Greater Manchester Integrated Care Partnership

Fairer Health For All

Engagement Draft

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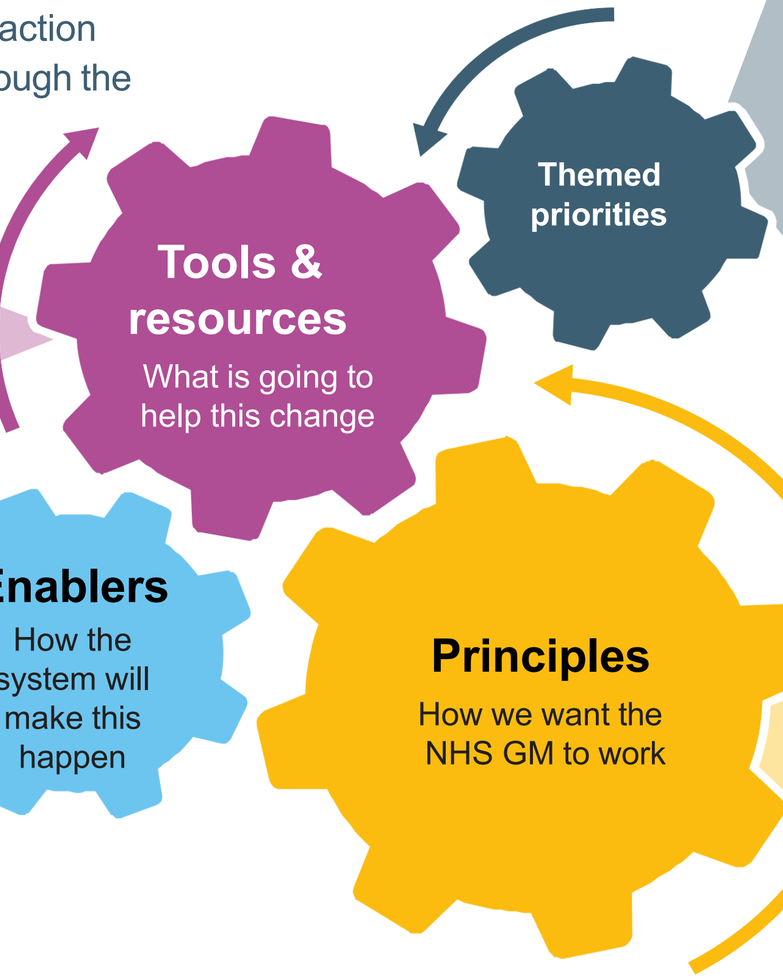
What is Fairer Health for All?

- Framework that outlines our **approach to addressing root causes of ill health and inequalities** across the city-region
- **Consensus of priority action** across the system and **roadmap for how we will work together** to:
    - **fulfil statutory NHS responsibilities to create a greener, fairer, more prosperous city-region** and deliver **health and care services that better meet the needs of the communities** we serve
    - **enhance and embed prevention, equality, and sustainability into everything we do**
    - **tackle the discrimination, injustices and prejudice** that lead to health and care inequalities
    - create **more opportunities for people to lead healthy lives** wherever they live, work and play in our city region

Fairer Health for All: in summary

The Greater Manchester Fairer Health for All framework will enable neighbourhood, locality and system action on health equity, inclusion and sustainability through the following model of delivery:



Focus **on targeted prevention**

Invest in the potential of people and communities to live well through the continued expansion of a **social model for health** and upstream models of care

Enhance the role of the Integrated Care Partnership as an **anchor system**

Strengthen our strategic approach to **sustainability** through delivery of our **Green Plan**

- GM Health and Care Intelligence Hub
- Fairer Health for All Academy

- Population Health Management & Strategic Intelligence
- Culture Change & Leadership
- Governance & Resourcing

- People Power
- Proportionate Universalism
- Fairer Health *with and for all*
- Representation
- Health Creating Places

Fairer Health for All principles

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The Fairer Health for All principles were co-designed by Greater Manchester partners and speak to how we will share risk and resources in a way that considers a strengths-led approach, building on the needs of individuals, communities and partnerships and to collaborative decision making, so that resource can be targeted and tailored to achieve good health across diverse places and people.

People power

We will work with people and communities, and listen to all voices – including people who often get left out.

We will ask ‘what matters to you’ as well as ’what is the matter with you’.

We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate universalism

We will co-design universal services (care for all) but with a scale and intensity that is proportionate to levels of need (focused and tailored to individual and community needs and strengths).

We will **change how we spend resources** – so more resource is available to keep people healthy and for those with greatest need.

Fairer Health is everyone’s business

We will think about **inclusion and equality** of outcome in everything we do and how we do it.

We will make sure how we work makes things better, and makes our environment better, for the future.

We will tackle structural racism and systemic prejudice and discrimination.

Representation

The mix of people who work in our **organisations will be similar to the people we provide services for**. For example, the different races, religions, ages and sexuality and including disabled people.

We will create the space for people to share their unique voice and be involved in decision making.

Health creating places

As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

We will focus on place and **work collaboratively** to tackle social, commercial and economic determinants of health.

Outcome targets

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What we will do:

1. **Improve health and wellbeing to narrow the gap in life expectancy and healthy life expectancy**
Between men and women living in Greater Manchester, between all ten localities, as well as the England average, by at least 15% by 2030.

2. **Reduce unwarranted variation in health outcomes and experiences**
Eliminate the fivefold difference between the highest and lowest social groups in the experience of having 3 or 4 multiple health harming behaviours such as smoking and excess alcohol consumption, through whole system approaches.

3. **Increased social and economic activity because of reduced ill health**
Narrowing the 15-year gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population to 5 years by 2030.

4. **Reductions in preventable or unmet health and care needs leading to reductions in demand**
Evidenced in part by closing the health inequalities gap in of smoking prevalence with England by 2030.*

5. **Reduce the difference in life expectancy for those with serious mental illness and the incidence of physical health conditions, narrowing the gap with England by 15% by 2030**

6. **Reducing infant mortality through measures including narrowing the gap with England by 15% by 2030 and closing the school readiness gap within the same period**

**Smoking is our single greatest cause of preventable inequalities. 1 in 4 hospital patients' smoke and smokers need social care on average 10 years earlier.*

What are the delivery tools?

The Health and Care Intelligence Hub

- Co-designed to **consolidate data and insights from public and VCFSE sector partners** across the city region into a single portal.
- Range of **web-based intelligence tools to e**nable adaptive capability for Population Health Management

Access to the hub can be requested via https://www.gmtableau.nhs.uk/gmportal/new_Request and is open to all VCSE and public sector partners.

Fairer Health for All Academy

The aim of the Fairer Health for All Academy is to**:**

- **Facilitate shared learning and innovation** on equity, inclusion and sustainability
- **Build skills and values required to shift towards upstream models of care** and social model for health

Appendices

Who are we going to engage and how?

This Engagement Draft of the Fairer Health for All framework sets out the **process of engagement to date** as well as i**nitial outputs of work** and will be used to **support a programme of detailed engagement across our health and care system** from now until the end of November.

Its purpose is to provide as much opportunity as possible for the final version to be informed and shaped by our colleagues from the **VCFSE sector and our service users, partner agencies, practitioners, staff and leaders from across all ten localities**, in the way it has been co-produced over the fifteen months to date.

We welcome all comments and will be engaging directly with all stakeholders to provide a space for feedback on parameters 1-4.

1. What are your thoughts on the key goals, targets and metrics we have identified in chapter 9? Are there any ambitions or key metrics that are missing or that require different emphasis?

2. Have we correctly identified the priorities – are there any that are missing or require a different emphasis

3. If we collectively implement the proposals set out in the framework, how will this make a positive difference to your experience of achieving Fairer Health for All either as a provider, service user or delivery partner? What could be added to framework to improve on this?

4. Do you have any other views on the framework?

Why is it needed? Deep rooted health inequalities

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Inequalities at a glance in GM

There are **2.8 million people** in Greater Manchester

1.1 million of these residents live in the **most 10% deprived areas** of the UK

Female healthy life expectancy in GM is 60.9 years

Vs England average of 63.9

A female born in Salford could expect to live **9.5 years less** in good health than a female born in Trafford.

There are differences within localities too:

A woman living in Salford in the **most deprived neighbourhoods** can expect to live **11.1 years less** **than a woman living in the wealthier neighbourhoods**

Male healthy life expectancy in GM is 61.4 years

Vs England average of 63.1

A male born in Oldham could expect to live **10.3 years less** in good health than a male born in Trafford.

There are differences within localities too:

A man living in Salford in the **most deprived neighbourhoods** can expect to live **11.7 years less** **than a man living in the wealthier neighbourhoods**

68,200 people

In GM are unemployed

5% compared to 3.5% UK average

117,400 residents

are economically inactive due long term sickness. 30% of our productivity gap is due to ill health

1/3 of the GM population are children and young people (CYP)

around 1 in 4 live in poverty

40% of children

living in poverty in GM **live in a smoking household**. Children living in a smoking household are **4 times more likely to start smoking**.

Asthma-related hospital admissions for CYP is consistently high in GM. **And 50% higher for CYP from disadvantaged GM communities.** Twice the rate of the national average.

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comments and questions to:

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