place during 2016 which resulted in the development of a set of high-level proposals. Based on this early work, a deeper review of the current public health system has been underway since November 2016 to further develop the high level proposals into a set of

evidence based propositions for creating a unified population health system for Greater Manchester.

- 1.6. This summary details the main findings from the review and presents the suite of proposals for the creation of a unified population health system for GM which supports the necessary effective delivery of the population health plan.

## **2.0 OUR VISION**

- 2.1. Given the strong emphasis under GM Devolution on integrated health & social care from a primary, community and acute care perspective, we see improvement of population health as an objective underpinning the entire system, thus creating an integrated wellbeing, health and care system. The focus is on a 'whole system approach' with GM and Localities working as a single system.

- 2.2. Our Vision is for a system that:

- is united in its focus on the delivery of agreed priority population health outcomes and long term financial sustainability.
- defines a set of population health goals that are recognised and embedded within all relevant GM programmes and services.
- develops greater consistency of approach and common standards for delivering population health outcomes across GM, in terms of planning, monitoring, commissioning and service delivery for population health.
- is consistent with the principle of subsidiarity (decisions are made at the most appropriate level) within GM, recognising the 'place' (Locality Authority footprint) as the primary unit of planning whilst also being cognisant of the needs of communities of identity.
- creates a strong and able cadre of population health leaders across GM, supported by clear governance and accountability and reporting systems, and a specialist public health workforce.
- extends commissioning and delivery of some public health functions at GM level to achieve additional impact, complementary to that at Locality level.
- drives out inefficiencies and unnecessary variation in the system where it does not make sense to do things multiple times, or where current focus and investment does not deliver the best outcomes.

- 2.3. Our expectation is that the nine leadership values for GM, which underpin public service reform, are embedded in system leadership for population health. Our objectives for place based assurance are underpinned by the GM Assurance framework. Our vision for commissioning for population health is ensuring consistency in how we procure, commission and contract for population health – which are quality, improvement, social value, outcome and cost driven, with a move

to commissioning across a whole system where feasible and beneficial. Our vision is underpinned by the principles set out in the GM Commissioning for Reform Strategy and aligned with the Commissioning Review currently underway.

### **3.0 KEY FINDINGS**

3.1. The key findings from the Review are:

- Investment is not strongly related to evidence based outcomes but instead based on historical inputs.
- We have good examples of commissioners working collaboratively and moving to cluster based commissioning approaches, with lead commissioner arrangements in place and lead provider procurements underway. But this is not consistent across GM and for all commissioned services where this would make sense.
- We are seeing little evidence yet of commissioning across a whole system, use of integrated budgets across programme areas, or commissioning for outcomes.
- We have a mixed provision of health protection functions across GM as well as varied governance and assurance arrangements. There is no overarching GM system for health protection which is being held to account.
- There is a skilled public health cadre across GM but we are not fully maximising the capacity, resources nor skills sets effectively, which results in duplication and often inefficiency. We have invested in some GM leadership for Population health but given the profile and ambition set for transformation this needs expansion.
- There is a gap at GM level for PH intelligence with weak informatics support, and at the locality level there is repetition and fragmentation in the system.
- Governance and accountability needs to be strengthened in a number of areas to ensure visibility in decision making and enhanced assurance.
- As a system we are not getting the best value for money and there are opportunities for looking at efficiency savings.

### **4.0 OUR PROPOSALS**

4.1. Enacting a new way of working as a GM system for population health is an iterative process which is about changing cultures, behaviours, perceptions and ways of working in a more integrated way. In addition, it is about putting in place the right system architecture for delivery:

- agreed target population health outcomes and common standards for the system to achieve the best health gain;
- integration of local population investment with wider community investment;
- the right spatial level for core public health functions and commissioning;
- an effective and able cadre of population health system leaders;
- effective governance and accountability supported by system enablers.

4.2. We have developed the following suite of interrelated proposals



#### 4.3. Common Population Health Goals

4.3.1. We have developed a set of common population health goals designed to reduce unwanted variation in achieving our population health outcomes. It is intended that ways of reducing that variation will be for local discretion, but working to GM agreed common outcomes and standards to be met, and at a GM level providing facilitation through data, workforce investment, leadership development etc.

4.3.2. Key components are:

- **Common Standards** - core priority areas (0-5 including oral health; substance misuse; sexual health; tobacco control; mental health; ageing well) for all localities to prioritise and invest in. These sit alongside and enhance existing national mandation.
- **Development of core strategies** - for those areas committed in the Population Health Plan as well as for GM Sexual Health Strategy; GM Health Protection Strategy and GM Guidance and Standards on health response to outbreak; and GM Age Well Strategy.

#### 4.4. New System Design for Public Health Functions

4.4.1. Key components are:

- **A Unified GM Health Protection Function** – designing the optimum pathway and system for GM.
- **GM Population Health Intelligence Function** – as part of the wider GM Health Intelligence function.
  - **Outcomes Framework** - refresh of the existing GM Population Health Outcomes Framework in line with the refreshed GM Strategy.
  - **Risk Stratification Tools**
  - **Information Dashboard** – at a glance view of where the system is in meeting population health outcomes, reducing variation and inequalities in outcomes, with ability to commission reports on the relationship between variables.

#### 4.5. Commissioning for Population health

##### 4.5.1. Key components are:

- **Whole System Integrated Sexual Health Service** – includes all commissioners and their services (NHSE; CCG; LA) and covers a range of interventions via clinics, outreach, digital platform, delivery split between GM and locality level depending on the service.
- **Substance Misuse** – As a minimum commissioning Tier 4 Inpatient Detox & Residential rehabilitation at a GM level.
- **Digital Platform for Lifestyle & Wellness** – this is the commitment made in the Population Health Plan.
- **GM Service Specifications** – for those GM Commissioned Services.
- **Good Practice Guidance** - for commissioning population health at a place based level ensuring that population health outcomes are reflected in local commissioning decisions.

#### 4.6. System Enablers

##### 4.6.1. Key component is:

- **Standard for Health Checks** – A robust GM Pathway for Health checks that forms a systematic and scaled approach to identifying the missing individuals with, or at risk of developing long term conditions.
- **Digital Tools**

#### 4.7. Population Health System Leadership

4.7.1. Key components are:

- **Developing system-wide leadership** – using training and development to embed the population health ethos across services and sectors.
- **Evolved DPH role** – having a clear leadership role broader than public health to being a population health leader. DPHs acting as part of a networked structure across GM, blending working at the locality and GM level. Network arrangements are for local determination, as some may localities may decide to adopt a shared role. Accountability for the DPH resides with the LA.
- **Specialist public health workforce (consultants, health intelligence, health protection)** – Networked at the locality level and working across GM to the same arrangements as above.
- **Support from the GM Mayor** for key areas (active lifestyles; healthy environments; changes to regulatory frameworks) to enable impact at scale.

#### 4.8. Governance and Assurance

4.8.1. Key components are:

- **Use of established local governance** – effective system stewardship by the Health and Wellbeing Board and standards, programmes and target outcomes embedded in processes for delivery of locality plans, including work of emerging Local Care Organisations.
- **Use of established GM governance** – delivery of unified health system made the responsibility of the Population Health Board reporting up to Strategic Partnership Board and GM Reform Board as appropriate.
- **Use of GM health and care assurance framework** – including review of progress as part of quarterly assurance meetings.

### 5.0 WHAT THIS SHOULD MEAN IN FUTURE

5.1. As a result of these reforms, we should experience:

- A stronger commitment to reduction in unwanted variation in standards and population health outcomes, and a more consistent adoption of evidence based practice and benchmarking data to reduce that variation.
- Integrated population health system leadership to join up conversations across and between children's, adults' and wider public services, spanning physical and mental health.
- Changing behaviours, to ensure that accountability for population health is spread widely, not concentrated within single organisations or within the

boundaries of traditional health and care services. Also creating a culture of mutual accountability in that system peers and partners proactively challenge and support delivery.

- Leadership for population health and collaboration through placed based systems of care requiring the breakdown of professional siloes in pursuit of the greater good of the populations they collectively serve.
- Greater local determination in using and maximising available resources in the most efficient way, including communities making more decisions for themselves about the best way to secure improvements.
- Maximising the existing skills and capacity in the system towards delivering the GM ambition for a radical upgrade in population health through more networked arrangements.
- Investing more in wider community, voluntary and business sector infrastructure to be part of a reformed delivery system and also to make better use of the wider paid public sector workforce.
- Local Care Organisations, working with the local community and voluntary sector, to provide a platform for implementing new and innovative models of care and prevention programmes which will improve population health and well-being.
- Creating a platform for further devolution 'asks' from central government to enable Greater Manchester to have more control over the key levers for securing population health gains, including regulatory and pricing mechanisms, and improvements to environmental quality.

## **6.0 A SET OF PRIORITIES FOR CHANGE**

6.1. In anticipation of sign off of the priorities, our next steps and priorities for change will be:

### **6.2. Immediate Priorities (March to April):**

- Working with colleagues to develop the protocol for the concurrent role of GMCA from April 2017 and any implications of the business rate pilot scheme.
- Engaging with the LCO development and single integrated commissioning framework regarding the proposals.
- Taking into account the outcomes of the Commissioning Review.

### **6.3. Further Work**

- Development of detailed mobilisation plan and transition plan to support the implementation of the proposals.



- Financial modelling.

#### **6.4. Implementing some quick wins:**

- Introduce new governance and accountability structures and PMO office.
- Revision of GM Population Health Outcomes Framework.
- Work with SCN and Partners to design the risk assessment tool for GM health checks.

#### **6.5. Commencing key programmes of work:**

- Development work for GM Standards.
- Development of integrated health protection pathway.
- Development of model for health intelligence.
- Commencing the work on sexual health and substance misuse by mapping the AS-IS position.

### **7.0 RECOMMENDATIONS**

#### **7.1. The Strategic Partnership Board is asked to:**

- Approve of the proposals outlined in the paper.
- Acknowledge that a detailed mobilisation plan and transition plan will be developed to support the delivery of the proposals.

# **BUILDING A UNIFIED POPULATION HEALTH FUNCTION FOR GREATER MANCHESTER – A REVIEW**

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# **BUILDING A UNIFIED POPULATION HEALTH FUNCTION FOR GREATER MANCHESTER – A REVIEW**

## **1.0 INTRODUCTION**

- 1.1. The implementation of the NHS and Social Care Act in 2013 marked a split in public health leadership and core functions between local authorities, Public Health England (PHE), NHS England (NHSE), with Clinical Commissioning Groups also having a significant interest. The landscape has continued to evolve with 0-5 public health commissioning functions transferring to local authorities in October 2015. There are strengths of the reformed system, for example, the ability of local authorities to develop a more place-based approach to public health and to link public health functions to wider public services. However, it has also resulted in some weaknesses, mainly that there is greater fragmentation of health protection, intelligence architecture and commissioning functions across a multitude of partners. The resulting architecture of the public health system is one of significant duplication and some unnecessary variation, which overall limits the capacity and effectiveness of the system. The GM health and care devolution programme gives us the opportunity for some significant improvements. (Appendix A provides some more detailed information on the current statutory and policy context.)
- 1.2. In June 2015, building on the Greater Manchester Agreement and the Health & Social Care Memorandum of Understanding (MoU) of February 2015, a set of partners (10 GM LAs, PHE, NHSE, Association of GM CCGs, GM NHS providers and GM ‘blue light’ services) signed a Public Health MoU. The Public Health MoU set out how public health leadership could come together to support the necessary rebalancing of GM health and care system towards prevention and early integration. The MoU therefore created a framework by which partners committed to create a single unified public health leadership system capable of contributing to a transformational and sustainable shift in the health and wellbeing of the population. The MoU described how public health leadership in PHE, NHSE, GM and other partners would work together to secure accelerated improvement in the health and wellbeing of the GM population and capitalise on the devolution package by seeking to innovate and deliver new approaches to tackling the wider determinants of health including employment worklessness, educational attainment, housing and income levels. The key operational principles were set out as:
  - a robust and evidence-based public health contribution to growth and reform priorities of GM;
  - a focus on wellbeing, prevention and targeted intervention;
  - a recognition that the citizens of GM will be key agents in supporting and achieving better health outcomes;
  - a rebalancing of investment towards prevention; and

- a commitment that no decisions on public health leadership, investment or commissioning that relate to GM residents are made without GM.
- 1.3. The GM Taking Charge Plan (December 2015) further committed to population health by setting out a range of transformation programmes which would see the concentration of efforts to raise population health outcomes for GM to those projected for England and made the commitment to go further and faster.
  - 1.4. The Devolution Agreement April 2016 signalled the start of transforming public health leadership, with the devolvement of Section 7a commissioning responsibilities (immunisation and screening, CHIS and elements of health and justice commissioning) from NHSE to GMHSCP, along with the embedding of PHE and NHSE commissioning and healthcare public health resource into a newly formed Population Health Team in GMHSCP.
  - 1.5. The GM Population Health Plan was published in January 2017 and sets out our approach to delivering a radical upgrade in population health. The plan is aligned with the broader approach to reform across GM which is predicated on a new relationship between people and public services; connecting people to the opportunities of growth and reform; placed-based integration of services and early intervention and prevention. It is clear that most change happens in communities, supported by local organisations, so the priorities for change set out within the plan have been chosen to add value to the local delivery described in each of the 10 locality plans.
  - 1.6. The plan therefore focuses on those programmes of work that Greater Manchester Health and Social Care Partnership will deliver in collaboration with localities. It does not seek to duplicate those priorities that are best delivered at the locality level. The choices made in the plan are based on the best available evidence of impact and seek to achieve a balance of short, medium and long-term improvements.
  - 1.7. Creating a unified population health system is one of the key programmes of work of the Plan. The intent, set out in the Plan, is to build on the commitments set out in the Public Health MoU for the development of a single population health system across the GM economy – one which maximises both the impact and the capacities of a small and specialist public health workforce, but also supports the embedding of the pursuit of Population Health as being everybody's business and sees collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public working together as population health systems.
  - 1.8. In addition to creating a unified leadership system for population health, we recognise the need to create a unified approach to commissioning population health that enables us to commission services at the right spatial level, in collaboration with one another, and to improve population health outcomes and health inequalities as well as contributing to a more sustainable public health, health and care system.

- 1.9. The proposals set out in this paper create a framework for a unified population health system for GM, which is organised to deliver at pace and scale the commitments set out in the Population Health Plan.

## **2.0 HOW WE HAVE GONE ABOUT THE REVIEW**

- 2.1. Work on developing a set of evidence based proposals for creating a unified population health system commenced in November 2016, and we have combined a number of inputs:

- Review of local authority public health expenditure (for RA data 2016/2017 from Central Government Returns) to gain a better understanding of how the Public Health Grant is being used across GM.
- Work with commissioners and AGMA procurement hub to look at existing contracts for public health commissioned services. We have also undertaken a deep dive in one area by specifically engaging with sexual health commissioners and providers to gain a better understanding of how services are currently commissioned and delivered.
- Work with New Economy to do initial 'proof of concept' modelling work for sexual health to demonstrate the benefits from moving from single commissioning approaches to combined commissioning arrangements.
- Review of existing decision making and investment tools, namely Right Care and PHE SPOT (investment and outcome tools) to try and gain an appreciation of current investment in relation to outcomes. To take a GM perspective, further development work on the tools is needed.
- Assessment of the current spatial level for delivering health protection, health intelligence and commissioning for population health.
- Engagement across the system to understand stakeholder asks of a unified population health system. Those involved so far include:
  - LA CEOs
  - Directors of Public Health
  - Public Health Consultants
  - PHE
  - PSR Team
  - Wider System leaders
  - GM JCB
  - AGMA Wider Leadership Team

- 2.2. We have aligned our thinking with the broader approach to reform across GM that is predicated on a new relationship between people and public services; connecting people to the opportunities of growth and reform; place-based integration of services and orientating the system towards early intervention and prevention.

- 2.3. We have taken into consideration the wider policy context, legal duties, and the relationship with the wider health and care transformation programmes, in particular the development of locality care organisations (LCOs). We will align our proposals with the outcomes of the independent commissioning review being undertaken by Deloitte and we intend to further develop our thinking on workforce development in line with the publication of the GM workforce strategy.
- 2.4. Finally we recognise that achieving a radical upgrade in population health is not just the responsibility for health and social care services, nor of public health professionals, but instead requires co-ordinated efforts across population health systems. It requires efforts to change behaviours and cultures, and also to recognise that accountability for population health is spread widely, not concentrated in single organisations or within the boundaries of traditional health and care services.
- 2.5. The remainder of this paper describes:
- our vision for a unified population health system;
  - our findings on how the system is working today;
  - our proposals for a reformed population health system;
  - the benefits of the proposals;
  - a set of priorities for change.

### **3.0 OUR VISION FOR A UNIFIED POPULATION HEALTH SYSTEM**

- 3.1. Given the strong GM Devolution agenda emphasis on integrated health & social care from a primary, community and acute care perspective, we see improvement of population health as an objective underpinning the entire system, thus creating an integrated wellbeing, health and care system.
- 3.2. The focus is on a 'whole system approach' to population health improvement and health gain with GM and Localities working as a system. Public health is about using the expertise of a specialist workforce to embed knowledge, skills and expertise across systems in a place based model. Population health is a wider cross-cutting perspective which is many people and organisations' responsibility across public services, voluntary and community groups, and wider employers.
- 3.3. Our Vision is for a system that:
- Is united in its focus on the delivery of agreed priority population health outcomes and long term financial sustainability.
  - Defines a set of population health goals that are recognised and embedded within all relevant GM programmes and services.

- Develops greater consistency of approach and common standards for delivering population health outcomes across GM, in terms of planning, monitoring, commissioning, service delivery and evaluation for population health.
- Is consistent with the principle of subsidiarity (decisions are made at the most appropriate level) within GM, recognising the 'place' (Locality Authority footprint) as the primary unit of planning, whilst also recognising communities of identity.
- Creates a strong and able cadre of population health leaders across GM, supported by clear governance and accountability and reporting systems, and a specialist public health workforce.
- Extends commissioning and delivery of some public health functions at GM level to maximise outcomes and efficiencies to achieve additional impact, complementary to that at Locality level.
- Drives out inefficiencies and unnecessary variation in the system where it does not make sense to do things multiple times, or where current focus and investment does not deliver the best outcomes.

## **4.0 WHAT THE REVIEW HAS FOUND**

### **Use of Resources**

- 4.1. Appendix B provides some information on how GM public health grant resources are used today, recognising that this is only a small proportion of the total resource expenditure that impacts on population health from within the overall £22bn per annum spent on GM public service. Nevertheless, there are a number of general conclusions that can be drawn from our understanding of the use of the PH grant:
- The data suggests that investment patterns are not strongly related to evidence based outcomes but instead on historical inputs that have been allowed to perpetuate year on year.
  - The data suggests that investment does not necessarily follow the life course approach, with, for example, little investment at least from the core public health grant, on services for the ageing population.
  - There has been little analysis undertaken of the impact of the wider expenditure contributing towards population health, either in terms of quantum or impact.
  - Investment is currently made on individual services/interventions commissioned, rather than taking a wider pathway perspective (specifically for sexual health and substance misuse).



- The way we collect and report financial data does not support the development of integrated services e.g. smoking cessation is often included within a wider well-being service offer but reported separately.
- The level of spending on national mandated services is not prescribed which is why we can see such variation per head of the population. National mandation has limited protective impact leading to high variation in interpretation e.g. NHS Health Checks may only reflect spend of invitation, not delivery, follow up, nor holistic response.
- The challenge is about ensuring that the best evidence, including economic intelligence, is used to target investment in those areas which will give the biggest improvement in health gain.

## **Health Protection**

- 4.2. Health protection seeks to prevent or reduce harm caused by communicable disease and minimise the health impact from environmental hazards such as chemicals and radiation. This is achieved through programmes (e.g. national immunisation programmes), the provision of health services to diagnose and treat infectious diseases and planning, surveillance and response to incidents and outbreaks. Health protection therefore covers outbreak prevention and control; emergency planning; risk management; infection control; outbreak management; monitoring threats and immunisation.
- 4.3. Across GM there are a number of bodies that currently provide health protection functions namely, PHE; CSU/CCGs. GM HSCP, Local Authorities, AGMA Civil Contingencies & Resilience Unit and Transport for Greater Manchester (TfGM). Details of the role of each programme is covered in Appendix C.
- 4.4. As can be seen we have a mixed picture of provision of health protection functions across GM as well as varied governance and assurance arrangements. Local Authorities have already delegated emergency planning and elements of response into AGMA's Civil Contingencies & Resilience Unit. For the provision of Community Infection Prevention and Control (IPC) across LA's we are seeing variation of service provision, as well the size of any in-house teams. LA's either have direct employees or outsource that service to local providers. Where there are directly employed teams in the localities there is a mixed picture of provision, as some infection control teams are blurred with environmental health. Often this is a result of a historical position pre 2013.

4.5. We have undertaken a SWOT analysis of the current health protection functions:

<p><b>Strengths</b></p> <ul style="list-style-type: none"><li>• Strong DPH and PHE leadership</li><li>• Assigned leaders – DPH &amp; LA CEO</li><li>• Established LHRP</li><li>• Effective commissioning of immunisation services including roll out of several new programmes</li><li>• Track record of effective response</li><li>• Some strong programmes of strategic work (sexual health, hepatitis, air quality, AMR)</li><li>• Robust GM plans for generic response, outbreaks, and multiagency</li></ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"><li>• No overarching GM System for Health Protection (HP)</li><li>• Variation in delivery of HP across LAs and limited delivery of IPC at GM level</li><li>• Aging specialist IPC workforce with limited succession planning</li><li>• Variable borough level operational plans for HP incidents</li><li>• Limited resilience as reliant on good relationships of individuals</li></ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"><li>• Upskilling wider workforce while retaining specialist expertise</li><li>• Sharing of learning across System</li><li>• Strengthening governance &amp; assurance frameworks</li><li>• Develop resilient system</li><li>• Positive impacts on health and social care system and wider public sector through control of preventable ill health and prevention of disruption from outbreaks.</li></ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"><li>• DPHs are accountable for health protection in their own localities despite shared ownership between partners of the agenda</li><li>• Reputational damage for all organisations with any HP failings.</li></ul>

4.6. The following summarises our findings for health protection:

- There is clear accountability within each locality but currently there is an opportunity to develop an overarching GM System for Health Protection (HP) and overall accountability between the various partners.
- As a system there are areas where resilience could be strengthened further.
- All LAs deliver health protection functions, but there is some level of variation and an opportunity to develop overarching delivery of infection prevention and control (IPC) at GM level.
- There are locality level operational plans for HP incidents and an opportunity to create a stronger coherence through a GM standards approach.
- DPHs are accountable for health protection in their own localities, there are opportunities to strengthen joint accountability at local and GM level.
- Any health protection failings can result in significant reputational damage for all organisations.

## Public Health Intelligence

- 4.7. Public health intelligence encompasses the range of activities needed for evidence-based public health commissioning and practice. It includes, but is not limited to, evidence appraisal and synthesis; quantitative and qualitative evaluation; and data analysis, together with the communication and interpretation into appropriate recommendations for action, policy decisions and service commissioning and delivery. Analysts are seeing a broadening of their role to provide much more corporate analytical capacity that drives council strategy i.e. works to the wider determinants.
- 4.8. We have a highly skilled workforce, with good examples of local integration:
- We have 22.5 public health intelligence specialists across GM (source RA returns for PH grant), who operate either as part of a dedicated public health team or as part of wider general business intelligence function.
  - National PHE have a Knowledge & intelligence Team which localities have access to for accessing data and national tools/data.
  - GM HSCP also has access to NHSE resources regarding the services we commission for analytics and cost benefit analysis support (New Economy).
- 4.9. The following SWOT summarises the current position for population health intelligence.

<b>Strengths</b> <ul style="list-style-type: none"><li>• The use of health intelligence data to drive commissioning decisions locally.</li><li>• We have a highly skilled workforce, with good examples of local integration.</li></ul>	<b>Weaknesses</b> <ul style="list-style-type: none"><li>• Gap at GM level for PH Intelligence</li><li>• Repetition and fragmentation in provision.</li><li>• Expensive commodity not always being fully utilised.</li><li>• Current barriers in the system to support GM offer</li></ul>
<b>Opportunities</b> <ul style="list-style-type: none"><li>• Networking resources to maximise capacity and capitalise skillsets.</li><li>• LCOs/SICFs will require access to HI specialist to support their commissioning decisions.</li></ul>	<b>Threat</b> <ul style="list-style-type: none"><li>• In some cases the wider integration of Health Intelligence staff as part of a dedicated business intelligence poses a risk of a loss of specialism</li></ul>

- 4.10. In summary:
- There is a mixed picture of provision for public health intelligence, with in general a small highly specialised workforce which is unevenly distributed, and often repeating work locality by locality. There is little resource at GM level and there is a need to understand better how to deploy this resource to best effect alongside other partners in PHE and New Economy.
  - We are not always placing intelligence at the forefront of our commissioning decisions.

- Information governance issues make it a challenge in accessing health data.
- There are opportunities in the system to support a GM offer through:
  - Creating oversight, accountability and governance across GM to enable the development of single large GM pieces of work
  - Developing more common styles/formats to support localities and to draw out overarching themes to build a GM wide narrative.

### **Commissioning for Health improvement**

4.11. From our understanding of the utilisation of the PH grant, and from engagement with stakeholders we have found that:

- There is a varied approach to commissioning population health services and there are significant opportunities for reprioritising commissioning services/interventions based on outcomes and greater alignment with locality plans, HWB strategies and the population health plan work-streams.
- There is good work under way in rethinking sexual health and substance misuse commissioning - with localities now working in clusters to collaboratively commission services; standardised service specifications have been introduced for sexual health, and a single 'provider framework' has been introduced for substance misuse with all providers being put onto it..
- Despite this we mainly commission in silos e.g. substance misuse and sexual health both spend on prevention and health promotion – but there are few examples of combined service offers.
- Some areas have embraced place based commissioning far more than others.
- There is significant potential to get a greater range of benefits from population health commissioning and procurement by embracing a social value based approach.
- We have a significant public health commissioning resource across GM which we may not be maximising and effectively utilising the capacity.
- We need to support more consistency across GM and for all commissioned services where this would make sense, this would increase the current ability to tie localities to agreed GM approaches.
- Stakeholders are asking for standardisation and consistency across GM such as:
  - guiding principles that express best practice;
  - standardised service specifications to reflect shared outcomes;

- GM level commissioning where it makes sense to do so and that will make the biggest difference in achieving population health outcomes.

## **System Leadership**

- 4.12. Public Health leadership is primarily based within the ten localities, as well as some retained provision within Public Health England (PHE), PHE North West, GMHSCP, GM Directors of Public Health Group (this is the same resource as in the localities) and a discrete resource has been invested in the GM Public Health Network. Further details are included in Appendix D.
- 4.13. The role of the Director of Public Health (DPH) is a statutory role appointed jointly with the Secretary of State and has overall responsibility for their LA duties in taking steps to improve public health for their local population. There are currently a number of arrangements for how that role is constituted across localities. Directors of Public Health (DPHs) appear to be at their most valued and effective when operating at an executive level within their organisation. Enabling them to influence more broadly population health through commissioning, focusing on outcomes, managing partner relationships, lobbying and engaging with communities.
- 4.14. There is a long history of partnership working of Directors of Public Health across GM who have in the past taken the lead, prior to Devolution, on core pieces of work on behalf of GM around Population Health. For example each DPH is taking a leadership role in supporting GM business, for example GM Alcohol and Substance Misuse Programme; GM Civil Contingencies; GM Mental Health Executive.
- 4.15. There are also examples of good practice emerging from individual localities that other localities look to, for instance Stockport in spatial planning and Oldham in Asset based working. Informally, sharing of good practice is taking place across the DPHs, but there are opportunities for strengthening and resourcing those activities to enable scalability and spread across GM.
- 4.16. For the specialist public health workforce (consultants, public health intelligence) pressures on the public health grant have translated into a reduction of the public health workforce from that originally novated over to the LAs.
  - There are also gaps in capacity to support health promotion and health improvement more generally across GM.
  - Public health specialists are an expensive commodity and not always being fully utilised. The wider integration of those staff as part of a dedicated business intelligence, along with a lack of career pathways in local authorities poses a risk of a loss of specialism.
  - For health protection overall we have an ageing specialist Infection Prevention and Control workforce with limited succession planning. We have an opportunity for upskilling the wider workforce while retaining specialist expertise.

- 4.17. For commissioning; health protection and health intelligence we have duplication in those areas where there is a shared agenda and there are opportunities for greater collaboration and aligned working.
- 4.18. We have invested in some GM leadership for Population health but given the profile and ambition set for transformation, this needs expansion. Currently this lack of capacity has been undermining the contribution to the Devolution programme.
- 4.19. In summary, although there is a good public health leadership cadre across GM the opportunity going forward is to fully maximise this capacity, resources and skills sets more effectively. There are also opportunities to maximise the strategic leadership role of the DPH to build on existing approaches to influence the wider determinants of health across a system footprint.

### **Governance & Accountability**

- 4.20. We have not fully explored the governance and accountability for population health across the System. The following summarises our knowledge of systems in place.
- 4.21. Prior to 2013 the governance and accountability for the GM Directors of Public Health Group sat with the Association of GM PCTs. Since 2013, the group has not been within the GM governance structures. DPH groups across the country arose out of previous NHS reforms and were intended to be informal peer support and resource management tools.
- 4.22. We are aware that there are a number of commissioning networks that exist across GM, for instance the Sexual Health Network Commissioning Group (originally as a subset of the Public health network). Again these are arrangements that were put in place prior to Devolution and have been built on the long history of partnership working across GM. There is a huge value in those networks and indeed as a collective the commissioners operating as a forum have been able to achieve significant amounts through working at scale. Agreements have been put in place, such as SLAs between the various commissioners, but there is an opportunity of revisiting the governance per se of those networks to ensure transparency in their accountability and decision making for GM.

### **Value for Money**

- 4.23. At locality level, in some areas there has been a drive on efficiency savings but we need to look at the capacity opportunity and capability of workforce across the system. As a System we can get better value for money and there are opportunities for looking at efficiency savings e.g.:
- Health Protection – there are numerous doors into the system; immunisation at scale; outsourced work.
  - Estates - we have opportunities for exploring greater co-location of services, including the emerging neighbourhood hubs.

- Optimising use of scarce resources in commissioning and procurement (to be picked up with the Commissioning review)
- Prioritising the investment in those services/interventions that make a difference and decommissioning those that do not, with far better use of data and evaluation to underpin decision-making.

## **5.0 EMERGING OPPORTUNITIES**

### **LCO's & Single Integrated Commissioning Functions (SICFs)**

- 5.1. We recognise the current timeliness of embedding of population health outcomes in the architecture of the emerging LCOs, as well as the development of single local commissioning functions and the move to place based integrated commissioning across GM. This includes the incorporation of existing functions of CCGs, Adult Social Care, Children's Services and public health with the scope to further develop and expand these over time.
- 5.2. Population health is integral to each localities LCO development and they are using that opportunity to develop, integrated commissioning (inclusive of pooled budgets), and integrated delivery models (either community or acute or both). All at varying levels of development. In some localities public health functions and resources have aligned/or there is the intent to align them into the single commissioning function through the enablement of Section 75 agreements.
- 5.3. LCOs are central to our programme of reform to support the delivery of those outcomes, along with localities working together as a place based system with a range of partners towards achieving the population plan/locality plan outcomes.
- 5.4. We have an opportunity, through the implementation of new system architecture, to review the best delivery models for local population health services under locality plans.
- 5.5. What we know:
  - As part of the LCO development many localities are considering moving their provision for infection control and planning into the developing organisations as part of community services.
  - We appreciate that LCOs/SICFs will require access to health intelligence specialists to support their commissioning decisions.
  - LCOs operating as a 'whole system', working with the local community and voluntary sector, provide a platform for implementing new and innovative models of care and prevention programmes which will improve population health and wellbeing. This is a fundamental shift towards operating as population health systems.

- Community prevention efforts to improve population health are important elements of LCO partnership models, and will need to be resourced.
- There is significant potential to get a greater range of benefits from population health commissioning and procurement by embracing a social value based approach.

### **Health Protection**

- 5.6. PHE, in response to the Health Select Committee inquiry into health protection provision, will be undertaking a review of health protection provision across the country and it is expected that there will be published national recommendations/guidance in relation to that. We have the timely opportunity therefore to develop a GM blueprint for what that service offer would look like for health protection across GM which maximises the current skill set and capacity of partners to develop a resilient system.

### **Population Health Leadership**

- 5.7. We have the prospect to explore and maximise the opportunity presented via the collaboration between clinical commissioners, elected politicians and public service professionals to deliver a new model of place based population health leadership. This means that Population Health is regarded as a wider system responsibility that works across education, health, housing welfare services, planning, transport and many more.

### **Governance & Accountability**

- 5.8. The delivery plan for the Population Health Plan is now seeing a move to tighter governance around the SRO and leadership for those work streams. There is an opportunity to redefine the role of the DPH group specifically to include support to the continuing development and implementation of the implementation of proposals outlined in this paper, as well as for the Population Health Plan more broadly.

## **6.0 OUR PROPOSALS**

- 6.1. Enacting a new way of working as a GM system for population health is an iterative process which is about changing cultures, behaviours, perceptions and ways of working in a more integrated way. We appreciate that for some localities this is already akin to their normal way of working, for others it will be more of a departure. Moving to a more place-based system of organising and deploying resources to improve health and care for the populations that localities serve, means organisations collaborating with themselves and the population to manage the common resources available to them.



6.2. At a minimum, developing a population health systems perspective therefore requires:

- greater pooling of data and budgets;
- informed population segmentation;
- place-based leadership drawing on skills from different agencies and sectors based on a shared vision and strategy;
- shared goals based on analysis of local needs and evidence-based interventions;
- effective community engagement; and incentives to encourage joint working;
- offering a range of interventions tailored to the needs of different individuals and population groups to support people to remain healthy and to deliver the right treatments when they become ill.

6.3. We have designed the following suite of interrelated proposals for creating a unified population health system for the whole of GM which reflects this, and will support the delivery of the population health plan, plus locality plans. Our thinking is more advanced in some areas which is a reflection of the maturity of discussions to date. Further work is needed to support the mobilisation of the proposals as well as any transition into new ways of working.



6.4. We see this work fitting in to the broader context of PSR and wider reform work, and delivery of some of the proposals may sit alongside/align with emerging work from areas such as the Transformation of Adult Social Services and, without question, the LCO Network Development.

6.5. We are aware of relatively few examples in the world where this type of vision of a unified population health approach is being harnessed with an accountable care delivery system. There are some comparisons with the Scottish model of reform and also New Zealand. Another is the New York State Medic-aid system reforms, particularly in their 'best in class' areas such as Staten Island. We have invited the

core team in Staten Island to visit GM to demonstrate how you can combine great data analytics, community-based population health programmes and integrated care to secure improved outcomes.

## **7.0 ACHIEVING OUR VISION: COMMON POPULATION HEALTH GOALS**

### **GM Common Standards**

- 7.1. We consider that there are core priority areas where we would expect that all localities work to which will make a difference for achieving the population health outcomes across GM. This is consistent with Taking Charge Together. The GM Standards will sit alongside current national mandation and supports GMs desire to use the business rates pilot, being introduced from April 2017, to see a wholesale upgrade in prevention. Each locality will be asked to review and supplement these standards where necessary to align with their own local priorities. There will be a joint responsibility to review and update the standards (both in localities and in GM) this will be done in partnership. As a minimum we would expect the following to be the core priority areas. There may be other areas that we would wish to consider over time:

- 0-5 including oral health
- Substance misuse
- Sexual Health
- Tobacco control
- Mental health
- Ageing Well

### **GM Strategy Development**

- 7.2. We wish to develop the following strategies:
- GM Sexual Health Strategy (to complement the suite of strategies already developed /developing for Substance Misuse (Alcohol & Drugs); Tobacco Control and Early Years.
  - GM Health Protection Strategy and GM Guidance and Standards on NHS response to outbreak – to ensure a consistent response and forms part of the LCO development.
  - GM Age Well Strategy.
  - GM Physical Activity Strategy (GMCA) (identified in the Population health plan)

- GM Healthy Weight and Nutrition Strategy (identified in the Population health plan)

## **8.0 ACHIEVING OUR VISION: NEW SYSTEM DESIGN FOR PUBLIC HEALTH FUNCTIONS**

### **A Unified GM Health Protection Function**

- 8.1. We intend to develop a new delivery model for health protection which unifies the existing partners and will cover a range of functions including outbreak prevention and control; emergency planning; risk management; infection control; outbreak management; monitoring threats and immunisation. It is envisaged that this model will have clear leadership, governance and work to a pooled budget model, similar to that of the service provided by the Civil Contingencies Unit for current emergency planning and response for LAs.
- 8.2. We wish to develop a blueprint for infection prevention and control into the developing LCOs as part of their community services offer. We envisage a level of infection control and prevention resource to be available within LCOs.
- 8.3. We intend to develop a system wide, multi-speciality workforce plan for health protection built into CPD. This supports succession planning and ensures a consistent minimum understanding of health protection.
- 8.4. We see value in the delivery of targeted immunisation programmes at scale at specific times in the year, for instance flu vaccinations.
- 8.5. We intend to set up a sharing and learning programme across GM from any incidents/outbreaks that occur in any locality so that as a system we can learn and move forward more proactively.

### **GM Population Health Intelligence Function**

- 8.6. We propose to create a unified population health intelligence function that sits within a wider GM intelligence function as depicted below:

#### **Wider GM Intelligence Function**

- New Economy
- The Farr Institute
- Connecting to Healthy Cities
- Health Innovation Manchester
- Data Well
- Etc...

#### **GM single population health information and knowledge repository**

A networked PH Intelligence system across GM including PHE, LA, CCG other key partners including Academia and New Economy.

##### **Minimum functions:**

- Development of GM JSNAs
- Development of dashboards and metrics
- Risk Stratification Tools
- Innovation & Sharing good practice
- Development tools to support local PBC

8.7. We see the following functionalities could be incorporated into a unified population health intelligence function:

- “Do once” work across GM - could include lifestyle surveys needs assessments
- Data to inform GM Standards/commissioned services
- Specifications for collecting data – eg 0-19 Public Health services information,
- Accessing data
- Software and Data Tools - There are opportunities in procuring software and data (e.g. Tableau, Mosaic etc.) collectively across the whole of GM.
- Shared training/workforce development

8.8. We also see that the following deliverables will fall under the remit of a unified GM population health intelligence function:

#### **GM Population Health Risk Stratification Tools & Dashboard**

8.9. We wish to develop a range of risk stratification tools for locality use. Key features of the tools would thus include population segmentation and risk stratification and strategies to target different population segments. As a starting point these will be for Health checks, to ensure targeted identification and uptake; Health Protection; and supporting investment and outcomes stratification.

8.10. At GM level we will work collaboratively with the wider system to co-produce a population health dashboard and metrics which will give a system wide view of progress against target outputs and outcomes and also provide localities with a means of comparing and benchmarking their outcomes with other localities across GM. We intend to make data about programme and system performance readily available, including how money is spent, and openly tracking progress against target outcomes and impact on narrowing the health inequalities gap.

#### **GM Population Health Outcomes Framework**

8.11. We wish to undertake a refresh of the existing GM Population Health Outcomes Framework (in line with the refreshed GM Strategy) so that it can become part of the developing GM Outcomes Framework which will be used to shape and inform commissioning decisions and locality planning.

## 9.0 ACHIEVING OUR VISION: COMMISSIONING FOR POPULATION HEALTH

- 9.1. We intend to align our proposals with the propositions that result from the commissioning review currently underway and we are starting to have discussions with the LCOs/SCF leads regarding public health provision/commissioning in an LCO and within the single commissioning function.
- 9.2. We understand that emerging from the commissioning review will be a framework which will agree what services will be commissioned once at GM and which should be commissioned at other spatial levels.
- 9.3. In the interim the following are our proposals for how best to commission for population health across GM.
- 9.4. We have used the Commissioning for reform principles to underpin our proposals.



What this means for this work:

- Applying those CRP principles
- In addition:
  - Applying the principle of subsidiarity
  - Not wanting to disrupt local service integration
  - Seeking opportunities to maximise procurement and contracting including increasing efficiencies
  - Do once where it makes sense to e.g. lower volume, higher specialty

- 9.5. Our vision for commissioning for population health is to:
- Ensure consistency in how we procure, commission and contract for population health – which are quality, improvement, outcome and cost driven.
  - Ensure that population health outcomes are embedded into all provider service specifications.
  - Ensure that social value is embedded within procurement decisions. This means developing the GMCA Social Value Procurement Policy to cover population health outcomes and general health and wellbeing outcomes described in the GM strategic Plan 'Taking Charge'.
  - We commission as a 'system' and where possible move to commissioning across a pathway for population health.
  - Any future commissioning/decommissioning decisions for population health are underpinned by the Commissioning for Reform Strategy.

## 9.6. **GM Whole System Integrated Sexual Health Service**

- 9.6.1. This covers a range of interventions via clinics, outreach, digital platform, delivery split between GM and locality level depending on the service.
- 9.6.2. Specialist access, health information, chlamydia, HIV treatment and care.
- 9.6.3. The intention is to look at the opportunity to include other non-LA commissioned services currently commissioned by NHSE and CCGs.
- 9.6.4. To enable a whole system approach to commissioning for sexual health we are proposing initially to undertake a System wide review to develop a new integrated delivery model across GM. This will include:
- undertaking a JSNA;
  - modelling the best level of provision and level of estate needed;
  - reviewing the possibility of pooling budgets with LA/NHSE/CCGs;
  - developing a standardised payment mechanism;
  - reviewing the opportunity of moving to an outcomes based and lead contractor model;
  - determining the best place for the operational commissioning and contract management.

## 9.7. **Substance Misuse (Drugs and Alcohol)**

- 9.7.1. We are proposing as a minimum to commission Tier 4 Inpatient Detox & Residential rehabilitation at a GM level, supported by the development of:
- GM Drugs & Early Warning System & Intelligence
  - GM Drugs & Alcohol common standards for early intervention, targeted interventions, recovery and communities, and treatment
- 9.7.2. We are proposing, alongside Sexual Health, to undertake a system wide review of current service provision with the aim of describing the optimum service delivery model. This will include:
- modelling the best level of provision and level of estate needed;
  - reviewing the opportunity of any integrated services with sexual health and mental health for same population cohort;
  - looking at current contracting mechanisms and payment flows;
- 9.7.3. This may mean commissioning other substance misuses services over time.

## 9.8. **GM Digital platform for Lifestyle & Wellness**

- 9.8.1. The Population Health Plan has indicated that a GM level digital platform for lifestyle and wellness to support individual behaviour at scale will be developed. It is anticipated that this will be commissioned over time at a GM level. This will complement existing locality platforms.
- 9.8.2. There is a possibility that over time the following could also be commissioned at a GM level. This is transformation work underway from the population health plan:
- Oral Health Improvement Programme 0-5 - (fluoride interventions and clinical dental services)
  - Commissioning of Baby Clear (Smoking Cessation in Pregnancy)
  - IMT proposition for Early Years – improving the collection, storage and transfer of intelligent data across a multi-agency system that includes parents
- 9.8.3. For any service that we are proposing to be commissioned at a GM level we are asking that localities don't decommission any services in anticipation of any change.
- 9.9. We also wish to develop the following:
- **GM Service Specifications** – for GM Commissioned Services
  - **GM Good Practice Guidance** - for commissioning population health at a place based level ensuring that population health outcomes are reflected in local commissioning decisions.
- 9.10. Our summary view of what we consider might be commissioned at different spatial levels is captured at Appendix E.

## 10.0 **ACHIEVING OUR VISION: SYSTEM ENABLERS**

### **GM Standard for Health Checks**

- 10.1. We are proposing to develop a robust GM Pathway for Health Checks that forms a systematic and scaled approach to identifying the missing individuals with, or at risk of developing long term conditions. This pathway will incorporate the stratification of risk prior to the invitation of 20% of the population on a rolling 5 year programme for the NHS Health Check.
- 10.2. Currently health checks are delivered by a range of professionals. We see the opportunity of:
- Linking health checks onto the digital platform.

- Linking the health checks with wider social care checks to form a population health check – this could link in with a range of professionals from other public sector services, such as the fire service, as well as with voluntary sector organisations eg LGBT.
- Linking in with the lung health check service.

## **GM Behaviour & Lifestyle Social Movements & Publication Materials**

- 10.3. These can be used in support of the GM strategies that are being developed, and to sit alongside the digital lifestyle and wellness platform.

## **Sharing Good Practice**

- 10.4. We wish to work with the PSR team and their infrastructure to actively promote and share good practice emerging from the localities.

## **Digital tools**

- 10.5. We have already described the data systems, including mapping and visualisation, that we intend to develop for the localities and for GM purposes. We will also work in partnership with health innovation and others to develop apps and other digital means to engage with the population with respect to their health.

## **11.0 ACHIEVING OUR VISION: SYSTEM LEADERSHIP**

### **Value-based approach**

- 11.1. Our expectation is that the nine leadership values for GM which underpin public service reform are embedded in system leadership for population health.

1. **Delivers the GM Ambition** - Understands the GM ambition and the need for it to be delivered in all corners of GM.
2. **Leads from Place** - Understands what it takes to transform places. Leads within, and on behalf of their organisations, systems and places.
3. **Takes an asset based approach** - Recognises and values the strengths of people and places, enabling them to build on these to overcome challenges and make the most of opportunities.
4. **Understands impact** - Makes decisions ensuring the impact of people and places informs professional/clinical information and judgements.



5. **Is democratically astute** - Creates a collective responsibility to deliver the GM ambition, understanding governance systems, and accountability to people and place.
  6. **Acts collaboratively** - Acts with authenticity, honesty, and integrity to build strong collaborative relationships and connectivity across GM.
  7. **Building trusts** - Has a deeply held sense of purpose and is able to share power in a way that supports citizens and others to create the best conditions for people to thrive.
  8. **Connects with people** - Connects with and respects with other people's stories and history.
  9. **Is focussed on better outcomes** - Is resilient, innovative, curious, and relentless in getting better outcomes across GM.
- 11.2. Our intention is that any proposals for changes in system leadership are delivered through (at least) a cost neutral model supported by more integrated ways of working.

#### **Developing system-wide leadership**

- 11.3. We deliberately start with our proposals with respect to the wider workforce before we consider a discreet set of issues around the organisation of the specialist public health leadership whose role will increasingly be to support that wider effort.
- 11.4. We would expect asset based approaches, harnessing the skills of the community and VCSE, to engender a widespread focus on prevention and addressing the wider determinants of health. Population health place based leadership at the locality level is therefore about ensuring the development of a culture of 'population health is everyone's business'. This includes the role of the elected members in influencing the health and wellbeing agenda and wider population health. This applies to all councillors, not just the portfolio holder for health and wellbeing, but to other portfolio holders and ward and district councillors.
- 11.5. It is also about encouraging leadership and delivery of population health in LCOs, in working with other providers and creating the culture in their own organisation. Creating a culture of population health integrated into core business is through:
- Population health outcomes integrated into locality plans.
  - Common standards for public health services which lift the performance to the best in GM across the whole system.
  - Using peer to peer support (such as sector led improvement programmes) as a tool to support this.

- Providing population health training programmes. For example, on Staten Island in New York State, this has led to certified training opportunities around HIV, the needs of veterans, improving the health of people with disabilities etc.
- 11.6. This wider leadership approach extends to GM leadership. It impacts on other GM bodies such as Fire and Rescue, Police, Transport, New Economy, Growth Company etc., all of whom can contribute to our population health goals. It obviously means us penetrating a wider leadership cohort as well, most notably, educational leadership. This is one of the reasons why the new Children and Young People's Health and Wellbeing Board will have population health goals at the heart of its system stewardship work.
- 11.7. We will make maximum use of existing leadership training and development programmes to reach this broader leadership cadre, including the GM Leaders Programme.

## **Developing a Wider Public Health Networked Workforce**

### Directors of Public Health

- 11.8. Moving from a 'public health' to being more of a local 'population health leader', we are seeing, as a minimum, the following leadership role:
- Frontline leader for population health.
  - Being a system leader across organisational boundaries, working strategically in a complex system with a range of stakeholders.
  - Building partnerships (public, voluntary sector organisations, businesses) to deliver a whole system approach across public sector and beyond. For instance ensuring 'blue light' service integration into LCOs – spatial planning, health checks design and delivery, housing.
  - Providing professional leadership on specialist public health workforce and growing that workforce.
  - Developing a wider population health workforce (paid and voluntary) and ensuring that social value is embedded into the culture of the health and social care workforce, through values based discussion, training, awareness raising and participation in service design to maximise social value benefits.
  - Engaging with commissioners, managers, clinicians and front line staff in the LCOs/ACOs to ensure that prevention and wider population health become embedded in the culture of emerging organisational structures.
  - Providing assurance and leadership and advocacy to the cabinet members.
  - Ensuring the GM population health plan and outcomes are delivered within locality plans and embedded locally.

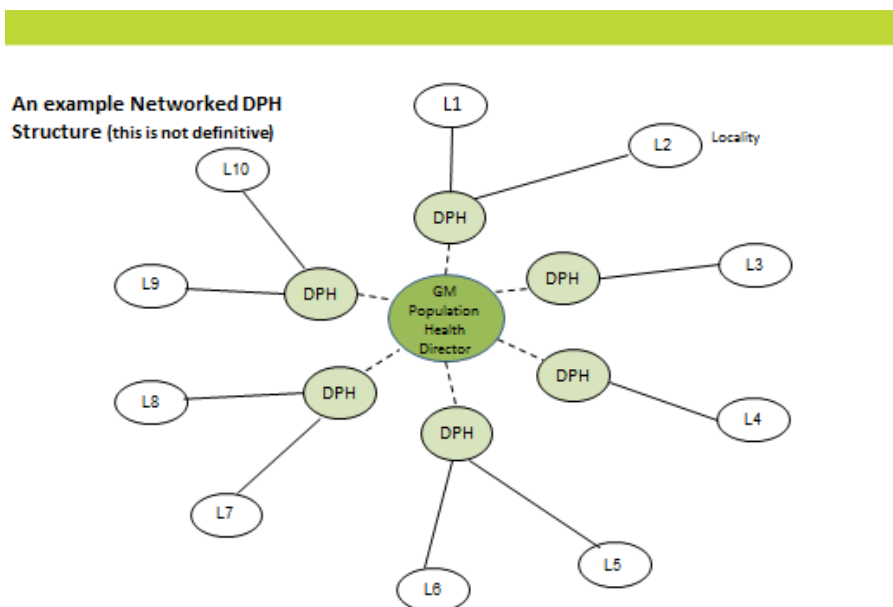
- Ensuring evidence base, risk stratification and data for population health is driving commissioning decisions.
- Engagement of public champions/citizens programmes – cancer champions are example of this.
- Using local networks for social movement.

11.9. We see DPHs as being part of a networked structure across GM, which means that DPHs would be employed at the locality level but also work at a GM level, to support the delivery of the population health plan and the programmes of work which would need to underpin the proposals set out in this paper.

11.10. Similarly, we are proposing to network the specialist public health workforce (consultants, public health intelligence, health protection), to ensure a blended leadership and delivery model.

11.11. Network arrangements are for local determination, as some localities may decide to adopt a shared role. Accountability for the DPH would still reside at the LA level. A networked arrangement would still have to ensure that statutory responsibilities are being met in each authority. For any network arrangements we would anticipate that they would be underpinned by a strong and capable supportive networked consultant leadership.

11.12. The following is an example network structure:



11.13. It is unclear at this stage whether there is the right level of overall resource of the different parts of specialist workforce. A national survey is soon to be undertaken which will be reviewing this. It is proposed that we wait until the recommendations come out of that survey and we can then review the position for GM, although it is our expectation that a networked model should potentially lead to some efficiencies through economies of scale.

### GM leadership

- 11.14. We are currently looking at the support needed at GM level to support delivery and implementation of the proposals.

### The role of GM political leadership

- 11.15. The Population Health Plan provides a clear road map for what GM wishes to achieve for Population Health. However, we know that there are some big ticket items that can only be secured with the highest level political support. In May we will be electing the first GM Mayor and we believe that areas such as active travel; creating a smoke free GM; alcohol control; creating a GM Public Health Bill and improving the educational achievement of our young people may benefit from Mayoral support.

### **Organisational Change & Development**

- 11.16. In order to evolve the model of leadership to a GM networked approach that meets the needs of both specialist and wider workforce, we will need to invest in support and development that covers at least the following common areas:
- Leadership and delivery of population health in strategic commissioning functions and LCOs.
  - Developing new partner networks – with voluntary sector and commercial.
  - Use of data in stratifying and targeting sub-populations.
  - Integrating activity across contracts.
  - Developing cross continuum protocols.
  - Shaping cultures and addressing professional barriers.
  - Asset based and social movement working.
  - Embedding prevention in strategy and locality planning.
  - Outcome-based commissioning and contracting.
- 11.17. We will also wish to develop a GM-wider offer for the specialist public health workforce.
- 11.18. These ambitions will be built into our wider Workforce Strategy and will be delivered with key partners such as Public Health England and the NW Leadership Academy.

## **12.0 ACHIEVING OUR VISION: GOVERNANCE AND ASSURANCE**

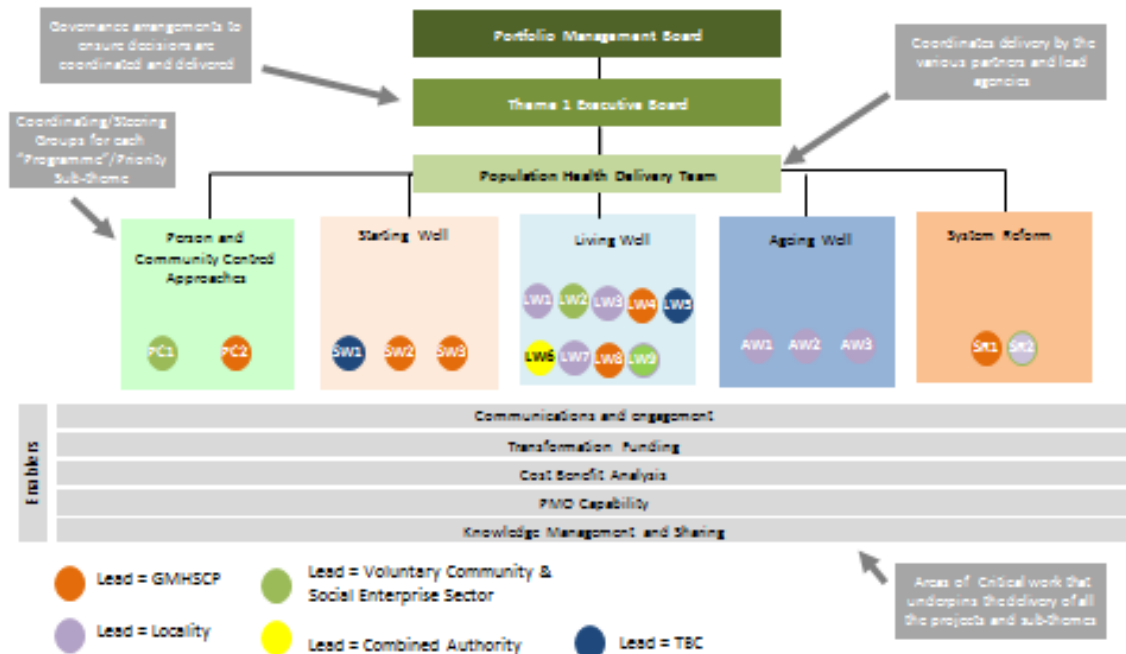
12.1. Our proposed approach to governance and assurance is based on the following principles:

- Integrated framework – the work of a unified system in delivery of the population health plan and the relevant parts of locality plans, cannot be considered in isolation. Any governance and assurance arrangements need to be part of the wider arrangement for the whole of the health and care devolution programme.
- Local democracy – in particular, respecting the work of local Health and Wellbeing Boards and the GM Reform Board under the Combined Authority.
- Transparency – we should make data about programme and system performance readily available, and how money is spent, and openly track progress against target outcomes.
- Public involvement and engagement – we should be full engaging people on design of programmes and projects, and actively seeking their feedback on progress.

### **Governance**

12.2. In accordance with the above principles, and as this programme of work is part of the population health plan, we intend that the delivery of the proposals outlined in this paper will be mainstreamed into the governance and PMO structure of that overseeing the delivery of the population health plan, including the Population health Programme Board (Theme 1) as set out below. The Portfolio Management Board will report progress into the Strategic Partnership Board structure and thus, into the public domain. It will also report into the Reform Board which will have a lead governance role on programmes which require wider public service reform, e.g. Early Years, Work and Health

# Governance for Delivery



Population Health Programme Board has the wider partners from across the system including PHE. It aligns with Children's Health & Wellbeing Board and with PSR.

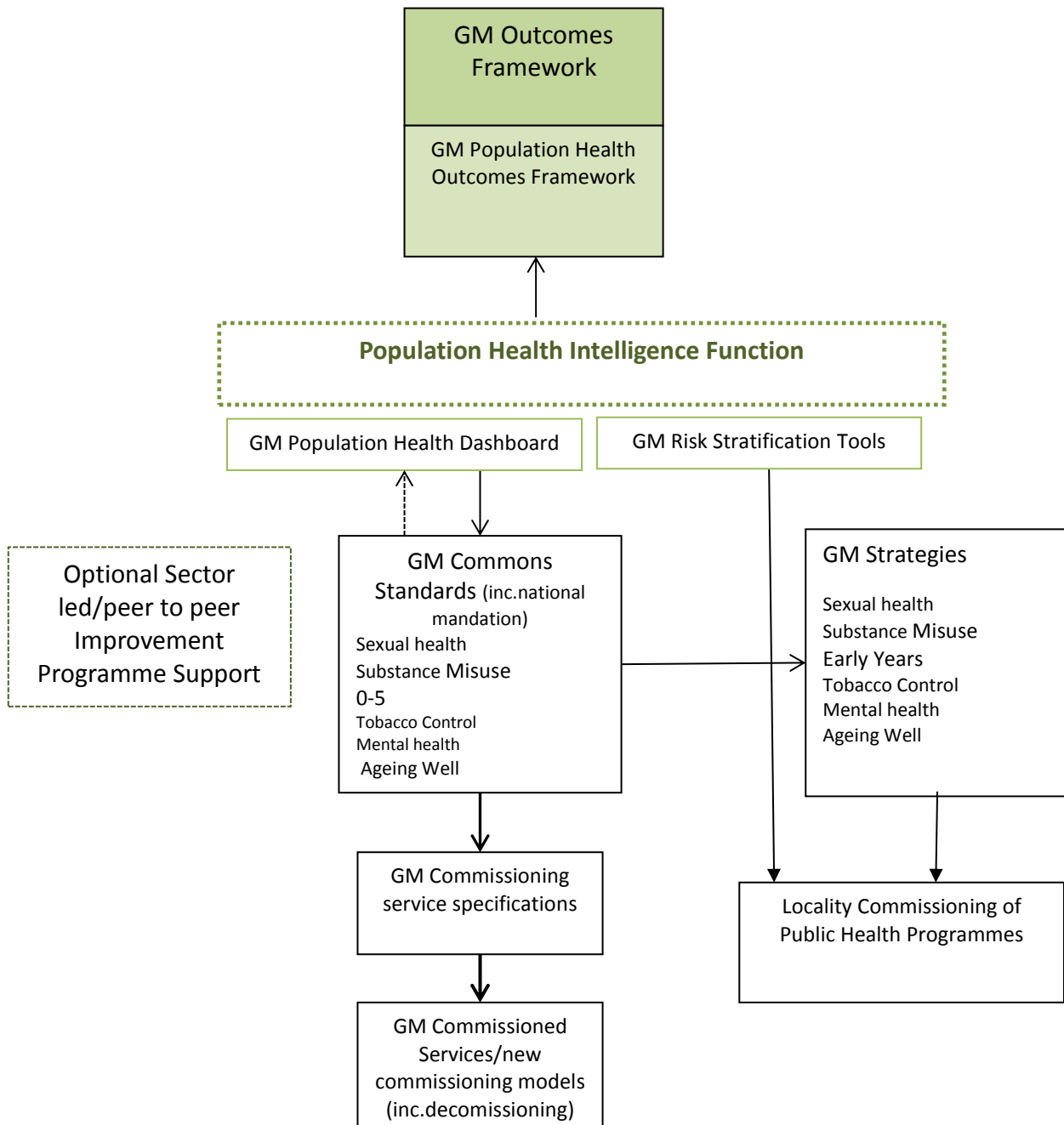
- 12.3. We will introduce a governance and reporting framework for the DPH group into the same governance framework for the population health plan. We intend to identify leaders from across the system to be SROs overseeing the delivery of the individual workstreams underpinning each of the proposals.
- 12.4. Going forward, there will also be an important role for the GM Joint Commissioning Board & Executive. Depending on the extended duties of the GMCA for public health and any commissioning responsibilities it may have, as a minimum we intend to work with the JCB and JCBE for the following purposes:
- New commissioning models, initially for sexual health and substance misuse.
  - Development of GM common standards.
  - Development of GM service specifications.
  - Good practice commissioning guide for population health.
  - Other commissioning areas that may come on stream over time (these may require engagement with the Children's HWB Board).

- 12.5. At the locality level, we would expect the population health transformation work to be integrated into the wider governance arrangements overseeing the delivery of the Locality Plan under Taking Charge Together. The overall stewardship of local population health would continue to sit with the Health and Wellbeing Board, and we envisage that the DPH, in their statutory role, will continue to have overall accountability for public health leadership.

### **Assurance**

- 12.6. While there is much merit in collectively agreeing joint GM standards, what we do not want to do is create a layer of assurance on top of national mandation. As LAs are accountable for improving population health it will be for localities to self-assure with respect to meeting the agreed standards, with the GM Partnership only raising issues where additional support may be required to facilitate delivery of the improved outcomes.
- 12.7. We intend to agree a programme of sector led improvement around agreed priority areas to support any localities which may require additional support. Over the next year, we propose that there is an initial in-depth review to baseline localities' current strengths and weaknesses, and therefore where a sector led/peer-to-peer improvement programme may add value.
- 12.8. Progress against common goals and the ambitions in locality plans would be assessed through existing GM quarterly assurance meetings with localities.

12.9. Bringing it all Together - The following illustrates the relationship between the various proposals.





## **13.0 A SUMMARY OF THE PROPOSALS**

### **COMMON POPULATION HEALTH GOALS**

1. GM Common Standards
2. Development of GM Strategies

### **NEW SYSTEM DESIGN FOR PUBLIC HEALTH FUNCTIONS**

3. A Unified GM Health Protection Function
4. GM Population Health Intelligence Function
  - GM Population Health Outcomes Framework
  - GM Population Health Risk Stratification Tools

### **COMMISSIONING FOR POPULATION HEALTH**

5. GM Whole System Integrated Sexual Health Service
6. GM Substance Misuse
7. GM Digital Platform for Lifestyle & Wellness
8. GM Service Specifications
9. GM Good Practice Guidance

### **SYSTEM ENABLERS**

10. GM Standard for Health Checks
11. GM Behaviour & Lifestyle Social Movements & Publication Materials
12. Sharing Good Practice
13. Digital Tools

### **POPULATION HEALTH SYSTEM LEADERSHIP**

14. Developing system-wide population health leadership
15. Evolved and networked DPH role
16. Networked Specialist public health workforce (consultants, health intelligence, health protection)
17. The role of GM political leadership

### **GOVERNANCE & ASSURANCE**

18. Use of established local governance
19. Use of established GM governance
20. Use of GM health and care assurance framework

## **14.0 BENEFITS OF THE PROPOSALS**

### **14.1. As a result of the reforms we are expecting to see:**

- A sustainable system that secures better outcomes for local people.
- A reduction in unwanted variation in standards and population health outcomes, with a more consistent adoption of evidence based practice and benchmarking data.
- The system working together to deliver the scaled implementation of the Population Health Plan's transformation programme of work.
- Accelerated knowledge and skills exchange, with the implementation of best practice and innovation consistently.
- A focus on the role of health and care provider system to make a substantial contribution to population health growth, both in their role in being part of the pathways ('making every contact count') and as a major employer.
- Visible integrated population health system leadership across the system which will minimise siloed working and enable join up conversations across and between children's, adults' and wider public services, spanning physical and mental health.
- Maximising the existing skills and capacity in the system towards delivering the GM ambition for a radical upgrade in population health through more networked arrangements.
- Greater local determination in using and maximising available resources in the most efficient way, including communities making more decisions for themselves about the best way to secure improvements.
- Commissioning at GM level to achieve additional impact complementary to that at locality level.
- The deployment of Population health intelligence in the context of a GM place based function focused on GM priorities of growth and reform.
- Creating a platform for further devolution 'asks' from central government to enable Greater Manchester to have more control over the key levers for securing population health gains, including regulatory and pricing mechanisms, and improvements to environmental quality.

#### 14.2. We see benefits for specific proposals:

##### **Common Population Health Goals**

- Enables Localities to be rooted in a set of common priorities, as the business rates pilot sees the ring fencing of public health grant end, and with the general move to pooling of budgets and integrated commissioning.
- It also reflects the ask of stakeholders across the system of having a clearer direction as to the core set of priorities that all localities need to be working to that which will make a difference for achieving the population health outcomes as a GM system.
- We believe that it drives more of a system wide approach to prevention.
- Ensures alignment with transformation programme for Adult Social Care and PSR Children's review so that the GM System is aligned around a single set of priorities.
- The shared goals reflect the 'asks' outlined in the Population Health Plan.

##### **Unified GM Health Protection Function**

- Maintains and transforms GM Health protection planning and response capabilities.
- Provides a clear and consistent and safe offer to each LA across the GM system.
- Embracing and fostering change and innovation to deliver quality improvement in infection prevention and control.
- Brings health protection assets in line with the local authority AGMA CCRU arrangements, which also have a shared statutory duty.
- Maximises potential specialist expertise in health protection and recognizes the need for succession planning around geographical areas.
- Drives out inefficiency and creates savings in the system from redesigning the pathway and decommissioning some services.

##### **Unified GM Health intelligence function**

- Networking our specialist public health intelligence resource across GM to ensure the continued localised place based intelligence support, whilst at the same time as working at a GM level on a 'do once' approach. This will

maximise the capacity of our specialist workforce and avoid duplication in the system.

- Maximising the capacity of specialist workforce.
- Enabling consistent access to specialist support to shape and inform commissioning and locality planning.
- Avoids duplication by commissioning products on a 'do-once' basis across GM

### **Population Health Commissioning proposals**

- Enables the freeing up of resources for investment elsewhere in the system.
- Allows the delivery of more efficient and integrated services.
- Ensures consistency in how we procure, commission and contract for population health – which are quality, improvement, outcome and cost driven.
- Ensures that population health outcomes are embedded into all provider service specifications.
- Ensures that social value is embedded within procurement decisions. This means developing the GMCA Social Value Procurement Policy to cover population health outcomes and general health and wellbeing outcomes described in the GM strategic Plan 'Taking Charge'.

### **Population health system leadership**

- Ensures that every locality has ready and effective access to public health expertise and skills.
- Maximises and strengthens skills, knowledge and expertise.
- Aligns capacity in support of delivery of GM Population health Plan and the proposals in this paper.
- Manages capacity better across the system
- Strengthens skills and competencies
- Builds system resilience.
- Avoids unnecessary disruption of structural change.

## **System enablers**

- Supports the achievement of the population health goals in localities and across GM, and also to underpin the new system design and commissioning model.

## **15.0 A SET OF PRIORITIES FOR CHANGE**

15.1. Our intended next steps and priorities for change will be:

### **Immediate Priorities (March to April):**

- Working with colleagues to develop the protocol which describes the operational working for the concurrent duty between LAs and the GMCA. (see A3 - Appendix A)
- Determining the governance for business rates pilot from April 2017 and thus providing assurance into the DH.(see A4 – Appendix A)
- Engaging with the LCO development and single integrated commissioning framework regarding the proposals.
- Taking into account and applying, where relevant, the outcomes of the Commissioning Review.

### **Further Work:**

- Development of a detailed mobilisation plan and transition plan to support the implementation of the proposals.
- Undertaking further financial modelling work alongside the redesign of new pathways/commissioning models. In the short term we wish to do more of a deep dive to enhance our current financial understanding.

### **Implementing some quick wins:**

- Introduce new governance and accountability structures and PMO office, aligned with that supporting the delivery of the population health plan.
- Revision of GM Population Health Outcomes Framework.
- Work with SCN and academic partners and PHE to design the risk assessment tool for GM health checks.

**Commencing key programmes of work:**

- Development work for GM Standards - Detailed work to work up overall guidance (governance, reporting, ongoing monitoring) and detail behind each GM standard.
- Development of integrated health protection pathway with partners.
- Development of model for health intelligence – a workshop has been scheduled to do this.
- Commencing the redesign the system work for sexual health and substance misuse by mapping the AS-IS position.

## Indicative Timeline

## APPENDIX A – CURRENT STATUTORY & POLICY CONTEXT

A1. The current statutory public health (PH) responsibilities of LAs are:

- Duty to improve public health - LAs to take appropriate steps to improve the health of the people who live in their areas. The Secretary of State continues to have overall responsibility for improving health with national public health functions delegated to PHE.
- Regulations on the exercise of LA PH functions - LAs to take particular steps in exercise of their PH functions, or aspects of the Secretary of State's PH functions under which LAs are mandated (national mandation) to:
  - protect the health of the local population;
  - ensure NHS commissioners receive the PH advice they need;
  - ensure appropriate access to sexual health services;
  - deliver the National Child measurement programme;
  - deliver the NHS Health Check Assessment;
  - provide health visiting services (0-5 services).
- Responsibility for oral health improvement services.
- Responsibility for sexual health services (commission testing of STIs, including HIV together with sexual health advice, prevention and promotion).
- Duties of Directors of Public Health (DPH) – Each LA to appoint a DPH whose duties and responsibilities are to:
  - be responsible for all their LA duties to take steps to improve public health;
  - health protection/health improvement functions delegated to LA;
  - planning for and responding to emergencies that present a risk to public health;
  - co-operation with police, probation and prison service to assess the risks posed by violent sexual offenders;

A2. National mandation was introduced at the point of transition (from PCTs to LAs in 2013) to ensure a nationally consistent approach, with a standard format (such as health protection) to ensure universal coverage. Mandation was not determined on the basis of importance in contribution to population health outcomes and is open to local discretion as to how much is invested in provision of those mandated services.



- A3. From April 2017 GMCA will be given the same duty as LAs to 'take such steps as it considers appropriate for improving the health of the people'. Currently the GMCA has no health functions. The steps that may then be taken by the GMCA would include: providing information and advice; providing services or facilities designed to promote healthy living providing services or facilities for the prevention, diagnosis or treatment of illness. Consideration needs to be given to the development of a protocol which describes the operational working for this concurrent duty between LAs and the GMCA. We have an opportunity through this work to support the development of the protocol.
- A4. From April 2017, the GM Business Rates Pilot (BSR) will commence which will see funding transfer from being a specific grant to being funded by business rates income and the ring-fence on the grant will be removed. National mandation will however remain. We understand that LAs may have already have budgeting strategies which includes PH grant.
- A5. This programme of work should be directly informing the pilot so that we can work with the Department of Health and PHE on the development of our outcomes tracking to give them the reassurance they require.
- A6. In May 2017 we will see the appointment of the GM Mayor. We have looked to London and Liverpool, where at a city-wide level, the Mayoral Health Commissions have cited ambitious plans for services to work together across their cities, boroughs and local communities to improve the health of their populations and tackle the wider determinants of health. We have the opportunity of framing a number of ambitions for the GM Mayor which would make the biggest health gains for our population. Identified in the GM Population health Plan is the ask for instance that the Mayor could lead the way for GM by making the public places controlled by Greater Manchester authorities smoke free.

## **APPENDIX B - HOW PUBLIC HEALTH GRANT IS CURRENTLY USED IN GREATER MANCHESTER**

- B1. We have looked at the utilisation of the PH grant as a starting point to understand the application of available resources. This is work in progress and currently gives an indication of, rather than a definitive position due to the lack of robustness of existing data (reporting and classification) at this stage. The data is from Central Government returns (RA returns 2016/2017) which relate to budgets and an intention to spend across the various categories which may differ significantly from what actually happened as detailed in the RO return.

### **Headlines - Our current understanding of the use of the PH Grant**

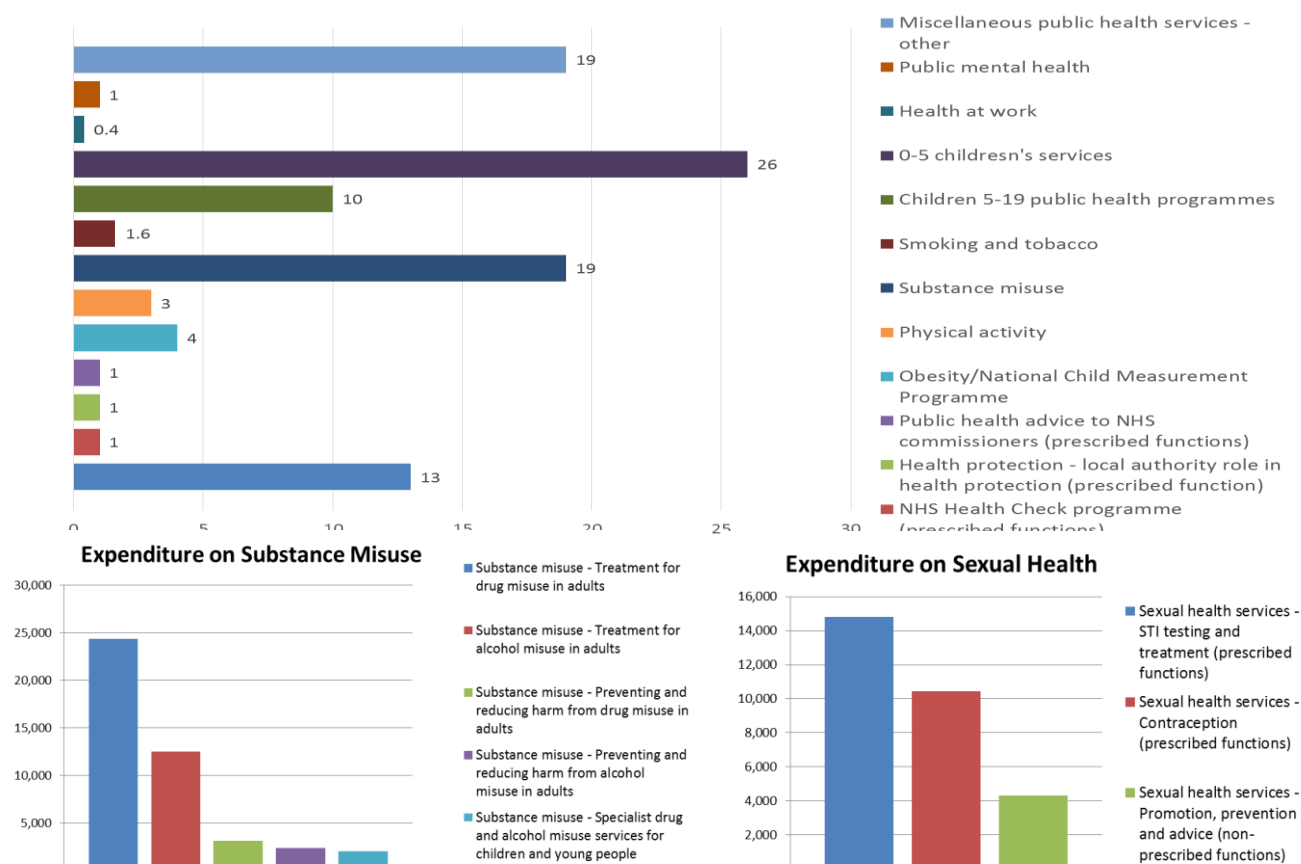
- The allocation varies and the way it is spent is an amalgam of various commissioners.
- Year on year reductions to the Public Health Grant – 9% over 4 years.
- All areas are under significant pressure due to the recent significant funding cuts to LAs
- LAs have focussed on transformation and service redesigns to date to drive out efficiencies at the same time as improving outcomes.
- PH Grants form part of integrated LA budgets transitioning to single commissioning function pooled budget arrangements.

- B2. The total LA spend across GM is £229.2M
- This equates to £67.78 per head of population in GM
  - 34% of overall expenditure is on mandated services
  - The largest use of the grant is allocated to:
    - 0-5 children's services (26%)
    - substance misuse (19%)
  - \* miscellaneous spend (19%) – see below
  - sexual health (13%)

## Miscellaneous Spend

Category	£,000	Category	£,000
Management & General salaries	7,772	Falls	227
Other Council PH Priorities	4,594	Young People inc Teenage Parent Floating Support	218
Various proportions of PH contracts not fitting other RA Criteria	2,566	Social Inclusion	200
Health Integration	2,437	Neighbourhood Investment	184
Central Support Services	1,911	CVS	130
Live Well / Big Life Contract	1,855	Local Authority Role in Surveillance and Control of Infectious Disease	128
Wellbeing services	1,820	Acute Contract-Staffing	125
Mental Health Supported Accommodation	1,819	Community Alarm	119
Equipment and adaptations	1,730	Dental Public Health	111
Homelessness Prevention schemes	1,372	Commissioning support	100
Extracare	1,321	JSNA & Research	75
Youth and Play	1,096	Healthy Schools	75
Mental Health Recovery Prog	1,015	Specialist Physical Activity Service	70
Sheltered housing	959	Primary & Secondary Prevention in Primary Care	70
Prevention Activities	911	Other Child Health	63
Healthy Contract	845	Vulnerable People Commissioning	52
Domestic Violence	702	Seasonal Death Reduction initiatives	51
Advocacy and Advice	680	Start Well	50
Well North, Falls, Nutrition	657	Health Inequalities	47
Carers	644	Health Chats	35
Management & General salaries	449	Housing Energy	33
Other Council PH Priorities	435	Good Neighbour Scheme	26
IDCs/Supplies & Services	389	Volunteering Budget	25
Age Well / Older People Services	332	Public Health Capacity Building	25
Marketing/Training/Admin Costs/Rent	314	Project Delivery	19
Long Term Condition Prevention	308	Information & Intelligence	9
GM Public Health Network Subscription	303	Public Health Campaigns	5
Nutrition Initiatives	238	Total	41,770

**Figure 1:** Distribution of expenditure of PH grants:



**Figure 2** above suggests that for both those commissioned services, services are commissioned individually rather than as a full pathway. There may be opportunities for combining parts of the provision e.g. prevention.

### Figure 3: Range of spend per head of the Population

*Spend per head amounts have been arrived at by dividing total spend by total population of the borough – and not weighted for age / sex / deprivation – so any variation may be warranted.*

Spend per head below suggests variation in investment.

Spend per head	Minimum	Maximum	Average	Median
Sexual Health	4.67	15.57	10.81	9.89
NHS Health Check Programme	0.46	1.33	0.86	0.95
Health Protection – local authority role	0.02	3.63	0.89	0.79
Public Health advice to NHS Commissioners	0.2	2.1	0.79	1.28
Obesity / NCMP	0.04	9.26	3.19	5.10
Physical activity	0.01	7.7	2.68	5.97
Substance misuse	11.21	24.36	16.23	17.34
Smoking and Tobacco	0.04	5.01	1.42	2.77
Children 5-19	3.13	16.69	7.90	6.77
0-5 children's services	14.44	29.07	22.04	24.54
Health at work	0	2.15	0.31	1.07
Public mental health	0	1.61	0.67	1.08

#### Variation in spend can be down to:

- Sexual health –demand for open access in certain areas
- Health protection – LA dedicated teams v outsourced contracts
- Local interpretation by LA when reporting
- Local prioritisation by LA

## APPENDIX C – OUR GM PARTNERS IN HEALTH PROTECTION

PHE	PHE North West provides case and incident response, technical expertise, surveillance, epidemiology, strategic and system leadership for health protection in GM with reach back into highly specialised PHE national functions and resilience from wider PHE North West. There is a dedicated GM function within the PHE NW Health Protection Team.
CSU/CCGs	CCGs have a key role in the NHS response to cases and incidents as well as strategic programmes to prevent and control health protection threats. CCGs have commissioned the CSU to do their NHS emergency planning.
GM HSCP	Immunisation was delegated from NHSE to GMHSCP as part of Devolution. There is a PHE Screening and Immunisation team embedded within GMHSCP. GMHSCP also has responsibility for elements of the NHS planning and response to incidents.
LA's	Community Infection Prevention and Control (IPC) and Environmental Health resides with LAs. For IPC, LA's either have direct employees or outsource to local NHS providers. For directly employed teams, there is a mixed picture of provision, as some IPC teams are integrated with civil contingencies and/or environmental health.
AGMA CCRU	AGMA Civil Contingencies & Resilience Unit provides emergency planning & elements of response across GM for local authorities. A business partner model has been established which enables the collective working of a team across GM with the agility to support localities.
TfGM	TfGM leads air quality work across GM with support from LAs and PHE.

## APPENDIX D – CURRENT PUBLIC HEALTH LEADERSHIP

- D1 Public Health went through the most radical reform for decades post Health & Social Care Act 2012, which saw Local Authorities taking responsibility for public health within their locality. At the time there was little reimagining of public health for the transition into local authorities. This resulted in a variety of different approaches to how public health was integrated into local government leadership structures.
- D2 When PH teams moved from PCTs to LAs, the opportunity that public health presented was not always initially understood and this has been reflected in the positioning and embedding of public health as part of the core functions. Across GM therefore we have a range of different public health models in operation:
- **Fully distributed model** - Fully integrated Public Health capability within Council functions which sees the embedding of population health responsibility and perspectives across the local system, to shape environmental factors and wider determinants of health.
  - **A retained PH function** - A minority of councils have a model whereby the PH expert advisory function is retained either as a defined directorate or integrated within a broader directorate infrastructure.
  - **Alignment to ICO/LCO development and locality plans**
- D3 The Devolution of NHS England S7a commissioning resources to GM saw the transfer of relevant commissioning and contracting resources to the GMHSCP, as well as the responsibility for commissioning screening (cancer and non-cancer); immunisation and vaccination programmes, Child Health Information Services and elements of health and justice commissioning.
- D4 A Population Health Team within GMHSCP was established in 2015 which includes NHSE public health commissioners and PHE's assigned staff which operates as an integrated commissioning team under the leadership of the GM Executive Lead – Commissioning & Population Health. The team has recently expanded its resources and remit by securing the existing GM resource which supported the development of the population health plan, as well as resource from the GM Public Health network (which has been redesigned and is being aligned into the population health function). The additional remit of the team, working with system leaders across the system, is to support the delivery of the GM Population Health Plan. The overall SRO for overseeing the delivery of the Population health plan is a LA CEO.
- D5 PHE is committed to supporting GM in its aim to transform health and ensure that the full range of expertise and capabilities available to PHE as a national body are made available to support the major transformational programmes associated with delivery of the Population Health Plan. PHE North West Deputy Director of Health and Wellbeing is working as part of the GMHSC as the Population Health Lead for GM. The purpose of the role is to work within and collaboratively with GM Health and Social Care Partnership and wider population health stakeholders in GM to take forward the population health work programme, to build public health capacity and

the potential for sharing good practice and success from GM in other parts of the country.

- D6 For several years the Public Health Network has been funded by each Locality to support the implementation of cross GM working. The team is hosted by Tameside Borough Council, and managed by the Tameside DPH, in her capacity as Chair of the GM Directors of Public Health. A comprehensive service review of the Network has been completed to develop a fit for purpose team structure that can effectively mobilise, align and complement capacity in the wider GM population health team.



## APPENDIX E: POSSIBLE SPLIT IN COMMISSIONING FUNCTIONS

### Greater Manchester

PH Functions	Commissioning
	Greater Manchester
Unified Health Protection	√
Health Intelligence Function	√
Section 7a	√
Whole System Integrated Sexual Health Service	√
Alcohol & Drugs Initially - Inpatient Detox & Residential rehabilitation Overtime the move to an integrated whole system approach	Tier 4 √
Oral Health Improvement Programme (0-5) *	√ *
GM Digital Platform – Lifestyle & wellness	√

### Cluster/Locality/Integrated Commissioning Function

PH Functions	Commissioning
	Cluster/Locality/Integrated Commissioning Function
Health Intelligence Function	√
Section 7a	
Whole System Integrated Sexual Health Service	
Alcohol & Drugs Initially - Inpatient Detox & Residential rehabilitation Overtime the move to an integrated whole system approach	Tier 1 Interventions
Oral Health Improvement Programme (0-5) *	√
GM Digital Platform – Lifestyle & wellness	√
Health Checks	√
Integrated Lifestyle & wellbeing services (physical, obesity, tobacco control) including National Child Measurement Programme (NCMP)	√
New Focussed Model of Care	√
Dental Public health	√
Integrated Services for 5-19	√
EYDM/Core model	√
Nutrition & Hydration	√

## LCO/ICO/Neighbourhoods

PH Functions	Delivery
	LCO/ICO/Neighbourhood
Unified Health Protection	Infection control within LCO
Section 7a	√
Whole System Integrated Sexual Health Service	Levels 1 & 2
Alcohol & Drugs Initially - Inpatient Detox & Residential rehabilitation Overtime the move to an integrated whole system approach	√
Oral Health Improvement Programme (0-5) *	√
GM Digital Platform – Lifestyle & wellness	√
Delivery of Health Checks	√
Integrated Lifestyle & wellbeing services (physical, obesity, tobacco control) including National Child Measurement Programme (NCMP)	√
New Focussed Model of Care	√
Oral Health Improvement	√
Integrated Services for 5-19	√
EYDM/Core model	√
Nutrition & Hydration	√
Falls prevention & fracture	√