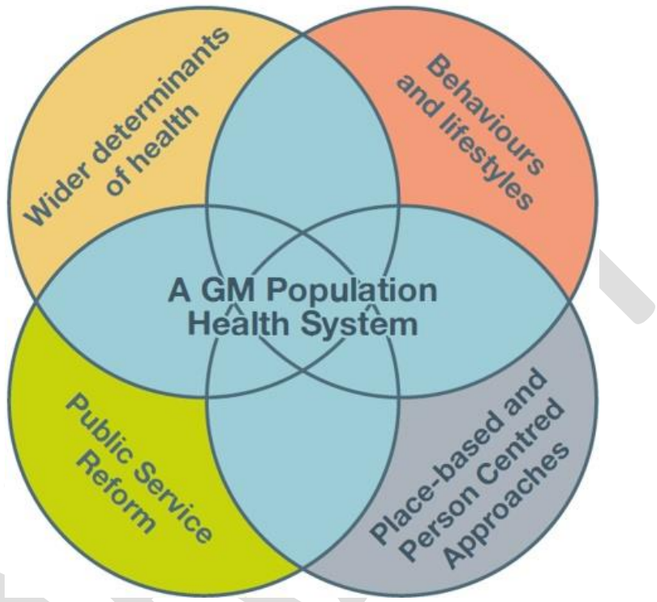
Greater Manchester Population Health System Framework

V2.5 (DRAFT)

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

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

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

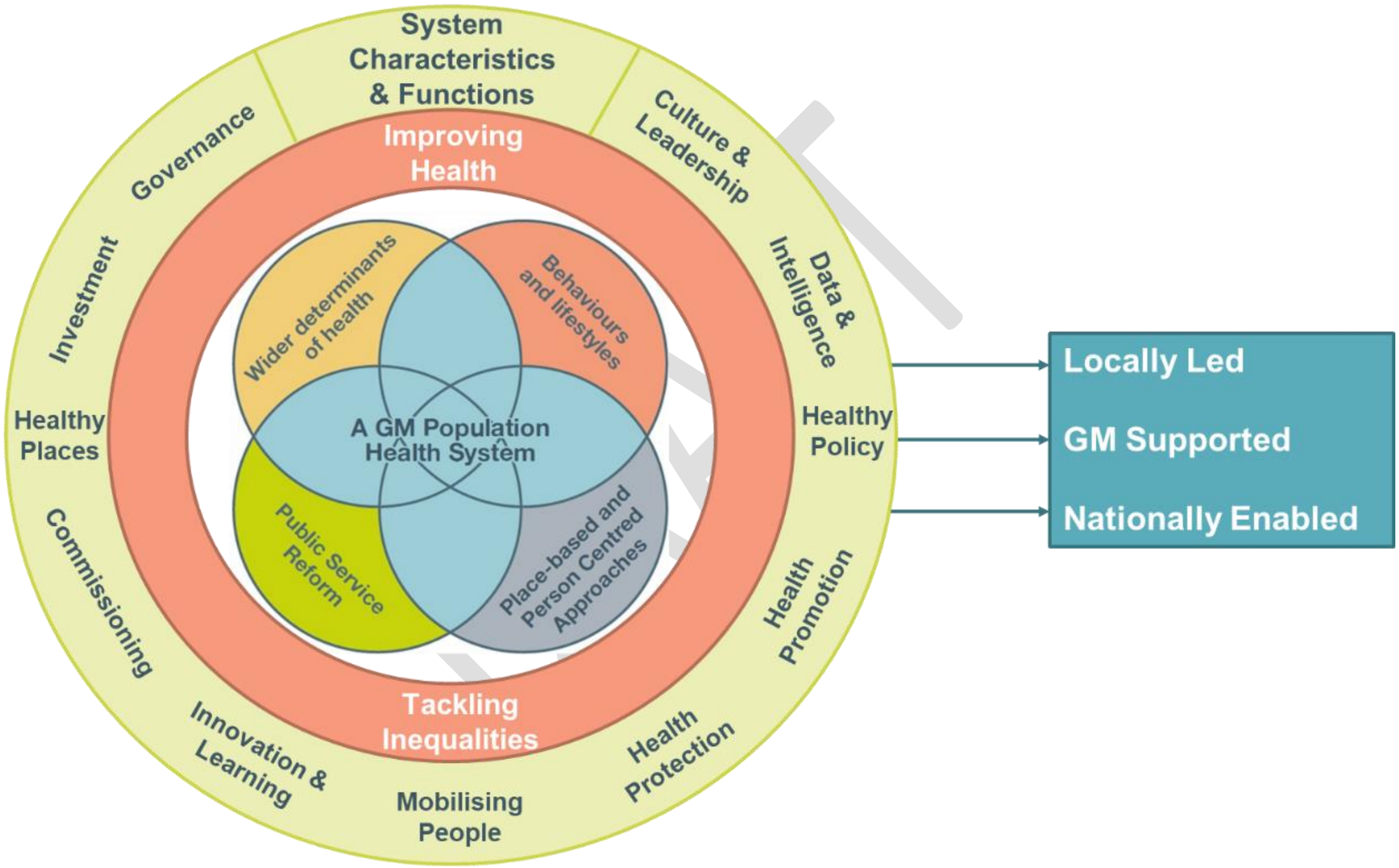


The model builds upon the existing principles for Public Service Reform that exist within Greater Manchester and are as follows:

GM Public Service Reform Principles:

1) A new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production, and joint delivery of services – we need to '*do with*', not '*do to*'
2) An asset-based approach that recognises and builds on the strengths of individuals, families, and communities rather than focusing on their deficits
3) Behaviour change in our communities that builds independence and supports residents to be in control
4) A place-based approach that puts individuals, families, and communities at the heart redefined services
5) A stronger prioritisation of wellbeing, prevention, and early intervention
6) An evidence-led understanding of risk and impact to ensure the right intervention happens at the right time
7) An approach that supports the development of new investment and resourcing models, enabling collaboration with a wide range of organisations.

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



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

	services (including locality health and care arrangements, Health and Wellbeing Boards and the VCSE).	partners across GM is evolving, with more changes to come. The Director of Public Health links to the GM System via the GM DsPH group	
3) Mobilising and Involving People & Communities: a) Communities and citizens are viewed as equal partners who are enabled to lead change, and there is evidence of this happening in practice. b) There is clear evidence of engagement and co-production happening at scale.	c) A wide range of person and community centred approaches and tools are used to involve people living in neighbourhoods in co-design and delivery. d) There is a vibrant and sustainable VCSE and faith sector working with locality partners to support and enable local people. e) Local public services have strong links into their communities, good insight into their makeup and structures, and the ability to undertake impactful communication and engagement activity about health.	There are increasing examples of good practice. A new Framework has been developed as part of 'Let's Do It' which encapsulates the wide range of approaches into a single framework and high-level plan for further embedding these approaches to create systematic, routine mechanisms for engagement, co-production and mobilisation. The VCFA has been recommissioned with a strengthened role and on a on a more sustainable financial footing. Local public service staff have undertaken Strengths Based and Ethnographic Training and are building strong links with communities through the community hubs and with those with lived experience. Many are also engaged with the 'Building a Community Mindset' programme. A workforce collaborative bid that has been submitted to help support this work.	Oversight of the development work takes place through the Inclusion partnership and PSR Boards. There is mutual membership between these Boards and the Population Health Delivery Partnership. Population Health Delivery Partnership to support and champion application of community engagement and co-production within specific workstreams led by members. The Strategic Workforce Group will oversee the further roll out of training. There is mutual membership between the Strategic Workforce Group and the Population Health Delivery Partnership
4) Leadership: a) All senior leaders in GM recognise the role they play in approving Population Health and this sits at the heart of leadership development and throughout system organisational development programmes.	b) There is bold clinical, professional, managerial, community and political leadership and a willingness to invest personal capital in championing health-promoting policies and taking action to reduce inequalities. c) Locality development programmes for future leaders have a population health and inequalities focus.	Members of the HWBB are investing personal capital in championing health promoting policies and taking action to reduce inequalities. Local professional, managerial, community and political champions are also members of PH Programme Board Not currently aware of development programme for future leaders. Have small number of local staff undertaking level 6 Public Health Apprenticeship, UKPHR practitioner registration process and the PH fellowship programme. Locally run RSA level 1 in Health Improvement is offered.	The Population Health Delivery Board will provide opportunities for shared learning Develop a comprehensive Population Health Development Programme through the Strategic Workforce Development Group
5) Sustainable investment in Population Health: a) A sustainable investment strategy for population health is in place which incorporates agreed benchmarks for	b) Investment in improving health and reducing inequalities is seen as a strategic priority, and investment stretches beyond health-specific interventions and into tackling the social determinants of health.	Understood conceptually as important by an increasing number and range of strategic leaders but no clear investment strategy in place and no clear plan to shift balance of spend	Develop overall business case for investment in prevention Understand and make visible the current balance of spend

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

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

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