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Tameside Metropolitan Borough

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HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 21 January 2016
Time: 10.00 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No

GENERAL BUSINESS

1. APOLOGIES FOR ABSENCE

To receive any apologies for the meeting from Members of the Health and Wellbeing Board.

2. DECLARATIONS OF INTEREST

To receive any declarations of interest from Members of the Health and Wellbeing Board.

3. MINUTES 1 - 6

To receive the Minutes of the previous meeting of the Health and Wellbeing Board held on 12 November 2015.

ITEMS FOR DISCUSSION / DECISION

4. GREATER MANCHESTER STRATEGIC PLAN: TAKING CHARGE OF OUR HEALTH AND SOCIAL CARE IN GREATER MANCHESTER 7 - 68

To consider the attached report of the Chief Executive, Tameside MBC / Executive Member (Adult Social Care and Wellbeing) / Executive Member (Healthy and Working) and Executive Member (Children and Families).

5. GOVERNANCE AND ACCOUNTABILITY FRAMEWORK FOR HEALTH AND CARE INTEGRATION 69 - 126

To consider the attached report of the Chief Executive, Tameside MBC / Executive Member (Adult Social Care and Wellbeing) / Executive Member (Healthy and Working) and Executive Member (Children and Families).

6. CARE TOGETHER PROGRAMME 127 - 132

To receive the attached report from the Chair of the Care Together Programme Board / Programme Director.

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 to whom any apologies for absence should be notified.

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7. DEVELOPING A SINGLE COMMISSIONING STRATEGY 133 - 138

To receive a presentation from the Programme Director for Integration.

8. GREATER MANCHESTER DEVOLUTION AND WORKING WELL 139 - 146

To receive a presentation from the Assistant Executive Director (Development, Growth and Investment).

9. URGENT ITEMS

To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.

10. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 10 March 2016 commencing at 10.00 am.

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 to whom any apologies for absence should be notified.

TAMESIDE HEALTH AND WELLBEING BOARD

12 November 2015

Commenced: 10.00 am **Terminated: 11.50 am**

PRESENT: Alan Dow (Deputy Chair – in the Chair) – Clinical Commissioning Group
Councillor Brenda Warrington – Tameside MBC
Steve Allinson – Clinical Commissioning Group
Jane Ankrett – Stockport NHS Foundation Trust
Stephanie Butterworth – Tameside MBC
Judith Crosby – Pennine Care NHS Foundation Trust
Graham Curtis – Clinical Commissioning Group
Ben Gilchrist – CVAT
Angela Hardman – Tameside MBC
Karen James – Tameside Hospital NHS Foundation Trust
David Niven – Tameside Safeguarding Children Board
Steven Pleasant – Tameside MBC
Tony Powell – New Charter Housing Trust
Dominic Tumelty – Tameside MBC

IN ATTENDANCE: Sandra Stewart – Tameside MBC
Jessica Williams – Programme Director for Integration
Debbie Watson – Tameside MBC
Ben Jay – Tameside MBC

APOLOGIES: Councillor Kieran Quinn – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Lynn Travis – Tameside MBC
Christina Greenhalgh – Clinical Commissioning Group
Andy Searle –Tameside Safeguarding Adults Board

24. DECLARATIONS OF INTEREST

There were no declarations of interest submitted by members of the Board.

25. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 1 October 2015 were approved as a correct record.

26. CARE TOGETHER PROGRAMME: UPDATE

Consideration was given to a report of the first report of the Independent Chair and Programme Director summarising progress and key milestones for the Tameside and Glossop Care Together Programme. As the programme moved into a different phase, the structure of the programme had been realigned to ensure appropriate engagement in the detailed design work as well as delivery. The new structure identified the three main working parties focusing on Single Commissioning, the Model of Care and the plans to deliver an Integrated Care Organisation Foundation Trust. The architecture to support these groups was currently being determined and would be reported at the next meeting of the Board. A governance structure, risk log and an interim budget had been developed to enable the work to be progressed at scale and pace. A high level plan to demonstrate the milestones for the Programme was being finalised and would also be reported to the next Board meeting.

An important initial step in the development of an integrated care organisation was the transfer of the Tameside and Glossop community staff currently hosted by Stockport Foundation Trust into Tameside Hospital Foundation Trust. This process was now underway and would be completed on 1 April 2016. The governance arrangements for this transaction focused on a fortnightly Project Board and a number of work streams had been established to manage the detail and be accountable for progress.

RESOLVED
That the content of the update report be noted.

27. TAMESIDE AND GLOSSOP LOCALITY PLAN

Consideration was given to a report of the Chief Executive, Tameside MBC, and the Chief Operating Officer, Clinical Commissioning Group, explaining that in 2015/16 Greater Manchester Devolution was submitting a five year comprehensive Strategic Sustainability Plan for health and social care in partnership with NHS England and other national partners. Each of the GM areas had been asked to submit a Locality Plan to provide a "bottom up" approach to the development of the GM Plan. The GM Strategic Sustainability Plan would be based on the following objectives to:

- Improve health and wellbeing of all residents of Greater Manchester, with a focus on prevention and public health, and providing care closer to home;
- Make fast progress on addressing health inequalities;
- Promote integration of health and social care as a key component of public sector reform;
- Contribute to growth, in particular through supporting employment and early years services;
- Build partnerships between health, social care, universities, science and knowledge sectors for the benefit of the population.

As such, the Tameside and Glossop Locality Plan addressed how these objectives would be met locally and how health and care services would be reorganised to contribute more effectively towards better prosperity, health and wellbeing.

Tameside and Glossop had a significant financial challenge as evidenced by the estimated £69m gap in funding across the health and social care economy by 2020. Continuing with the current system was not an option and the proposals for a single health and care provider had been analysed and subjected to external financial scrutiny and once fully implemented, would reduce expenditure by £28m. Additionally, other key plans described within the Locality Plan showed how by leading together and pooling resources, financial sustainability could be reached within five years.

A clear vision and strong partnership in conjunction with the opportunities provided within the Greater Manchester Devolution, provided the platform to drive forward shared objectives. Working with local people across the statutory, private, voluntary, and community sectors would enable ambitions to be achieved.

RESOLVED
That the content of the report be noted and the Tameside and Glossop Locality Plan be endorsed.

28. WORKING WELL UPDATE

Consideration was given to a report of the Assistant Executive Director (Development, Growth and Investment) advising on progress with the current Working Well pilot and Phase 1 of the expansion from the existing 5,000 cohort to 15,000 across Greater Manchester. The report also set out the opportunities in the expanded Working Well Programme scheduled to go live in February 2016.

It was explained that the current Working Well pilot started in March 2014 to support the Employment Support Allowance Work Related Activity Group claimants who had spent two years unsuccessfully on the Work Programme into sustained employment. The scheme had been built around a key worker model giving providers the freedom to innovate and design services in the most effective and efficient way possible. Demonstrating that this model worked was a key priority for GM as it had a direct impact on future decisions around commissioning the Work Programme or its successor. Integrating Working Well with health services had been challenging although many successes had been achieved to date. The Working Well expansion provided a significant opportunity to develop integration at a faster pace on a larger scale.

So far, in Tameside, Working Well had been implemented successfully and was being managed by a local partnership Steering Group whose role was to understand, progress and problem solve any blockages or barriers to the programme. The Steering Group was continuing to explore opportunities to specifically integrate Working Well into health services and the key activities supporting this twin approach were highlighted.

The successes for the programme were detailed in the report together a number of cases studies. It also set out information about employment barriers clients faced when entering into the programme and it was noted that bereavement continued to be above the GM average.

Reference was made to the expansion of Working Well Phase 1 which represented an important change in the welfare to work system in GM and increased and widening of cohorts and enhanced integration should be viewed as key successes. The further expansion would enable providers to become more operationally involved in holistically tackling work, skills and health by providing a referral route and increasing opportunities for co-case management.

The Health and Wellbeing Board considered the opportunities of the expanded programme and how these could be realised through an updated Tameside Working Well Integration Plan which was being continually being developed by the Tameside Working Well Steering with local agencies and providers. Engagement and integration between work, skills and health was progressing and would be strengthened further by the expansion of Working Well.

RESOLVED

(i) That the progress of Working Well be noted.

(ii) That the opportunities for the expansion of Working Well in 2016 including the development of a health referral route be supported.

29. ADVISORY COMMITTEE ON RESOURCE ALLOCATION CONSULTATION 2016/17 ON PUBLIC HEALTH GRANT

Consideration was given to a report of the Executive Member (Health and Neighbourhoods) and the Director of Public Health explaining the Advisory Committee on Resource Allocation public health grant proposed target allocation formula for 2016/17 and how it had been developed and the implications for Tameside.

The Advisory Committee on Resources Allocation (ACRA) developed a formal for public health grants for the first time in 2012 which was used to set target allocations for 2013/14 and 2014/15 for public health grants to Local Authorities.

Between 8 October 2015 and 6 November 2015 the Department of Health was consulting, on behalf of ACRA, on interim recommendations for a number of changes to the target formula for the public health grant for 2016/17 onwards. The key steps in setting the Public Health allocations were:

- Setting the preferred relative distribution of resources;
- Setting the total resources available;

- Deciding how quickly to move organisations from their baseline position towards the level of resources implied by the preferred distribution.

A copy of the consultation response from Tameside Council was appended to the report.

Board Members referred to the existing public health grant formula and the proposed changes to the formula and their impact on Tameside MBC target allocation was summarised. The overall impact on Tameside of the proposed target allocation formula for 2016/17 was highlighted which represented a 0.1% reduction of relative share. The 1% decrease in the Tameside MBC allocated share would decrease from 0.25% to 0.24% which in financial terms was equivalent to a reduction of £340,000 in grant allocation for Tameside.

RESOLVED

(i) That the funding formula consultation for 2016/17, proposed changes and implications for Tameside be noted.

(ii) That the consultation response be endorsed.

(iii) That a further update following the autumn statement be submitted to the January 2016 meeting of the Health and Wellbeing Board.

30. 0-5 TRANSITION OF HEALTH CHILD PROGRAMME: UPDATE

Consideration was given to a report of the Executive Member (Children and Families) and the Director of Public Health updating the Board on the transfer of commissioning responsibilities for 0-5 public health services from National Health Service (England) to the Council and the transformation undertaken by the provider of Health Visiting and Family Nurse Partnership services.

Particular reference was made to health visitor performance, health visitor workforce, finance and the challenges ahead.

RESOLVED

That the key issues and update on the transfer of commissioning responsibilities for 0-5 public health services from the NHSE to Tameside MBC be noted.

31. CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES – TRANSFORMATION PLAN

Consideration was given to a report of the Commissioning Business Manager for Children, Young People and Families, Clinical Commissioning Group, and the Children and Young Peoples Emotional Wellbeing and Mental Health Plan for 2015-2012. This had been produced by the Children and Young Peoples Emotional Wellbeing and CAMHS Transformation Programme Board, led by the Clinical Commissioning Group.

RESOLVED

(i) That the Plan be accepted.

(ii) That the progression of the priorities and deliverables under the Plan be supported.

(iii) That the Board receive further updates on progress.

32. TAMESIDE SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT

The Chair welcomed David Niven, Independent Chair, who presented the Tameside Safeguarding Children Board Annual Report 2014/15, providing an overview of the Board's safeguarding activity against its 2014/15 priorities. It identified particular vulnerable groups and outlined emerging themes and details of the Board's strategic priorities for 2015/16.

RESOLVED
That the Tameside Safeguarding Children Board Annual Report 2014/15 be received.

33. HEALTHWATCH TAMESIDE ANNUAL REPORT 2014/15

The Chief Executive, Healthwatch Tameside, was pleased to present the Healthwatch Tameside Annual Report 2014-15. It highlighted the statutory functions, activities during the year and outcomes that have been achieved. In particular, the Board noted:

- Healthwatch Tameside engaged with significant numbers of local citizens, including people from seldom heard communities.
- Tameside Hospital welcomed and acted on a set of Enter and View visits undertaken by Healthwatch Tameside.
- Healthwatch Tameside has established a large online following as well as providing face to face contact in a number of community settings.
- Healthwatch Tameside took on the NHS complaints advocacy function this year with no additional funding. They have seen a 55% increase in active cases during the year (due to being more accessible to the local population).
- Healthwatch Tameside played a significant role in ensuring that local residents responded to the Healthier Together consultation. Our Borough had the highest number of responses for any area where the future role of the local hospital was not being consulted on.
- The report included three examples of 'impact stories' where Healthwatch has made a difference to local people or services.
- Future Healthwatch priorities including helping the local population to engage with Care Together and the GM Devolution agenda.

RESOLVED
That the content of the report be noted.

34. HEALTH WATCH TAMESIDE ANNUAL INTELLIGENCE REPORT 2014/15

Consideration was given to a report of the Chief Executive, Healthwatch Tameside providing a summary of the aggregated data from 770 patient stories and survey responses received by Healthwatch Tameside during 2014. The purpose of this is to enable themes and patterns to be identified that were not always immediately obvious when reading a single story in isolation. The report pulled together data from:

- Patient opinion;
- Healthwatch surveys;
- Patient stories we have been told but asked not to share on an individual basis;
- Informal comments collected by the Healthwatch Champions;
- Themes from NHS complaints where help had been provided for people to use the formal complaints system.

RESOLVED
(i) That the report be recognised as part of the evidence base for the Joint Strategic Needs Assessment with a new version being sent to the Board annually;
(ii) That the three main themes emerging from patients' comments especially where it may provide useful context and insight for future planning and commissioning decisions be noted and shared:
- **Appointments (GP and hospital);**
- **Communication (explanations, information, listening, advice and correspondence);**
- **Staff.**

(iii) That Healthwatch Tameside's intervention to work with commissioners and providers to identify and implement improvements in patient experience when the more detailed output from the follow-up data collection exercise around appointments, communication and staff is complete be supported.

35. PUBLIC HEALTH OUTCOMES FRAMEWORK SCORECARD

Consideration was given to a report of the Executive Member (Health and Neighbourhoods) / Director of Public Health providing an update regarding the current position of the Tameside Public Health Outcome Framework indicators and the comments against each indicator advising Members of the Health and Wellbeing Board of emerging issues or concerns within indicator movements.

RESOLVED
That the contents of the report be noted.

36. URGENT ITEMS

The Chair advised that there were no urgent items for consideration at this meeting.

37. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 21 January 2016 commencing at 10.00 am.

CHAIR

Report to :	**HEALTH AND WELLBEING BOARD**
Date :	21 January 2016
Executive Member / Reporting Officer:	Steven Pleasant, Chief Executive Tameside Council Cllr Brenda Warrington – Executive Member Social Care & Wellbeing Cllr Gerald P. Cooney – Executive Member Healthy & Working Cllr Peter Robinson – Executive Member Children & Families
Subject :	**GREATER MANCHESTER STRATEGIC PLAN: TAKING CHARGE OF OUR HEALTH AND SOCIAL CARE IN GREATER MANCHESTER**
Report Summary :	In February 2015, the 37 NHS organisations and all local authorities in Greater Manchester signed a landmark agreement with the Government to take charge of health and social care spending and decisions in the Greater Manchester city region. This included a commitment to produce a comprehensive plan for health and social care. The final draft of this plan 'Taking Charge of our Health and Social Care in Greater Manchester'; was endorsed by the Health and Social Care Strategic Partnership Board on Friday 18 December 2015. It details the collective ambition for the region over the next five years, setting out the direction of travel.
Recommendations :	The Health and Wellbeing Board are asked to note the attached Greater Manchester Strategic Plan.
Links to Health and Wellbeing Strategy :	Each of the ten localities in Greater Manchester has a place-based plan which was signed off by the Health and Wellbeing Board in January. The locality plans will be delivered through the Health and Wellbeing Strategy and form the bedrock of what will be delivered in Tameside.
Policy Implications :	The 37 statutory organisations involved in health and social care across GM have formally agreed to work together by taking control of the £6 billion of public money spent on health and social care in GM. Working within the NHS Mandate, associated national policy and quality assurance parameters, the plan will aim to deliver rapid and radical improvements over the next five years.
Financial Implications: **(Authorised by the Section 151 Officer)**	The Tameside Locality Plan was submitted to Greater Manchester Devolution in October 2015. The plan provides a supporting analysis of the estimated £69 million funding gap which is projected to arise within the economy by 2019/2020. The plan also explains the strategies required to deliver this projected gap. A supporting transformation fund business case is scheduled for submission to GM Devolution/Department of Health by end of January 2016. The business case will request a combination of revenue (£36 million) and capital (£13 million) funding (subject to revision prior to submission deadline) which is profiled over a five year period. The transformation fund will support the necessary transition within the economy towards the implementation of the

new care delivery model.

It is essential that the estimated funding gap is continually reviewed and updated to ensure additional savings strategies are implemented as appropriate.

Legal Implications:

(Authorised by the Borough Solicitor)

Public Service Reform (PSR) principles are at the heart of the Strategic Plan. The scale of public services will reduce over the next five years and current service provision will not be achievable. Making services, especially hospitals, more efficient will be insufficient without reducing or deflecting demand. The two actions must be considered together. It will be important to work on preventing demand and ensuring that the right intervention is made at the earliest possible stage. The public have a key role in taking more responsibility for their own health care, including more emphasis on prevention. PSR provides the backdrop to the changes by developing new approaches to investing and aligning priorities from a range of partners, and across a wide number of services. Increased use of evidence and evaluation underpins the move to reducing demand and focusing resources in the most effective interventions.

The Plan aims to ensure health and social care transformation with the intention of reducing complex dependency and enhancing services to children and early years. Devolution provides the opportunity to remove barriers to reform.

The Locality Plan needs to be aligned to the Greater Manchester Strategic Plan

Risk Management: There are no risks associated with this report

Access to Information: The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing by:

Telephone: **0161 342 3358**

e-mail: debbie.watson@tameside.gov.uk

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Taking charge of our Health and Social Care in Greater Manchester

The Plan

FINAL DRAFT v11.3 • Dec 2015

Greater Manchester Health and Social Care Devolution

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Contents

Foreword

In February 2015 the 37 NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement with the Government to take charge of health and social care spending and decisions in our city region.

We wanted to do this because we believe having the freedom to radically transform the health of our population and to build a clinically and financially sustainable model of health and social care is a huge opportunity, as well as a great responsibility.

Greater Manchester has the fastest growing economy in the country and yet people here die younger than people in other parts of England. Cardiovascular and respiratory illnesses mean people become ill at a younger age, and live with their illness longer, than in other parts of the country. Our growing number of older people often have many long term health issues to manage.

Thousands of people are treated in hospital when their needs could be better met elsewhere, care is not joined up between teams and is not always of a consistent quality. We also spend millions of pounds dealing with illnesses caused by poverty, loneliness, stress, debt, smoking, drinking, air quality, unhealthy eating and physical inactivity.

The £6 billion we currently spend on health and social care – and the way we spend it - has not improved this picture across Greater Manchester.

The challenge is significant; if we don't start to act now to radically change the way we do things, by 2021 more people will be suffering from poor health and we will be facing a £2 billion shortfall in funding for health and social care services.

But like the challenge the opportunity is huge. Our goal is to see the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people in the towns and cities of Greater Manchester.

In order to achieve this, we know we need a radical change in how we build resilience in people and communities, as well as providing safe, consistent and affordable health and social care. We need to strike a new deal with people in Greater Manchester.

Our focus must be on our people and our places, not organisations. There will be a responsibility for everyone to work together, from individuals, families and communities as well as the approxiamtely 100,000 staff working in the NHS and social care, to the voluntary sector and the public bodies.

We want our city region to become a place which sits at the heart of the Northern Powerhouse, with the size, economic influence and above all skilled and healthy people to rival any global city.

Put simply, skilled, healthy and independent people are crucial to bring jobs, investment and therefore prosperity to Greater Manchester. We know that people who have jobs, good housing and are connected to families and community feel, and stay, healthier.

So we need to take action not just in health and social care, but across the whole range of public services so the people here can start well, live well and age well.

We are taking charge of Greater Manchester through our strategy of growth and reform of public services. All 37 organisations in Greater Manchester are taking responsibility and working with their communities to understand how every person here can play their role.

We welcome the positive contribution of Healthwatch and patient groups as well as input from voluntary, social care and 3rd sector organisations. We look forward to continued and stronger partnership working as we implement the Plan.

We hope you will support our bold and ambitious Plan; the first of its kind in the country.

Lord Peter Smith
Leader Wigan Council
Chair of the Greater Manchester Health and Social Care Strategic Partnership Board

Dr Hamish Stedman
Chair of NHS Salford Clinical Commissioning Group
Chair of the Greater Manchester Association of Clinical Commissioning Groups

Ann Barnes
Chief Executive Stockport NHS Foundation Trust
Chair of the Greater Manchester NHS Provider Trust Federation Board

Dr Tracey Vell
Chair of the Association of Greater Manchester Local Medical Committee
GM Primary Care Representative

Sir Howard Bernstein
Joint Chair of the GM Health and Social Care Devolution Programme Board
Head of Paid Service
Greater Manchester Combined Authority

Ian Williamson
Chief Officer
Greater Manchester Health and Social Care Devolution

Chapter 1

The Greater Manchester context

Summary

Across Greater Manchester (GM) we are working together on the radical reform of public services. Our ambition is to improve outcomes for our people, increasing independence and reducing demand on public services. The £6 billion we currently spend on health and social care has not improved the long term outcomes for people living in GM.

GM faces an unprecedented challenge now, and over the next five years, in health and social care service provision. We know that if we don't act now, not only will our outcomes remain worse than the rest of the country, but by 2021 we will have a £2 billion gap in our public service finances.

Our response to this is to place health and social care reform at the heart of our city region reform and growth agenda; healthy and independent people play a key part in enabling us to achieve our ambition for a growing and sustainable GM in the future.

In order to achieve this, we know we need radical change at scale in how we provide health and social care and a new deal with people in GM. Our focus must be on people and place, not organisations. This is critical in helping us to achieve our vision 'to deliver the fastest and greatest improvement in the health and wellbeing' of the 2.8 million people living across GM.

We need to take action across the whole range of care services; upgrading our approach to prevention, early intervention and self-care; redefining how primary, community and social services become the cornerstone of local care; standardising and building upon our specialist hospital services through the development of shared hospital services; and creating efficient back office support.

This plan explains how, as a system, we are going to approach and achieve this and how our transformation fund will help us change, to radically shift the nature of demand and reform service provision.

Our ambition for Greater Manchester

Our ambition is for GM to become a financially self-sustaining city region, sitting at the heart of the Northern Powerhouse with the size, assets, skilled and healthy population, and political and economic influence to rival any global city.

In April 2011, GM established the first combined authority in the country (GMCA), providing stable, efficient and effective governance of our strategic agenda through the ten local authorities in GM. In 2014, the Growth and Reform Plan, built on our long history of collaboration, was underpinned by a common commitment by all of our local authorities to increase the prosperity of the people of GM.

The 12 Greater Manchester clinical commissioning groups (CCGs) formed the Greater Manchester Association of CCGs (GMACCG) in 2013, building upon a strong history of collaboration between NHS commissioners in the region. It has been instrumental in planning and delivering a number of significant transformation programmes within GM including: stroke reconfiguration, primary care medical standards and Healthier Together.

GM also has a strong track record of collaboration with all of its key stakeholders, particularly business. The GM Local Enterprise Partnership (LEP) works constructively with the GMCA and with the extensive network of business organisations to ensure not only that business plays a full part in helping to shape the strategic direction of GM, but also through its participation in the Manchester Growth Company, where it plays an active role in overseeing the delivery of key investment and growth responsibilities.

The reform of health and social care is vital to improving GM's productivity by helping more people to become fit for work, get jobs, get better jobs and stay in work for longer. It will also help to manage the demand on services created by an ageing population. Addressing together the issues of complex dependency will help those further away from the job market to move towards jobs and assist the low paid into better jobs. Reform of Early Years provision is key to increasing productivity of parents and, in the future, their children.

Why we need change

NHS England's Five Year Forward View acknowledges that some improvements have been made in health and social care over the last 15 years: cancer survival is at its highest ever, early deaths from heart disease are down by over 40 per cent, and long waits for operations have reduced from 18 months to 18 weeks.

However, the current fragmented health and social care system has not enabled us to improve the lives of people in GM at a scale and pace to realise our ambitions. The challenge we now face is bigger than ever.

The health outcomes for GM people are worse than those in other parts of the country and health inequalities are deep-rooted. Older women in Manchester have the worst life expectancy in England. The high prevalence of long term conditions such as cardiovascular and respiratory disease mean that GM people not only have a shorter life expectancy, but can expect to experience poor health at a younger age than in other parts of the country. Our population has aged and our older population will increase by 25 per cent by 2025. As more people have developed multiple long term conditions the focus has shifted from curing illnesses to helping individuals live with chronic ill health.

Many people are treated in hospital when their needs could be better met in primary care or the community. There is too little co-ordination between urgent services and emergency services - A&E, ambulance, GP out of hours and NHS 111. There are real risks of significant market failure in domiciliary, residential and nursing care across social care and this impacts on system resilience and hospital discharge planning. There is a rising burden of illness caused by lifestyle choices like smoking, drinking and obesity. These changes have put the NHS and social care under increasing pressure and a growing number of people with multiple problems receive care that is fragmented or leads to wasteful duplication.

On present trends, if we do nothing, the GM health and social care system will face an estimated financial deficit of £2 billion by 2020/21. That pattern of rising demand is connected to our current organisation of services and the imbalance between preventive early help services and those which respond when crisis occurs. The scale of the challenge demonstrates why radical change is needed, both in the way services are delivered and in the way the public use them. This is why we must use this opportunity to take charge.

Reforming our services

On 1 April 2016 a new era in GM's history begins when it becomes the first region in the country to have devolved control over integrated health and social care budgets, a combined sum of more than £6 billion. For the first time, health and social care will become integrated and local people will be taking charge of decisions on the health and care services for GM.

But GM is not just taking charge of health and social care provision. Fundamental to the success of the ground-breaking agreement between the Government and GM will be our ability to draw together a much wider range of services that contribute to the health and wellbeing of GM people.

The impact of air quality, housing, employment, early years, education and skills on health and wellbeing is well understood. In GM, General Practitioners (GPs) spend around 40 per cent of their time dealing with non-medical issues. Therefore GM is embarking on a large scale programme of whole-system public service reform, bringing together decision making, budgets and frontline professionals to shape services in ways that better support local people and communities.

With local services working together, focussed on people and place, we want to transform the role of public services and take a more proactive approach rather than responding to crises. We want to transform the way we use information, empowering our frontline workforce to make more informed decisions about how and when they work with individuals and families. Building on the principles of early intervention and prevention, GM aims to deliver the appropriate services at the right time, supporting people to become healthier, resilient and empowered.

This Plan shows that GM has seized this unique opportunity to shape its future, drawing on the assets of world-class public services, a strong business base, and healthy, strong communities. We are taking charge of our future, working together to help GM thrive.

What we think is needed

Our vision is 'to deliver the fastest and greatest improvement in the health and wellbeing' of the 2.8 million population of GM, creating a strong, safe and sustainable health and care system that is fit for the future. To do this we have focused on delivering change in two critical areas:

1. Creating a new health and care system

Our Plan is a national first. The devolution agreement means we can think differently and promote service and system change in ways that build on people's views and strengthen local decision-making and accountability, to deliver significantly better outcomes.

We want to see the gap in health inequalities and finances reduced further and faster, for the first time, by providing joined up care from across the public sector and beyond.

We will take action across the whole range of care services, upgrading our approach to prevention, early intervention and self-care; redefining how primary, community and social services become the cornerstone of local care; standardising and building upon our specialist hospital services through the development of shared hospital services; and creating efficient back office support. These proposals are explained in Chapter 4.

By working together, unhindered by artificial and bureaucratic barriers, organisations will provide integrated care to support physical, mental and social wellbeing, improving the lives of those who need help most. Our new models of care will build on NHS England's Five Year Forward View by re-orienting our health and care systems so that we focus on preventing the big health and care problems, like cancer, cardiovascular disease, diabetes and respiratory, but also social isolation and deprivation which undermine our prosperity as a city region, and investment in early years and employment.

We know a critical enabler of the transformation we are pursuing is a fit for purpose health and social care workforce. GM's NHS and social care workforce is currently approximately 100,000 strong, but we know we need to address some skills and capacity shortages going forward in all parts of the system if we are to improve outcomes for people in GM.

The scale of change will impact significantly on our workforce and a key aspect of the Implementation Plan will focus on how our workforce becomes an enabler to support the delivery of our ambition. We need a workforce which is fit for purpose, able to adapt to changing demographics and embrace new models of care. We need a more flexible workforce with a breadth of skills and knowledge that enables to us transform, lead and develop new models of care.

2. Reaching a 'new deal' with the public

At the heart of our approach to devolution is the brokering of a new relationship with the people of GM.

The long term health and wellbeing of people will only be secured through a new relationship between people and the services they use; striking a new deal which needs both sides to deliver on its promises if we are going to transform the long-term health of GM.

In its simplest form public services will take charge of and responsibility for their localities. For example they will:

- Ensure there are a wide range of facilities within local communities including parks, open spaces, leisure, safe cycling routes, good quality housing.
- Ensure easy, timely access to good quality seven day a week primary care to screen, diagnose and treat and prevent disease as early as possible.
- Support families to bring up their children to have the best start in life through our Early Years New Delivery Model.
- Support all people to live well, supporting unemployed people into work or training and helping people benefit from the fastest growing economy in the UK.
- Assist people to age well; keeping healthy and connected to their neighbours for as long as possible at home.

At the same time the people of GM must take greater charge of, and responsibility for, their own health and wellbeing. This could include:

- Keeping active and moving at whatever stage of life.
- Registering with a GP and going for regular check-ups, taking charge of their own health and wellbeing.
- Drinking and eating sensibly, not smoking and encouraging their children to do the same.
- Taking time to be supportive parents, bonding with their babies and encouraging their children to be the best they can be.
- Taking advantage of training and job opportunities setting high aspirations for themselves and their families.
- Supporting their older relatives, friends and neighbours to be as independent for as long as possible.
- Getting involved in their local communities.

Devolution of health and social care to GM provides the first opportunity to tackle the historic fragmentation of leadership, planning and service delivery in our health and care services. By working collaboratively and planning together for change, we will improve services to increase the wellbeing of our people and create a strong, safe and sustainable health and social care service that is fit for the 21st century.

Population health outcomes

We recognise that we generally have worse health outcomes than England. We will therefore concentrate our efforts closing the gap between GM and England by raising population health outcomes to those projected for England in five years' time, in other words we will go further, faster.

The impact of housing, employment, air quality, early years services, education and skills on health and wellbeing is well understood and we have organised our prevention and early intervention work around a life course approach – Start Well, Live Well and Age Well.

Outcome	Measure
START WELL	
More GM Children will reach a good level of development cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3250 more children, with a good level of development by 2021.
Fewer GM babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in GM to projected England rates will result in 270 fewer very small babies (under 2500g) by 2021.
LIVE WELL	
More GM families will be economically active and family incomes will increase.	Raising the number of parents in good work to projected England average will result in 16,000 fewer GM children living in poverty by 2021.
Fewer people will die early from Cardio-vascular disease (CVD).	Improving premature mortality from CVD to projected England average will result in 600 fewer deaths by 2021.
Fewer people will die early from Cancer.	Improving premature mortality from Cancer to projected England average will result in 1300 fewer deaths by 2021.
Fewer people will die early from Respiratory Disease.	Improving premature mortality from Respiratory Disease to projected England average will result in 580 fewer deaths by 2021.
AGE WELL	
More people will be supported to stay well and live at home for as long as possible,	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

We will ensure that we are addressing the health outcomes which are important to the people of GM. We will therefore engage with the public to refine, add to and amend our outcomes frame work as we develop our implementation plans.

Chapter 2

Our leadership journey

Summary

On 25th February 2015, the Chancellor George Osborne, the Secretary of State Jeremy Hunt, NHS England Chief Executive Simon Stevens and the leaders of local authorities and NHS organisations in Greater Manchester announced ground-breaking plans for the devolution of health and social care as part of the Northern Powerhouse.

NHS England, 12 NHS Clinical Commissioning Groups, 15 NHS providers and 10 local authorities entered into a landmark Memorandum of Understanding (MoU) agreement to formally take control of the £6 billion of public money spent on health and social care to transform the system and deliver radical change over the next five years.

We have committed to work together 'to deliver the fastest and greatest improvement in the health and wellbeing' of people across GM.

We have already achieved significant progress together, through eight early implementation work streams (as detailed from p14), which have demonstrated our ambition, determination and capability to make rapid, system-wide service change.

The Plan

Our journey

The GM Devolution Agreement was settled with the Government in November 2014. It describes how decisions around a range of public services (transport, planning and housing) would be devolved to GMCA, giving people and their local representatives control over decisions which have previously been taken at a national level.

The reform of health and social care is a key part of this and following the wider agreement, NHS England, the 10 GM local authorities, 12 CCGs and 15 NHS and foundation trusts agreed to work together to transform health and social care.

In February 2015, the Memorandum of Understanding (MoU) between the Government, the GM health bodies and local authorities and NHS England, gave local control over an estimated budget of £6 billion each year from April 2016. The MoU covered all services including acute care, primary care, community services, mental health services, social care and public health.

Leadership challenge

As part of the MoU we committed to the production, during 2015/16, of this Plan. This, aligned with NHS England's Five Year Forward View, would describe how a clinically and financially sustainable landscape of commissioning and provision could be achieved over the subsequent five years, subject to the resource expectations set out in the Five Year Forward View, appropriate transition funding being available and the full involvement and support of national and other partners.

The 37 statutory organisations involved in health and social care across GM (listed at the back of the document) have formally agreed to work together by taking control of the £6 billion of public money spent on health and social care in GM. Working within the NHS Mandate, associated national policy and quality assurance parameters, we will aim to deliver rapid and radical improvements over the next five years.

Following the formal agreement to work together, the leadership and governance arrangements in GM had to be developed at pace and scale to ensure the system could reach decisions together in a robust, fair and equitable way. These governance arrangements were designed and agreed with the full involvement of senior leaders across the health and social care system.

Following the signing in February, a Programme Board met for the first time on 20th March 2015 to oversee the transition to full health and social care devolution. Co-chaired by Sir Howard Bernstein, Head of Paid Service for the Greater Manchester Combined Authority and Simon Stevens, Chief Executive of NHS England it includes representatives from the NHS and local authorities in GM, and NHS England.

Early implementation priorities

We agreed a set of early implementation priorities as a GM system to help us to test our devolved arrangements and deliver change at pace and at scale.

In July 2015, we agreed and created a unified public health leadership for GM.

This is the first agreement of its kind in England and is between GM, NHS England and PHE to place a greater leadership emphasis and focus on prevention and early intervention to stop people in GM becoming ill, so that they can remain independent and have the best family, work and lifestyle opportunities to contribute to a transformational and sustainable shift in the health and wellbeing of the population.

By the end of 2015, everyone living in GM who needs medical help will have same day access to primary care services, supported by diagnostic tests, seven days a week.

In February 2014, we published our GM Strategy for Primary Care, which outlined our primary care commitments. As part of the delivery of this strategy, we developed the GM Primary Care Medical Standards, which will be implemented in the ten GM localities by December 2017.

In January 2016, we will extend our Working Well pilot to an additional 15,000 out of work GM people.

In March 2014, GM established a Working Well pilot through a unique agreement with Government, which supports people who have been unemployed for a long time back into sustainable employment.

Due to the success of the GM pilot, in January 2016, we will launch the expansion of the programme to improve support for a further 15,000 out-of-work people who face barriers to work. This approach across health, employment and skills is the first example of its kind in England.

We have started the implementation of four shared, single site services as a result of the Healthier Together programme. This will save up to 1,500 lives across GM over the next five years.

In 2012, the CCGs in GM embarked on a programme to develop single shared services (where care is provided by a team of clinical staff working together across a network of linked hospitals) for urgent and emergency care, acute medicine and general surgery across the acute trusts in GM because there was variation in outcomes for patients undergoing abdominal general surgery at different hospitals.

In July 2015, the 12 GM CCGs, through the decision making body the Committees in Common, agreed to have four shared, single site services. As a result, hospitals will work in partnership to form shared single services. One of the hospitals within each of the single services will specialise in emergency medicine and abdominal general surgery for patients with life-threatening conditions to ensure quality and safety standards are met and all hospitals can continue to provide care to their local population.

In September 2015, we launched Health Innovation Manchester – a partnership between leading healthcare research, academia and industry organisations across GM.

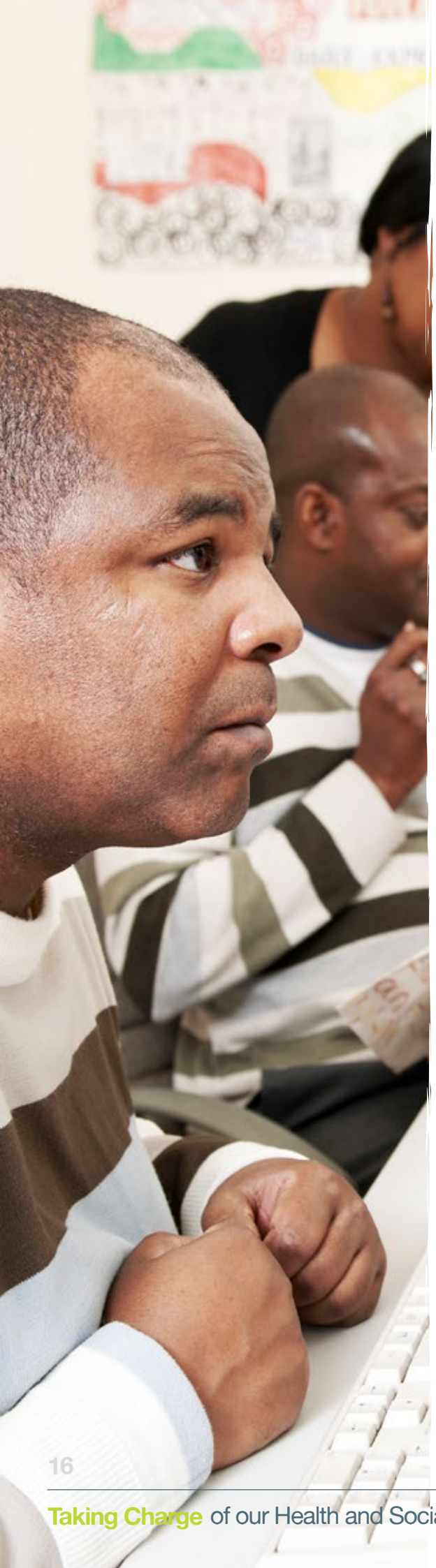
Health Innovation Manchester has been established to accelerate the discovery, development and implementation of new treatments and approaches, with a focus on improving health outcomes and generating economic growth. The combination of our research strengths, business base and eco-system and devolution makes this a unique opportunity within the UK and globally. We aim to be one of the best regions in the world for partnerships with innovative lifescience companies, driving economic growth and improving health outcomes.

Getting new ideas tested, adopted and widely used takes too long in the NHS – sometimes up to 20 years. To overcome this, GM has taken this unique step to accelerate health innovation into the local health and social care system. It is already in a strong position with three teaching hospitals, a research-led university base, a critical mass of life science firms and skilled workers, and a large and diverse population.

We will identify and spread the interventions that will have the biggest impact on the greatest number of people in GM. We will work to source the rapid take up of innovations on a large scale and to achieve this, we will also work to create industry partnerships, to speed development and attract inward investment.

There are a number of key enabling platforms that GM has that will be further developed to support health innovation. The priorities are our informatics and clinical trial capability, which provide essential underpinning for discovering, developing and delivering new therapies. Work is already underway to identify those treatments or approaches that could be delivered at scale in the short term and bring short term benefits while also testing the innovation system. These will be chosen within the context of place-based priorities that focus on the particular health needs of the population.

We will work to develop a systematic programme of primary, secondary, and tertiary risk assessments using new technologies of genomics and health data. This will help us create new models of care based on prevention and prediction



We will set caps on locum and agency expenditure and develop a skills and employment passport by April 2016 to enable more flexible movement of our workforce.

An agreement is being negotiated to cap locum and agency expenditure across GM by April 2016.

In November 2015, we launched the GM three year vision for learning disabilities to improve independence for people living with learning disabilities and their families across GM.

Following the Winterbourne View scandal, a national strategy was announced to close long term institutions for people with learning disabilities and care for them in their communities closer to home.

There are currently 150 people with learning disabilities from GM in hospital who could more appropriately live in the community. In addition some people are in hospitals far from GM and are therefore unable to maintain good contact with their families and friends. There is a wide variation between the localities in GM in how people access services such as health checks and day care. We also have a higher number of children with learning disabilities in hospitals, compared to the average for England and Wales.

Our vision sets out how we will provide each person with a learning disability with a supported place to live, as close to their homes and families as possible. This should help people with complex needs to live in local neighbourhoods, encourage the development of skills and of social relationships, support them at times of crisis, and foster choice and independence.

This GM programme will align to the work taking place at a locality level to improve services for people living with learning disabilities.

In March 2016, we will launch a five year GM programme – Dementia United, to improve the lived experience of people with dementia and their families.

Dementia causes immense suffering to the individuals and families affected. To provide effective support, integrated services are vital - across NHS and social care, hospital and community services and physical and mental health services. Without good access, good co-ordination and good support, suffering is increased and costs rise.

By 2021, it is estimated there will be nearly 35,000 people living with dementia in GM.

Nearly a third (30 per cent) will have severe symptoms, requiring 24 hour care. By 2021 the cost of caring for them is estimated to be around £375 million annually.

We will create a dementia service for GM that supports the delivery of the Prime Minister's dementia challenge and serves as a beacon for the UK.

It will:

- identify patients early
- slow down deterioration through monitoring
- provide consistently high quality community care to prevent hospital admission
- provide consistently high quality hospital care to avoid increases in length of stay

Central to our five year programme is the theme of 'connectedness' within which we have identified three key areas - Monitor my Health, Enrich my World, Connect me to my Support System.

To deliver this, we will create a single commissioning framework to support the following:

- Preventing well – reducing the risk of dementia, for example through health checks for vascular dementia
- Diagnosing well – developing a "seek and treat" system offering early assessment
- Living well – establishing dementia friendly communities
- Supporting well – providing access to health and social care as necessary, to reduce emergency admissions and care home placements
- Dying well – ensuring people die in the place of their choosing

We will support people newly diagnosed with dementia, with a case worker who will provide increasing levels of support to them and their carers as the condition progresses.

Taking charge of Cancer Services

A great example of how working together across GM can create improved services is the work we are doing on cancer. Our goal is to push GM's outcomes and survival rates to at least the national average and to ensure, through prevention, that fewer people have cancer.

GM has some of the very best cancer services and clinical outcomes in the country. One year survival rates have increased faster than elsewhere over the last 15 years and have now surpassed the average for England. But it also has some of the worst rates of premature death from cancer because of lifestyle factors for example smoking and delays in patients seeking help. More than a quarter (28 per cent) of cases of cancer are diagnosed in A&E, when it is often too late for treatment to be effective. We also know that how people access services varies across different places.

As part of a GM Cancer Strategy by 2021, our vision is that we will have:

- a single GM cancer commissioning organisation to manage and monitor cancer services across GM
- a system leader that will be accountable for integrating all elements of cancer prevention and care
- a strategy for partner engagement to drive improvement
- innovative models of care such as delivering services closer to home
- reduced delays in referrals for treatment
- improved outcomes and survival comparable with top European countries
- reduced inequity across the conurbation by tackling unacceptable variations in access and quality of care
- a clear focus on prevention and rapid access to diagnostics
- support for education and research
- consistent quality standards
- a financially sustainable service

We will run a three year pilot (2015 – 2018) spanning the entire spectrum of cancer care from public health and primary care through to diagnostics, treatment, long term support and end of life care.

We are leading the way in GM, with cancer services working with the Royal Marsden and University College London Hospitals within a single National Cancer Vanguard established to test out new models of care delivery across the entire cancer patient pathway. The aim of this is to bring significant improvements in outcomes and patient experience through a strengthened focus on early referral and rapid access to diagnostic services.

Taking charge of Mental Health Services

We have developed and agreed a GM Strategy for integrated mental health services across public service provision. Implementation of this strategy will commence from April 2016.

Mental illness can seriously affect the lives of individuals and their families. People with mental health problems are far more likely to suffer physical ill health. For example they are approximately three times more likely to use emergency care, often for reasons not connected with their mental state.

Health costs for people with long term conditions are at least 45 per cent higher if they also have a mental health problem. Up to 18 per cent of all NHS spending on long term conditions is linked to poor mental health – equivalent to £1.08 billion in GM. Employment rates are below the national average and sickness absence is high.

Life expectancy for those with severe mental illness is 10-15 per cent shorter than the general population.

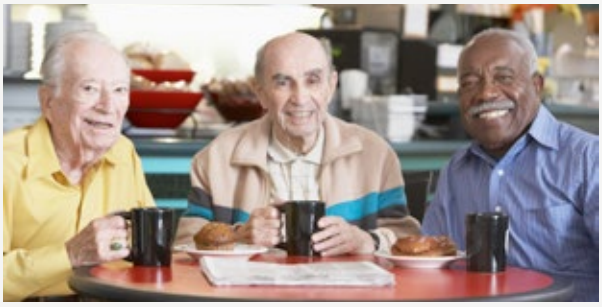
There are many examples of good practice in mental health across GM but quality, access and support vary.

We will explore the integration of mental health service across the ten GM localities, and across the wider GM conurbation, with a single point of contact making it easier for service users and professionals to navigate.

Stronger links will be forged with the following programmes: Troubled Families, Working Well and Complex Dependency.

We are committed to achieving parity of esteem for people with mental health issues in GM through the development and agreement of a GM Mental Health Strategy. Through this we will focus on four priority areas:

- Prevention and early intervention through strengthened community services and public health campaigns
- Improved access through increased collaboration among services with 24/7 crisis support and shorter waits for psychological therapies
- Creating a sustainable system with common standards and payments for outcomes
- Integrating care across the life course and with a focus on delivering the right care at the right time in the right place



Chapter 3

Building and governing the Plan

Summary

Following the signing of the MOU in February 2015, harnessing the strong leadership across the GM system, we agreed that to transform our services we need to work across the pathway of intervention and support.

This means we are working together to agree and define how we:

- **Change our relationship with people**, helping them to stay well, care for themselves and prevent illness and intervene early
- **Transform care in localities** by integrating primary, community, acute, social and third sector care through the development of new locally accountable platforms with single integrated commissioning hubs to facilitate clinical co-ordination
- Standardise and create consistent **evidence based hospital services**
- **Redesign our back office support** to create the most efficient services we can
- Create systems once at GM level which **incentivise our new models of care** and support

This Plan has been built from ten locality plans, provider reform plans and a range of GM strategies; it is complementary to and driven by what's happening in each local area. It has been developed with the input and support from national bodies and regulators, including NHS England, NHS Improvement (Monitor and the Trust Development Authority) and the Care Quality Commission.

Principles of the Plan

All of our plans are focussed on people and places rather than the different organisations that deliver services. This means we are thinking more innovatively about pulling services together and integrating them around people's homes, neighbourhoods and towns.

Our plans are developed on the principles of co-design and collaboration, all 37 statutory GM organisations have been working together to agree how we do things once, collectively, to make our current and future services work better.

We aim to secure financial sustainability through our plans and service reform.

Each locality is putting the money we have for health and social care into pooled budgets, so we can buy health, care and support services once for a place in a joined up way.

We develop plans based on the principle of fairness to ensure that all the people of GM can have timely access to the support they require.

We are innovative in our approach, using international evidence and proven best practice to shape our services to achieve the best outcomes for people in the most cost effective way.

We aim to deliver the best quality, outcome based services within the resource available.

We have used this early work to begin to create a plan between commissioners and providers at a GM level and submitted a bid as part of the government's Comprehensive Spending Review (CSR). This was our first piece of whole system modelling and financial planning and was submitted as part of the overarching Devolution CSR bid.

Building the plan

Our Plan for health and social care in GM is built on a history of collaboration between health and local authority partners, and we are used to working together.

We are working to ensure that we agree and take decisions in GM about GM at the right level - at neighbourhood, locality (there are ten localities in GM see below), cluster (more than one locality) or GM wide.

We are working to agree the most appropriate levels of service delivery at which to plan, take decisions and deliver.

This Plan marks a significant change in the approach to planning that has been in place in previous years, where each statutory organisation developed its plans separately. This Plan describes how the GM health, care and support system and its 37 statutory organisations will work together. They will still have their own plans, as statutory bodies, but these individual plans will be shaped by the strategic context of the locality plans as well as the overall GM Strategic Plan.

Following the signing of the MoU, we have worked with all of the national and regulatory bodies to develop our plans at locality and GM level across commissioners and providers. This includes NHS England, NHS Improvement (Monitor and Trust Development Authority) , Public Health England (PHE), the Care Quality Commission (CQC), the National Institute for Health and Care Excellence (NICE), Health Education England (HEE), the Department of Health (DH), Her Majesty's Treasury (HMT) and the Department for Communities and Local Government (DCLG). Their strong support and commitment has been vital in achieving rapid progress and we will continue to work with them to implement our plans. We have signed an agreement for how we will work with PHE as a devolved system and will sign agreements with the remaining national bodies before the end of March 2016.

The Plan is built from locality plans, NHS provider plans and GM work stream plans.

Locality plans

We have based this Plan on the ten localities - Bolton, Bury, Rochdale (including Heywood and Middleton) Manchester, Oldham, Salford, Stockport, Tameside (including Glossop), Trafford and Wigan.

Each of our ten localities has a place-based plan which will be signed off by their Health and Wellbeing Board.

The locality plans form the bedrock of what will be delivered in their area and set out how the savings from the integrated better

care models and prevention will be delivered. The plans have been developed from work already underway to develop Better Care Fund (the integration of health and social care funding) plans, but have been radically extended across public sector services to integrate social care, mental health and learning disability services.

Each locality will start to align the CCG and local authority commissioning functions from April 2016 to develop a single commissioning plan, pool budgets, integrate governance, decision-making and commissioning skills. Across GM we have committed to pool £2.7 billion. This will ensure the outcomes, that health and wider public services aim to achieve, are aligned.

The plans also outline the intention to create single service models in each locality delivered through integrated neighbourhood teams, to remove the fragmentation between services.

Work will focus on aligning primary and community care to ensure high quality re-ablement, rehabilitation, discharges and referral management.

Sharing these plans has enabled us to see where there is best practice in our localities, identify opportunities to scale up and roll out changes and determine the key priorities for delivery in the next five years and beyond to integrate our public service offer.

Each locality plan includes a place-based ambition to contribute towards the delivery of the wider GM ambition. They capture the full range of initiatives to improve health and wellbeing and many go beyond traditional health services to include work on housing, employment, Early Years, Troubled Families and community development.

NHS provider plans

All of the NHS providers in GM agree plans each year to run their services, including hospitals. These have always been agreed in individual organisations and with the people who regulate trusts (NHS Improvement - Monitor, Trust Development Authority). For the first time, the 15 individual provider plans have been shared across GM between providers and with commissioners. The providers are working together with their commissioners to deliver local requirements, but are also working on some key work streams together where this makes sense.

GM work stream plans

Work in our localities alone will not fully address our financial sustainability challenge and in some cases there can be a greater benefit to plan and commission services at a cluster or GM level. We are always striving to integrate and provide services at the level closest to where people receive them, but how we change some services and connect people to the growth and economic reform opportunities is better done once at a GM level. This approach enables us to understand when we need to propose bold ideas that can only be planned and commissioned at a cluster or GM level, but will need to be delivered in the context of our neighbourhoods and localities.

We have developed and agreed plans which are aiming to address some of the specific challenges that exist across all localities in GM, like mental health, cancer, high levels of unemployment and deprivation. We have focussed these on areas where it makes sense to do the thinking once and agree how we can improve health care and support for people. The GM strategies include:

- Primary Care
- Specialised services
- Mental Health
- Public Service Reform programmes
- Cancer
- Learning Disabilities
- Dementia
- GM information sharing: GM Connect

Agreeing how we work and take decisions

To successfully deliver our Plan and deliver the change that is required, the 37 statutory organisations involved in health and social care across GM have formally agreed to a new governance system – the first time this has been accomplished at this scale in England. This will enable GM to establish integrated leadership founded upon collaboration and evidence-based decisions about services delivered to GM people. Commissioning will be undertaken in accordance with statutory responsibilities at locality level or when it is most appropriate, by commissioners collaborating at GM level.

Our governance system is based on the principles agreed in the MOU:

- GM NHS will remain within the NHS and subject to the NHS Constitution and Mandate
- Decisions will be taken at the most appropriate level
- GM will take decisions that are relevant to GM
- CCGs and local authorities will retain their statutory functions and their existing accountabilities for current funding flows
- Clear agreements will be in place between CCGs and local authorities to underpin the governance arrangements
- GM commissioners, providers, patients and public will shape the future of GM health and social care together
- All decisions about GM health and social care to be taken with GM as soon as possible

The new governance structure has:

- A Strategic Partnership Board (SPB) which sets the vision, direction and strategy for the GM health and social care economy
- A Strategic Partnership Board Executive (SPB Executive) which supports the SPB and will develop policy and make recommendations to the Board. It will be the engine that drives delivery of the Plan and ensures business at the Board is transacted efficiently
- A Joint Commissioning Board (JCB) which commissions services at the GM level to deliver the vision set out by the SPB. It will be the largest single commissioning vehicle in GM and will produce a commissioning strategy in line with the Plan. The decisions it takes will be joint and binding
- An NHS Provider Trust Federation Board where the 15 trusts in GM have joined together to allow them to work more effectively and efficiently
- An overarching Provider Forum which will bring together NHS and non-NHS providers (domiciliary providers, private sector health providers, voluntary and hospices) to be part of the development of new models of care
- Primary Care is represented at the SPB and SPB Executive and has also formed a Primary Care Advisory Group made up of representatives from Dentistry, General Practice, Pharmacy and Optometry

The members of these groups come from all 37 statutory GM health and social care organisations plus national bodies as appropriate (NHS England, NHS Improvement and others), as well as other providers and representatives from primary care, the voluntary sector and patients, including Healthwatch.

A key principle of the governance arrangements is that local commissioning will remain a local responsibility. The JCB will intervene in local decisions only where it agrees that it would be more efficient and effective for decisions to be made at a GM level.

Some national services (for example highly specialised services) will remain within the remit of NHS England, for practical and cost effectiveness reasons, and will be co-commissioned in many circumstances.

These arrangements will enable us to be clear about responsibility, accountability and assurance around the decisions that we take together.

Chapter 4

Health and social care reform

Summary

Our health and social care reform is built on the need to reimagine services across our whole care system.

By upgrading prevention and self-care we are proposing to change the way GM people view and use public services, creating a new relationship between people and public services. This means more people managing their health, looking after themselves and each other. This means increasing early intervention at scale and finding the missing thousands who have conditions, but do not know it yet. We want to work across GM to have standardised support that helps people to start well, live well and age well.

Through the transformation of community based care and support we are proposing to enhance our primary care services, with local GPs driving new models of care and Local Care Organisations (LCO) forming to include community, social care, acute, mental health services, the full range of third sector providers and other local providers such as schools. We want LCOs to be the place where most people use and access services, in their communities, close to home.

Through the standardisation of acute and specialist care we are proposing that NHS providers across GM increasingly work together and collaborate across a range of clinical services. We want a sector which is functioning to the best clinical pathways and the highest level of productivity so people get high quality care when they need it.

Through the standardisation of clinical support and back office functions we are proposing to redesign our services to meet the delivery and efficiency challenges of a redesigned care system. We want clinical support services which deliver at locality level and back office functions which drive the best possible service models for procurement, pharmacy and estate management.

In enabling better care we are proposing to work together to look at the most effective way to deliver our new care models and deliver standardised offers. We want a radically redesigned payment system to drive care in localities, we want technology to support this, we want an innovative and real time approach to research and development and we want one integrated approach to managing our public sector buildings.

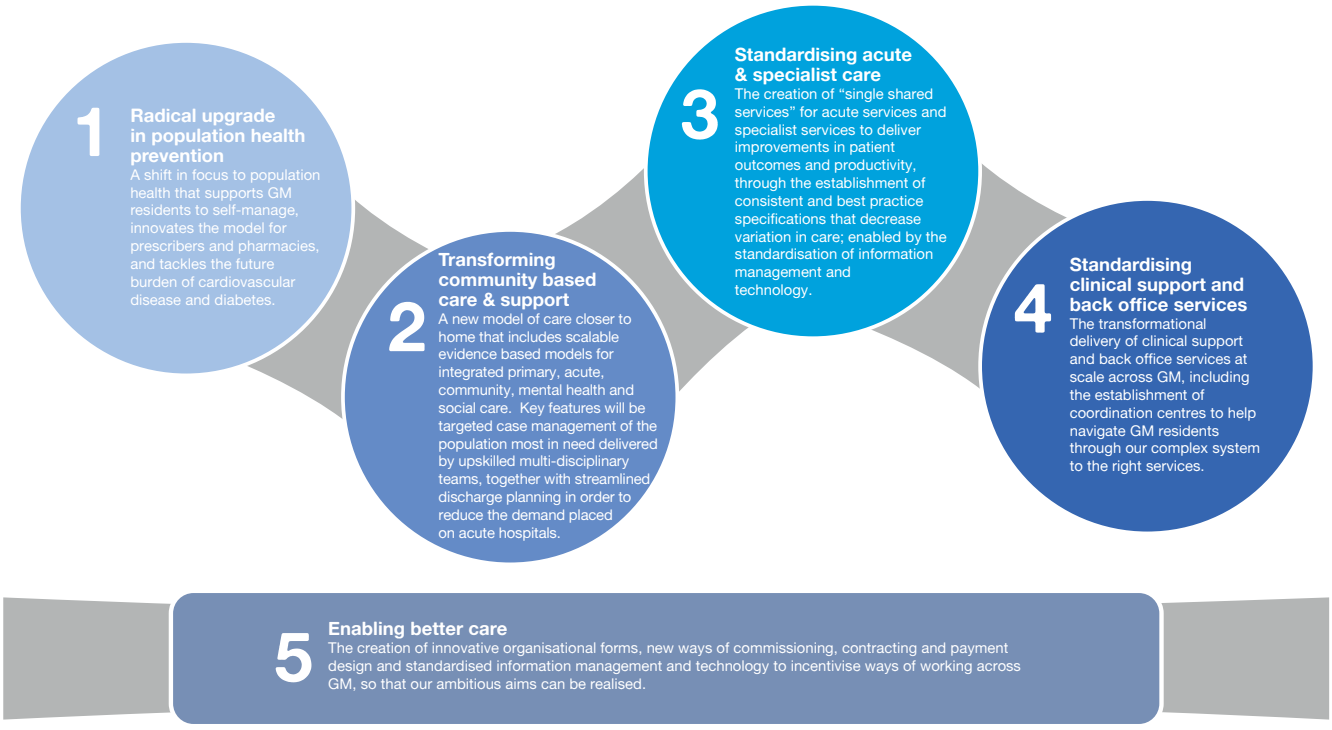
The Plan

Reimagining services across our whole care system

It is widely accepted that GM will not meet the challenges it faces over the next five years through incremental change. Additionally, no single locality can deliver the scale of reform proposed here acting alone. Our transformation must be comprehensive, covering all aspects of care and support and all parts of GM.

Engagement with NHS commissioners, providers and local authorities, alongside best practice from national and international experts has identified five key areas for transformational change, as in the diagram below.

By upgrading prevention and self-care we are proposing to change the way GM people view and use public services, creating a new relationship between people and public services. This means more people managing their health, people looking after themselves and each other. This means increasing early intervention at scale and finding the 'missing thousands' who have diseases, but do not know it yet. We want to work across GM to have standardised support that helps people to start well, live well and age well.



Through the transformation of community based care and support we are proposing to transform our primary care services, with local GPs driving new models of care and Local Care Organisations (LCOs) forming to include community, social care, acute, mental health services and the full range of third sector providers. We want LCOs to be the place where most people use and access services, in their communities, close to home.

Each locality will have a joined up commissioning approach between the local authority and health partners, using pooled funds for a substantive proportion of the health and social care spend. Joint spending plans will be agreed to deliver shared improved outcomes for their local people.

These services will be delivered through the range of models described in the NHS England Five Year Forward View. The choice of model will be relevant to the local circumstances (multi-specialty community provider (MSCP), primary and acute care system (PACS), integrated care organisations (ICO), accountable care organisations (ACO) and accountable healthcare management organisations (AHMO)) but will hold a range of common features to ensure scale of impact. Across all the GM localities, we will refer to these as LCOs.

Through the standardisation of acute and specialist care we are proposing that NHS providers across GM increasingly work together and collaborate across a range of clinical services.

We want a hospital sector which is functioning to the best clinical pathways and the highest level of productivity which means that people get high quality care when they need it.

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1. Radical upgrade in population

The future health of our children, the sustainability of the NHS and the economic prosperity of GM all now depend on a radical upgrade in prevention and public health, as the NHS England Five Year Forward View made clear.

Our progress in achieving wider public service integration is key to securing the health benefit of non-medical support and helping our health and care system function better. This can span from early help to crisis response across the whole public service, alongside the voluntary and community sector, to ensure our blend of support is as effective and appropriate as it can be.

For example, connecting health and care to housing providers will extend their established role in building communities and improving individual wellbeing by working in partnership across the region to support health services, particularly around prevention, early intervention and re-ablement. Additionally, GM is clear on the health benefit brought by the fire service as an expert in prevention and community engagement. Greater Manchester Fire and Rescue Service now acts as a prevention agent on behalf of all health and care partners whilst continuing to reduce demand relating to fire.

Our aim is to boost independence, improve health and reduce demand on services, through five key themes:

1: More people managing health: people looking after themselves and each other

The influence of people's behaviour on health outcomes can be seen in everything from preventing illness through to the management of long term conditions. 60-70 per cent of premature deaths are caused by behaviours that could be changed and around 70-80 per cent of all people with long term conditions can be supported to manage their own condition.

Our ambition is to develop a whole systems approach to self-care, which can be adopted across localities. This will entail changes in commissioning, organisational and clinical processes, workforce development and the support provided to individuals and communities.

Key elements of our programme are:

- Working with Health Innovation Manchester to develop new digital technologies to allow people to track and analyse their own health data and to share this with others to aid prevention and management of long term illnesses

- Large scale social marketing programmes, using behavioural insights, to support lifestyle change and engage the population to be more active in promoting their own and others' health
- Developing a GM framework for 'patient activation', motivating people to take control and supporting work to tackle health inequalities
- Increasing the range and profile of self-care support programmes and train our workforce to deliver them
- Working with Health Education England (HEE) to upskill our public sector workforce in key areas of practice such as self-management education, shared decision making, health coaching and patient activation
- Working to embed social responsibility across our public sector

2. Increasing early intervention at scale – finding the missing thousands:

Late diagnosis causes unnecessary suffering and means diseases are harder and more expensive to treat. We only know about half of the preventable disease that exists in our population. The people with illnesses we - and often they - do not yet know about are called 'the missing thousands'.

Finding people who already have, or who are at risk of developing, disease and successfully managing their condition(s) is crucial to prevent illnesses across GM and to reduce mortality, morbidity and inequalities in health.

Key elements of our programme are:

- Bringing together our screening and immunisation commissioning and our public health people to form an integrated commissioning team
- Implementing the evidence base for early detection of disease through screening and case finding to find the missing thousands who have a condition but have not yet been diagnosed. This will be supported by better information on a range of conditions including online advice, discussion forums and self-management programmes to empower people to look after themselves
- Proactively reaching out to people registered on a GP list who do not attend GP practices, to engage with the community and create a cultural movement for health awareness and improvement

3. Starting Well – supporting parents to give their children the best possible start in life

GM has consistently recognised the importance of a child's early years in achieving our long term ambition for growth and reform. Enabling parents to give their children the best possible start in life is essential in helping children reach a good level of development as measured by school readiness. Children who do not achieve a good level of development at age five will struggle in later years with social skills, reading, maths, physical skills and overall educational outcomes. They are more likely to experience difficulties with the criminal justice system, have poorer health and job prospects and ultimately die younger.

Across GM the percentage of children achieving a Good Level of Development (GLD) is 62.4 per cent compared with 66 per cent nationally. Within this there is significant variation across GM itself with some localities achieving 73.4 per cent whilst others only achieve 57.2 per cent. Creating consistency of achievement without stifling innovation and further progress in other areas is a key challenge to our GM programme.

Our Early Years New Delivery Model is based on consistent age appropriate assessment measures promoting early intervention and prevention, implemented through improved engagement with families with young children from pre-birth to school. This is supported by a series of evidence based interventions supporting short and long term benefits.

We will make sure children are ready to start school by:

- Prioritising delivery and effectiveness of universal and targeted services in the antenatal period and to children age 0-5 and their families
- Early identification of risks and developmental delays supported by evidence based assessments and interventions
- A GM wide approach to further improving high quality early education and child care and increasing the skills and qualifications of the early years and child care workforce
- Helping parents who are out of work to access education and training to help them towards work
- Focusing on prevention and early intervention through consistently high quality universal/early help services through maternity services, health visiting, Children's Centres and early education providers
- Addressing health and social inequalities by improving the physical and emotional health and wellbeing of the 0-5 population and their families
- Delivering integrated commissioning and provision across all early years services focused on: parent and infant mental health; maternity/health visiting communication; speech, communication and language; social, emotional and behavioural pathway including parenting; high needs pathway for vulnerable children and complex families
- Further improving the quality of early education for 2, 3 and 4 year olds including effective support to providers to increase the accuracy and use of assessment tools and information to improve outcomes for the most vulnerable children, making best use of the Early Years Pupil Premium and supporting effective transition to primary school.

In July 2015, the Government and local authorities agreed to undertake a fundamental review of the way that all our services to children are delivered. As a trailblazer, the Government will support the GMCA to develop and implement an integrated approach to preventative services for children and young people by April 2017.

4. Living well in Greater Manchester 'Good work – good health'

A healthy workforce can reduce sickness absence, lower staff turnover and boost productivity - this is good for employers, workers and the wider economy. We know that people in work tend to enjoy healthier lives than those out of work, and people with health conditions such as back pain, stress, depression and high blood pressure, find that getting back to work is often the best way to recover and that it isn't always necessary to be 100 per cent fit before returning.

Approximately 683,000 adults in GM have a mental health or wellbeing issue which can affect everything from health, to employment, parenting and housing.

Key elements of our programme are:

- In partnership with employers, we will establish a workplace wellbeing charter which will provide employers, of all sizes and from all sectors, with a way of improving workplace health and wellbeing.
- We will roll out the Work for Health programme which helps patients to better manage their health conditions and to stay in work by training front line health staff to consider work as part of the therapeutic intervention, encouraging self-management and problem solving.
- We will launch a programme in a number of neighbourhoods to help older people into work.
- Expanding our Working Well programme will support up to 50,000 GM people who are

claiming a range of out of work benefits and experiencing barriers to employment. The programme will fundamentally change how skills, health and employment services function together.

- Establishing the Working Well Talking Therapies service, as part of our participation in the national Mental Health Trailblazer programme. This aims to improve employment and health outcomes for out-of-work claimants who face barriers to work due to common mental health conditions.
- Improving mental wellbeing and providing high quality mental health services as part of the overarching GM Mental Health Strategy.
- 'Supporting Healthier Lifestyles' will explore the potential of a devolved and flexible approach to licensing, regulatory compliance and enforcement, particularly in support of the proposal to introduce 'Promoting Public Health' as a fifth licensing objective across GM. This would enable localities to consider the impact of alcohol consumption on communities, proactively encourage licensed premises to promote responsible drinking and to play a key role in identifying and supporting those for whom alcohol is a problem.
- 'GM Moving' our physical activity strategy outlines a series of ten pledges that will add value locally and at a GM level. Already this has seen a significant increase in the number of opportunities to participate in recreational cycling, with 4,000 ride opportunities being delivered across GM by March 2016 through investment from the Department for Transport and British Cycling.

5. Helping people age well

GM has an ageing population and we know we need to focus on helping older people stay well longer and supporting them to cope better if they have a long term illness, especially dementia.

More than a fifth of GM's 50-64 age group are out of work and on benefits, many because of ill health. The employment rate is 5.3 per cent below the England average and the gap has not narrowed for ten years. Unemployment imposes a significant burden on health and care services and the numbers in this age group are set to grow by 20 per cent in the next decade. Bringing the employment rate for 50-64 year olds up to the UK average would boost GM's earnings by £813.6 million.

By 2021, it is estimated there will be nearly 35,000 people living with dementia in GM, a quarter (25 per cent) with mild symptoms, almost half (45 per cent) with moderate symptoms and nearly a third (30 per cent) with severe symptoms, requiring 24 hour care. The current cost of caring for them is estimated at £270 million annually, rising to £375million in 2021. Integrated services are vital, without early diagnosis, good access, good co-ordination, and good support, suffering is increased and costs rise.

From April 2016, we will:

- Launch a programme in a number of neighbourhoods to help older people into work. The programme will be expanded as funds become available. We aim to increase the number of long term workless adults in employment by eight percent over five years.
- Establish the GM Ageing Well Hub to make GM an age-friendly city region. It will provide links to social movements to address social isolation and loneliness and have a focus on dementia
- The Dementia United programme for GM that serves as a beacon for the UK, supporting people newly diagnosed with dementia with a case worker (further details are in Chapter 2).

2. Transforming community based

GM has one of the highest rates of emergency hospital admission for conditions that would be better treated in the community. At any one time an estimated 2500 patients are in an acute hospital bed in GM, who could be treated at home or in a community setting, which would be preferable for the patient and more cost effective.

Fragmentation in services is seen most clearly in the referral into acute services and on discharge from them; between primary, community and social care, between those services and wider public services which can enhance health outcomes or prevent poor health emerging, such as housing, fire and rescue and employment services.

A key aim of combining the health and social care budgets is to enable care to be moved out of hospitals (where appropriate) into the community, closer to where patients want to be – at home. Even more significant however, will be our ability to radically reduce the demand for acute services through population level, integrated, community care and support which slows, or prevents altogether, the development of poor health.

Bringing GPs, community pharmacists, social workers, hospital doctors and community nursing teams together with a population focus, will help to make the connections between social and medical support, tackle loneliness and strengthen communities.

The sustainability of our hospital system will increasingly depend upon our ability to secure the right level of investment and capacity in community models to reduce demand on crisis and emergency services and facilitate reliable discharge home. The contribution to mainstream savings in this and the next Spending Review (SR) period are increasingly significant.

A focus on early intervention and prevention is a cornerstone of our approach to health and social care reform, ensuring we identify and treat early, reducing escalation of need. But this approach will only be successful if delivered alongside broader integration across local services. Across GM, we are seeking to tackle the complex issues that lead to escalating public service pressure in an integrated way. We will therefore not only bring together health and social care provision but a much wider range of organisations and services, tackling broader forms of complex public service demand.

Our ten localities and the neighbourhoods within them, will develop and design delivery models that fit the needs of their people and at a GM level. We will agree the core characteristics, common standards and key outcomes that those models will aim to deliver. A reformed system must recognise the limits of what formal care provision can offer and the important role of the 'informal' voluntary and community sector. The model of care needs to be

built around the person first and foremost, bridging some of the unnecessary splits between 'health' services and 'social care' services.

Primary care, social care and community services

Primary care is the driving force behind our prevention-focused approach within localities and across GM. Primary care is working to integrate and lead a wider public service community-based model, through the agreement of standards, which will be delivered within each locality of GM and the testing of new models of contracts for GPs, which promote prevention and self-management. This will be at the heart of a new model of care to predict and prevent ill health utilising the power of the registered list.

Social care, both publicly and privately provided, will be an integral part of the community service model working to reduce demand for acute services. Our new models will look to expand the role of services like leisure and libraries and further develop alternative and preventative community-based approaches from the voluntary and community sector. Assessment processes will concentrate on the individual and their aspirations, maximising what they can do, not what they cannot do.

GM needs a system of community care that enables people to step up / step down their support flexibly and easily, ensuring people receive the right type of care at the right time. Currently too many people are going into residential and nursing care, particularly from hospital, in part because of a lack of clear and planned alternatives.

- We will make every contact with public services count by ensuring our staff are able to understand the needs of the people they come into contact with and signpost them to the most appropriate service(s) for their needs.
- We will train our staff in recognising prevention, identifying risks, supporting discharge from hospital and transfer between services.
- The development of our current and future workforce is core to the development of our community services to enable our staff to work with communities and support people to have the knowledge, skills and confidence to take an active role in managing their own health.

The establishment of fully integrated Local Care Organisations (LCOs)

The community service models chosen within each of our localities varies depending on the objectives they are trying to achieve, but the essential characteristics of the models are the same.

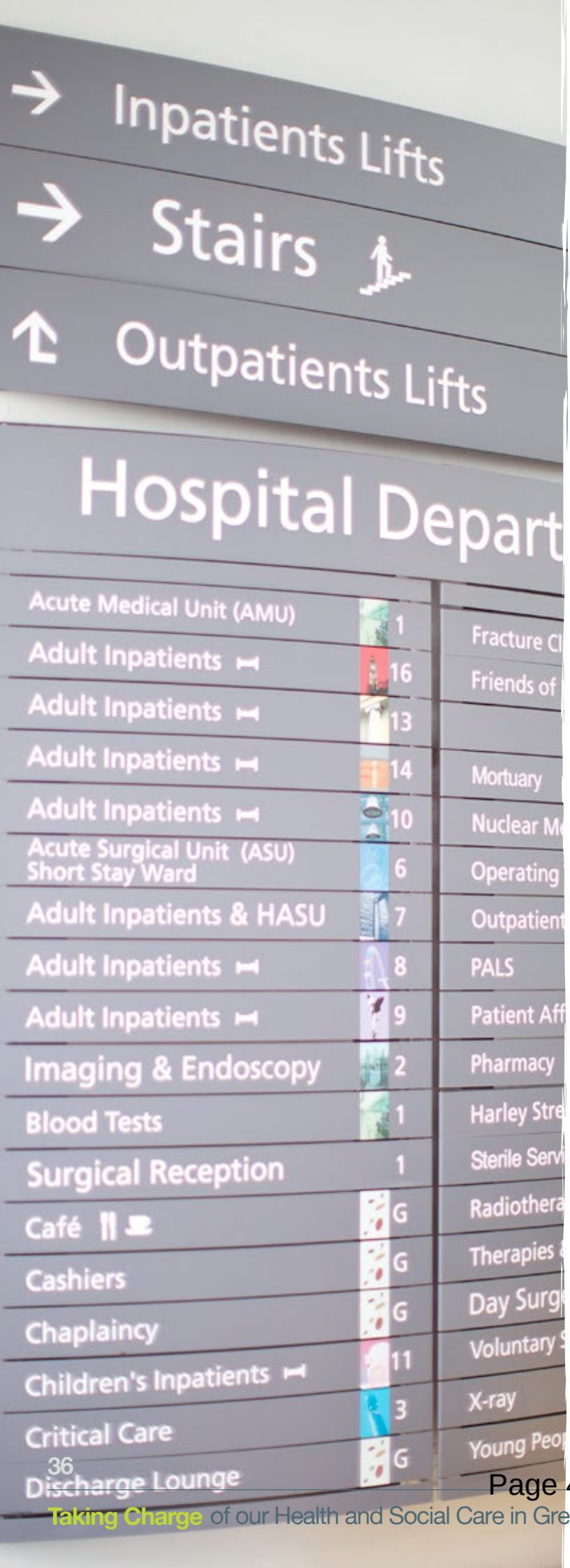
Health and social care providers will work collaboratively to provide care to a defined population (predominantly led by primary care). LCOs is a term developed at a GM level to describe how across GM, we will secure, in all parts of the conurbation, the principal features of a proactive, preventative, population health model, which delivers consistently high outcomes. It takes the best of local, national and international learning from Accountable Care Organisations and applies them to the GM context.

Primary care standards agreed at a GM level will be delivered within each locality to ensure that primary care drives our prevention-focussed approach within localities and across GM.

The LCO and its member organisations will be collectively accountable for delivery. The key elements of our programme from April 2016 are:

1. Enable conditions to be managed at home and in the community

People will only need to tell their story once and self-care will be encouraged and enabled.



We will introduce multi-disciplinary neighbourhood integrated care teams, built from clustered general practice, coordinating the care for a defined group of people (children and adults) using evidence-based pathways.

The locality approach will facilitate strengthened links with community groups and the voluntary sector and connect people to their local networks to promote independence and self-care.

The new models of provision in our localities will bring specialist acute-based consultants and nurses into the neighbourhood model via technology or face to face visits where necessary.

Technology has a critical role to play. Assistive technology like telecare can reduce the number of bed days and the level of home care needed. There is more detail later in this chapter.

2. Provide alternatives to A&E when crises occur

LCOs will develop models of care and support, which provide alternatives to hospital when crisis occurs. It is acknowledged that no community model could keep us all well all of the time, but it can provide safe, responsive and effective urgent care services that keep people out of hospital (unless it is appropriate for them to be there) and at home. Our community services in our localities will use different rapid response models, but they will all aim to achieve the same outcome to manage people as close to home as possible.

These local models will ensure that the estimated 2500 patients in an acute hospital bed in any given day in GM who do not need to be there, are treated more effectively and appropriately closer to home. The concept of 'virtual beds' is already an established model, a model of care that manages both step-up and step-down pathways for people with urgent care, rehabilitation and/or re-ablement needs.

We will ensure our system works to a common set of objectives, with an emphasis on improving outcomes and the principles of re-ablement. It will meet the aspirations of people with care and

support needs, support people to live well in the community, prevent people with significant health or care needs from having to use residential or nursing care and hospital; and help people with care needs maintain themselves in the community.

3. Support effective discharge from hospital

Our staff in our hospitals and in our community services work hard on a daily basis to ensure that patients are discharged in a safe and timely manner back to their chosen setting, but there are challenges due to different processes and requirements for the agencies concerned.

Our hospitals will work with the patient, their family/support networks and their GP to a planned date of discharge upon admission, they will ensure the patient is medically fit for transfer and then work with community services to ensure that the support services are in place when they transfer to their chosen next care setting.

We will build on work in our localities to introduce a standardised, streamlined discharge service and aim to develop an agreed GM discharge framework, which is focused on the standards that the people of GM expect to be delivered when patients are discharged and help them return home safely with a co-ordinated discharge plan.

4. Help people return home and stay well

It is important that patients leave hospital with a clear discharge plan that is communicated to their GP, families, relevant agencies and support networks within their community, with a clear understanding of who they need to contact if they are concerned.

This will require integrated working between integrated neighbourhood teams, GPs and hospital teams to agree care or support programmes.

Vanguards

In GM, NHS England has announced four Vanguards which are testing the implementation of new models of care to improve and integrate services as described in NHS England's Five Year Forward View:

- Salford Together (Integrated primary and acute care system – PACS).
- Stockport Together (Multi-specialty Community Provider - MSCP).
- Salford and Wigan Foundation Chain (Multispecialty chain).
- Accountable Clinical Network for Cancer (ACNC).

In GM, we recognise that new models of care need to be implemented in all our localities to address our system challenges. This will require an open and transparent approach which supports innovation and the testing of new ideas. The Vanguards have enabled work within three localities and across GM to take forward the design and implementation of a variety of new models of care as described in NHS England's Five year Forward View, and share their learning and the input from the national support team with the rest of the GM localities and our acute provider sectors.

3. Standardising acute & specialist

There are 15 NHS trusts and foundation trusts providing acute, mental health and community care across GM. Their dedicated staff deliver high quality care to the population of the region in the face of growing demand and tight budgets.

The present system is, however, not financially sustainable and it does not deliver the consistently high standards our population deserve. The total forecast deficit for these provider organisations is forecast to be £1.4 billion by 2020/21 before taking account of cost improvements. NHS trusts in GM must change and evolve to meet today's demands and the changing demands of the future.

Plans for our acute services will be developed with the public, patients and carers. They will be generated through the GM governance arrangements and by the Provider Trust Federation Board to enable greater collaboration between trusts.

The focus of work for trusts will cover:

- Improving the safety and quality of services
- Improving productivity: hospitals are drawing up plans to achieve efficiency savings of 2.5 per cent in 2016/17, and 2 per cent per annum in subsequent years
- Improving delivery: hospitals are working to introduce new care models to avoid emergency admissions and cut very long lengths of acute hospital stays. Trusts are working to deliver the four priority clinical standards for seven day working as part of the first phase of implementation by 2017
- Increasing collaboration: trusts have agreed to a programme of collaborative efficiency and to joint working to achieve significant savings targets

Whilst a large part of the improvement in GM will come from investment in and expansion of prevention and integrated primary and community services, we want to improve the quality, consistency and efficiency of services across the region and make sure there are adequate specialist staff present at the time of high risk procedures. Providers in GM are already working together to a greater extent, in order to spread good clinical practice. This focuses on maintaining local access to clinical services which might otherwise not be sustainable due to workforce shortages as well as achieving economies of scale through sharing services across GM. This ensures that the vast majority of acute care remains accessible in local hospitals whilst only the more complex treatments are provided in specialist centres.

The GM programme Healthier Together first initiated this concept with identification of urgent and emergency care, acute medicine and general abdominal surgery as a single service; taking the first step towards greater transformations that will be extended to other specialties.

GM will quickly establish the most appropriate governance form to secure provider collaboration through the development of groups, multi-site providers, lead provider arrangements and specialty service

chains building on our learning from national Vanguards. This will be essential to allow the benefits of standardisation to be achieved at scale. This reform can identify the best evidenced-based practices for patients and provide decision support systems for clinicians. This means that key scaled up functions can be delivered across organisations and operational delivery can continue to be taken forward within organisations and at neighbourhood level. This will provide better outcomes and implementing standardised processes across a chain or group of providers will deliver better care at lower cost.

Organisations with a strong track record of high performance, able to support their staff to assist in local improvement and with the capability to develop standardised operating procedures, will share their skills and knowledge with organisations to support standardisation across the acute sector.

GM will develop a framework to determine which services will be delivered at which level; neighbourhoods, localities, clusters and across GM. In summary:

- Care that does not require a hospital stay will be provided locally
- In-patient emergency care and all in-patient surgery would be organised at a cluster or group level.
- Highly specialised services requiring specialist skills and infrastructure will be organised at a GM level.

We know that basing clinical care protocols on evidence can help reduce variations in the delivery of care, increase the quality of our services and reduce cost. GM will proactively enhance and standardise care models and operating procedures across services beyond those which are included within the shared service model so that procedures of the same type will follow an agreed protocol.

GM Trusts will develop a culture for improving standards. Clinicians will have to justify deviations from the agreed evidence pathway and these deviations and the associated reasons will be continuously monitored and reviewed (by shared clinical governance arrangements) to determine if the pathways need to be improved, updated or amended. Clinical care protocols will provide a clear audit trail, which can be used to quickly spot anything unusual and any decline in performance, as well as providing real time insight into where improvements are needed. This data will be shared with commissioners and regulators. This approach relies on improved methods to collect data, which will be developed as part of this work. The adoption of evidence based protocols will be supported by the role of Health Innovation Manchester.

From April 2016, we will:

- **Deliver most services locally**, in conjunction with each LCO
- **Build on Healthier Together** to share acute services at scale. Providers will find new ways of partnering and collaborating to improve acute and specialist services delivered to patients. This will be achieved through consolidating services at a cluster and GM level
- **Agree cluster level services**. Trusts will work collaboratively to form cluster or group-level services, and clinical staff will work together across a network of hospitals within the shared single service. Based on clinical evidence, this will drive improvement in standards of care across all hospitals as they follow a consistent approach for care delivery
- **Agree GM level services**. These services will be provided in one network across GM, potentially across multiple sites, but with a lead service provider responsible and accountable for service delivery. We already have some services like this including adult major trauma, paediatric services, secure mental health and most recently the cancer Vanguard.
- **Develop standardised treatment and care pathways**. Protocol based care will enable staff to put evidence into practice by addressing the key questions of what should be done, when, where and by whom. This standardisation of practice reduces variation in pathways and will improve the quality of care uniformly across GM

4. Standardising clinical support

The development of standardised clinical support and back office services across GM is a critical part of our transformation work.

Back Office

Shared services are no longer a radical new idea; they are an accepted part of business strategy that has repeatedly demonstrated its value. All public sector organisations in GM have common business functions including: finance; technology; business intelligence; human resources; procurement; transformation and property services. As such there is an opportunity to generate significant efficiencies through organisational collaboration. GM will pursue the potential outlined in Lord Carter's report and be an early, large scale delivery site for that work.

Developing a shared service model across GM will drive greater efficiency while delivering world class business solutions. A shared service centre will not only deliver consistency in back office functions across GM, but will deliver significant financial savings.

Care Co-ordination

GM is clear that the integration of health and social care commissioning, whether at a locality, cluster or GM level is key to delivering agreed and shared improvement outcomes for people. This joined up commissioning approach will deliver significant changes in commissioning activity, with a greater emphasis and investment in prevention and early intervention. This will allow GM commissioners to shift activity and expenditure from high cost parts of the system to (where appropriate) care and services delivered closer to people's homes.

This will need to be underpinned by an effective means of care co-ordination to consistently track risk, activity, resources and outcomes across population segments. This will require the adoption of a whole system approach and the establishment of a multi-agency care co-ordination centre, encompassing primary, secondary and social care provision.

This would be able to:

- Track and co-ordinate patient care in a locality or cluster of localities
- Utilise real time demand data to support more proactive care planning
- Reduce the variability in patient or cohort costs by limiting or avoiding high cost episodes

and back office services

- Generate total patient costing information to support lower average patient costs as more efficient and preventative care is incentivised
- A central clinical team would work to reduce variations in care, ensure that care pathways are adopted consistently and refine pathways in line with the most effective interventions

Shared Clinical Services

NHS providers are already working together on radically reviewing how shared clinical services could be provided at a pan GM level to enhance individual organisational efficiency. These are focussed on:

- Procurement of goods and services through improvement in economies of scale and reductions in product variation
- Review of Private Finance Initiative arrangements across GM in order to gain greater value from these contracts
- Revised pharmacy arrangements through the improvement of drug procurement, logistics and medicines optimisation
- Centralisation of back office functions by coordinating and providing these services at the appropriate geographical level
- Making better use of the public sector estate to ensure that estate owned and managed by NHS and local authorities is utilised efficiently and effectively, or disposed where it is not needed
- Appropriate centralisation of pathology and radiology services in line with the recommendations set out in Lord Carter's 'Review of Operational Productivity in Hospitals'

From April 2016, we will be developing:

- A single GM level shared service; bringing together a common platform for all of the public sector in GM
- A care co-ordination system for GM
- Implementing shared clinical support services across GM

5. Enabling better care

The tolerance of variation across health and social care service provision is one of our biggest challenges. In GM, our approach will see us no longer accept this wide variation of outcomes and service standards within and between organisations. GM will need to deliver a significant programme of standardisation.

New care organisations

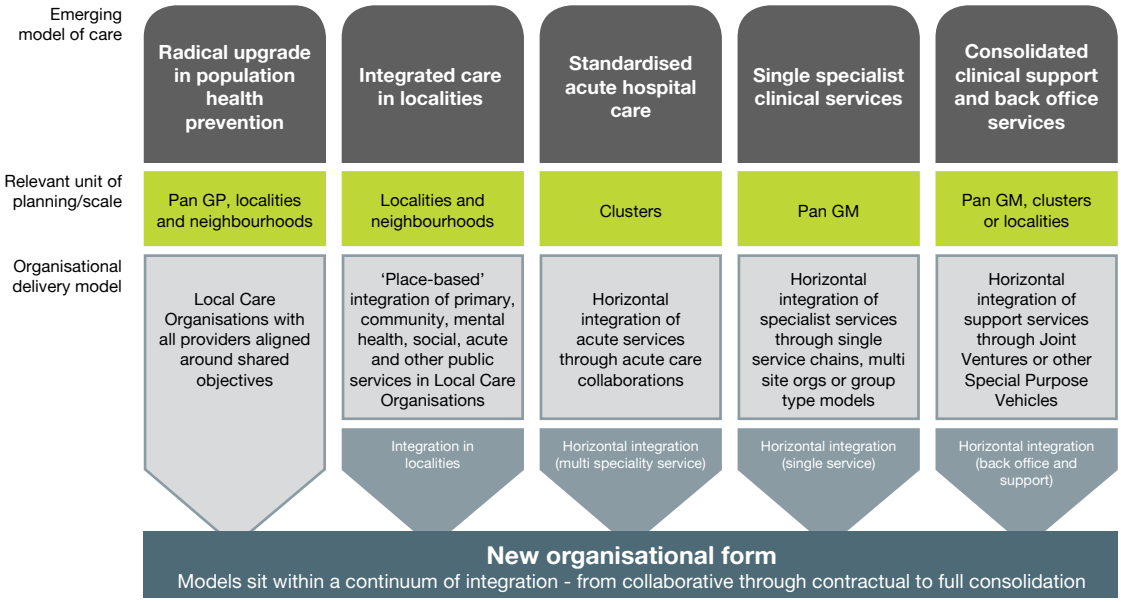
Health and social care providers in GM need to become more adept at standardisation and reliable implementation of best practice. Through our revised working arrangements, supported by our new governance structures, we will ensure that our new models of care remove tolerance to variation both in service delivery and standards.

There is growing consensus in GM that new organisational forms or delivery models will be required to enable integration and standardisation. To ensure that such integration and standardisation can occur, existing boundaries between organisations need to be removed. It is by removing these boundaries that efficiencies can be delivered and standardisation of service is achieved.

We will develop any changes with full discussion and, where appropriate, consultation.

It is clear that integration is required across different levels; horizontally across similar services and organisations, and vertically through different care settings.

There are a number of different options for organisational form, ranging from loose collaboration to full consolidation. Analysis of the potential options for the different types of integration has been undertaken and the table below represents the suggested models across each type of integration.



Contracts, payments and innovation

The successful delivery of new models of health and social care at locality, cluster and GM level will need to be driven through new, innovative, evidence-based contracting models and pricing mechanisms. The scope of these will need to be broad ranging covering all sectors and a wide range of providers.

The current Payment by Results system, agreed at a national level, albeit with local variation where appropriate, has created a system that incentivises different outcomes in different localities or providers. As a result it has failed to deliver whole system outcomes.

Whilst there will not be a one-size fits all approach, there will be a set of common principles across the whole of GM, and a defined list of options around contracting and payment choices. This will include primary care and specialised services as well as all the services currently commissioned by CCGs and local authorities. All models should:

- Incentivise cost reductions from efficiency improvements and effective demand management
- Incentivise integration within and across the health social and care system
- Facilitate a transparent and accountable pathway for patient outcomes
- Incentivise prevention to counter rising acute hospital care activity

It is recognised that the design of any such payment system will be complex and require specialist input through our partnerships established with national bodies including NHS Improvement, NHS England and DH.

Technology

In GM, many organisations still rely on inefficient paper based systems. Significant investment will be required to enable digital operation, without this investment it will not be possible to deliver a high quality efficient health and social care system.

Our new models of care will require technology enabled change. We will use technology to understand patient needs, and develop services more efficiently and effectively as a result. We want people to have greater access, ownership and responsibility over their own data, generating multiple ways to interact with the health and social care system and putting people at the heart of how their information is collected, stored and used. More effective use of information across organisations, driven by patient ownership, will reduce duplication and ensure more speedy access to the right services.

We want technology to support self-management, from staying well to living well with long term conditions. We need to share data and information across organisations on a day to day basis to support assessment, triage and integrated multi-agency case management.

The health and social care system in GM will work with the wider public sector on the implementation of our information sharing strategy GM-Connect. As part of the wider GM reform activity, GM-Connect will establish a new data commission for GM that will own the data sharing mandate and will deliver GM wide solutions for employees and people to access, update and analyse data. Implementation of GM-Connect will start in January 2016.

Accelerating discovery

Developing, testing and implementing new ideas takes too long. Fragmentation in funding, organisation approach and regulatory systems all slow up the process. This needs to change.

GM, supported by its three large teaching hospitals, a research-led university base, a critical mass of life science firms and skilled workers, and a large and diverse population, is putting innovation at the heart of its health and social care system.

Health Innovation Manchester will draw on the collective expertise of all partners from health and social care providers, academia and industry collaborators to address the health needs of the local population.

At the same time it will deliver economic benefits through manufacture and commercialisation. We aim to create one of the best regions in the world for innovative life science companies to be involved as partners. Additional detail on this is in Chapter 2

Buildings

The estate varies significantly in terms of quality, condition and suitability. Some of the estate is in excellent condition providing state of the art facilities, whilst at the other end of the scale there are a lot of properties that are in very poor condition and no-longer fit for purpose.

Estates is a critical enabler of the GM health and social care transformation programme which must continue to be fully informed and led by frontline service strategy. Collaborative working across GM agencies is well established and effective however it is recognised that a lot more is required to improve health outcomes for the people of GM and to increase efficiency.

The public sector estate in GM is under-used. Making the best use of the property and space available is a key part of GM's health and social care transformation plans. It is also vital to supporting our economic growth. The GM One Public Estate initiative is aimed at using public sector property assets as a single resource across organisations.

Integrating health and social care services across the region will mean changes are required to the buildings from which the services are delivered. A focus on prevention and care provided nearer to the home will mean that more facilities will be required in the community. This may result in the way that land is used at hospital sites changing as we need to ensure that our estate is able to respond to changing needs and demands of our people.

A rationalisation of our public sector estate will inevitably free up much needed space that is required to support our economic growth both through new housing and employment sites.

Current ownership and management of the public sector estate is complex. In the NHS, buildings are owned and managed by NHS trusts, foundation trusts, GPs, Community Health Partnerships, private landlords, NHS England and NHS Property Services.

To ensure we make best use of this estate we will develop a NHS Estates GM Delivery Team who will work closely with colleagues from across the public sector to deliver a 'one public estate' approach to property management.

A GM Strategic Estates Planning Board will be formed, which will be responsible for translating strategic requirements into a set of GM estates targets, ensuring it meets local health and social care needs. It will develop a clear framework to enable GM to make better investment decisions, for example in primary care, and to ensure that the buildings required to deliver new models of care can be realised.

To ensure we are able to reconfigure the GM public sector estate in a way that supports our transformed services we have requested that any receipts received from disposing of capital assets is be retained within GM for re-investment.

From April 2016, we will:

- Develop one public estate for GM and agreement of a framework to make estate investment decisions
- Develop the GM Estates Framework focusing on the following key elements:
  - Control - public bodies in GM have control over all estate policies, procedure, decision making and allocation of resources
  - Ability to incentivise - ability to retain and share savings and value released to fund change and align objectives across public bodies and departmental silos; introduction of locally aligned incentives
  - Funding – public bodies in GM have control over spending, receipts and associated revenue costs; pump prime funding for example to support asset rationalisation and improvements to the retained estate; ability to recycle savings and receipts for estates transformation
- Each locality will have a draft Strategic Estates Plan by the end of December 2015, which will be aligned to the locality and GM plan. In accordance with DH guidance with target savings/utilisations applied to each to deliver over a period of time and these will be further developed and implemented.

Chapter 5

Financial plan

Summary

In order to achieve our ambitions, we need the £6 billion invested in health and social care to flow differently around our system. We have produced a detailed GM financial plan which shows how we see the £2 billion gap emerging over the next five years.

This integrated plan, the first of its kind, enables us to drive change within the transformation areas described earlier and outlines the actions we will take to close the £2 billion gap over the next five years.

Central to the delivery of the Plan is the ability to access the Transformation Fund (TF) from NHS England across our GM system. This will enable us to develop new models of care to change the nature of demand and keep services safe and sustainable, while we make this radical shift.

The financial challenge

The integration of health and social care is a fundamental part of the growth and reform strategy essential to GM's priority of reducing unemployment, supporting people back into work, and providing growth through innovation. It is a key driver to ensure that the health and social care system becomes financially sustainable over time.

The population of GM is 2.8 million with forecast spend of £7.7 billion on health and social care services. This includes £6.2 billion on health services including mental health, GP services, specialist services and prescribed drugs and £1.5 billion on local authority, public health and social care services.

After taking into account the resources that are likely to be available and the pressures that the health and social care system will face over the next five years it is estimated that there will be a financial deficit of £2 billion by 2020/21. The scale of the challenge demonstrates why radical change is needed, both in the way services are delivered and in the way people use them.

Comprehensive Spending Review (CSR) assumptions

As described in chapter 2, the MoU outlined a 'road map' leading to full devolution on 1st April 2016. A key element of the MoU was the development of this Plan, including access to a Transformation Fund (TF) to enable us to deliver clinical and financial sustainability over the next five years. In order to support us to achieve this, the recent CSR settlement proposed the following for GM:

- A fair share of the additional funding of £8 billion that had been identified for health care nationally
- Funding to enable social care activity to continue at the current level in line with NHS England's assumptions in the Five Year Forward View
- Additional one off transformation funding of £500m to support the delivery of the savings opportunities
- Access to capital funding to support areas such as the development of a single patient record and for the reconfiguration of the health and social care estate required

GM submitted a high level Strategic Financial Plan in August 2015 to Government and NHS England as part of the CSR. This set out how it intended to meet the clinical and financial challenges over the five year CSR period and what was specifically required to significantly close the £2 billion financial gap.

Alongside GM's fair share of on-going funding in line with NHS England's Five Year Forward View (which would close the gap by £700m) proposals were shown to deliver a further £1.5 billion of savings, after reprovision costs, from the following areas:

- £70 million from prevention
- £488 million from better care models delivered across NHS and local authority commissioners and providers
- £139 million from reform of NHS trusts
- £21 million from commissioner collaboration
- £836 million from NHS provider productivity savings and joint working

Delivering these changes is estimated to cost £200 million in capital charges leaving a net saving of £1.3 billion.

In addition to the above, benefits to the wider economy are expected through increased employment and productivity in the workplace, estimated at £160 million to £315 million.

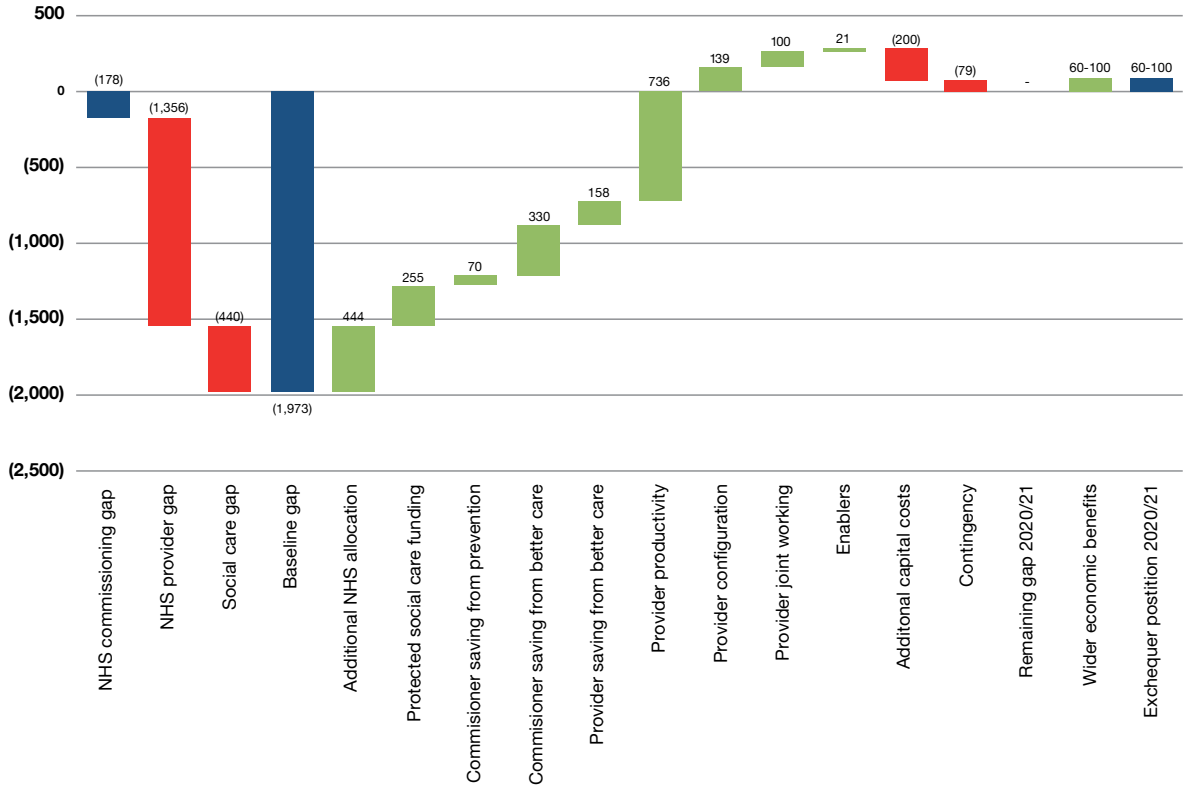
The bridge diagram below summarises the Strategic Financial Framework that was submitted as part of the CSR.

The Plan describes how these savings will be achieved. Key to this is the implementation of the new models of care in line with the transformation themes outlined in chapter 4 of this document. These provide the framework for a radical transformation of health and social care and will significantly impact upon patterns of demand. These are grouped into five main themes:

- Radical upgrade in population health and prevention
- Transforming community based care and support
- Standardising acute and specialist care
- Standardising clinical support and back office services
- Enabling better care

The TF described in the CSR is required to support the delivery of the significant change

Impact of GM strategic plan on the health and social care challenges



that GM will start to deliver from 1st April 2016. Achieving transformation of this nature requires critical enablers to be put in place, including an investment in the non-recurrent cost of putting new delivery models in place (including funding costs of staff development and new payment models), information and technology, community-based facilities and the renewal and adjustment to hospital capacity.

The TF will consist of £77m one off costs to enable delivery of change and £423m double running costs to support the implementation the new service models and change to existing models. In return for access to this funding, GM will deliver the £1.5bn cumulative savings, use of the fund will be fiscally neutral and GM would be clinically and financially sustainable by 2020/21.

Fundamental to the delivery of transformation is the work set out in the locality and provider plans which is underpinned by the pooling of budgets at scale at locality level, access to transformation funding for delivering the enablers and the dual running costs for moving to new models of care.

Financial assumptions to be agreed

The Strategic Financial Framework contains assumptions on:

- The future levels of funding available across health and social care
- Treatment of provider deficits
- Tariff deflator assumptions
- Level of transformation funding available

The expected changes to the above assumptions will have a significant impact on whether clinical and financial sustainability can be achieved during the five year period and on the development of detailed operational financial plans. The following key issues need to be resolved:

1. The level of the Transformation Fund (TF)

The amount of one off transformation funding was based on what was thought to be the minimum amount required to deliver the change to achieve clinical and financial sustainability over the five year period. If the amount or phasing changes then financial sustainability will not be achieved over the five years and will be reflected in commissioning and NHS provider organisations operating with financial deficits for a longer period.

The Strategic Partnership Board (SPB) Executive will propose allocation of the TF in accordance with criteria agreed and will secure independent assurance on each of these investments.

The use of the (TF) should be underpinned by the following principles:

- The total for the TF determined by NHS England is £450m. Work continues to finalise the detail of the financial and operational management arrangements.
- The governance of the TF will be the responsibility of the SPB. The TF will be focused on the delivery of the transformation programmes described in the Plan; all proposals will be independently verified to demonstrate value for money, strategic fit and robustness
- The TF will be separate from the conventional funding allocation to CCGs, but at the appropriate time CCGs will be expected to agree with NHS England how their budgets are supporting the transformation programmes
- NHS England has the right to determine the financing of the TF. However there must be the necessary degree of flexibility to enable the TF to deliver the transformation programmes set out in the Plan. To the extent that any national programmes are used to support the financing of the TF, then the TF will only fund those aspects of proposals which are wholly consistent with the transformation programmes in the Plan. To the extent that any proposals from these national programmes do not correspond to these programmes then these will fall for consideration by NHS England separately
- Deficit management will be the responsibility of the NHS and will be outside the funding scope of the TF. GM will play a full part to ensure that detailed deficit arrangements are aligned to the Plan

- The TF will be subject to a performance management framework. Once the detailed profile has been agreed, GM will produce a full range of outcomes across health and social care to be delivered by the TF which will form part of the performance management framework, for agreement by HMT, NHS England and DH.

2. Estates

The CSR proposals assumed access to capital funding to support both the enablers such as development of a single patient record and for the reconfiguration of the estate required. The work includes funding for the recurring cost of capital, although the amount will vary depending on the phasing of the transformation funding and implementation of change. The proposal is based around the ability to bring together the estates function across GM into a single property management function and the ability to retain any capital receipts. How this is implemented, alongside the detailed work underway, will inform the exact nature of the investment required.

A key component of the work will be securing access to the national funding 'pots' which are available with a proposal that GM requirements are 'earmarked' subject to the production of a detailed business case to be agreed by NHS England, DH and HMT before the end of this financial year.

A high level strategy will be developed by the 31st December 2015 and from this a business plan and financial proposal will be developed by 31st March 2016 for discussion with HMT, DH and NHS England.

3. Social care

The underlying principle in the CSR is that the funding should enable the current level of activity, as per the logic in NHS England's Five Year Forward View, to be delivered and for social care budgets to be maintained at their current level. For adult social care this represented additional funding of £180m for GM across the CSR period. This did not include funding for additional demographic pressures and the cost of implementing the changes to the minimum wage. The scale of the funding gap is linked to the overall outcome of the financial settlement so the numbers are subject to change.

There has always been some concern about how a national social care settlement could be responsive to the particular circumstances in GM, given the status on devolution. Discussions are ongoing as to the impact of the changes set out in the CSR. The early assessment is that the proposals leave GM with a shortfall of funding for 2016/17 and 2017/18.

The CSR announcement included two further areas for social care:

- The ability to raise an additional 2 per cent in council tax over and above the referendum limit
- Additional £1.5 billion Better Care Fund (BCF) monies that will go direct to local authorities

Council Leaders are considering a further radical step to pool funding for the five years for the CSR period to use the income generated from the 'social care precept', or equivalent income, to establish a platform for commissioning certain social care services on a GM wide basis. This is linked to there being a comprehensive settlement.

The additional BCF funding for local authorities will start to come on stream from 1st April 2017, with it being predominately back-loaded to the last two years of the CSR settlement. The phasing of the BCF nationally will not deliver what GM requires given that our transformation journey will start on 1st April 2016.

GM, after it has evaluated the impacts of the local government finance settlement on social care, will want to discuss with HMT, DH and DCLG the impact of the settlement on social care spend in the early years of the transformation programme and whether the funding is sufficient to enable the transformation objectives to be delivered.

Achieving transformation of this scale is a significant ambition, which will require leaders at all levels across GM to promote the need for change and the development of detailed implementation plans over the coming months.

Chapter 6

Implementation

We have already started implementing some of the changes we need across the system. A critical part of our work between January and March 2016 will be to engage with people across GM and staff working in the health and care system, about the direction of travel and the changes we are proposing. We have shared our thinking early so that people have a chance to be part of building our plans for the future.

We are developing a draft high level implementation plan which describes what we think will need to happen across the five years to create a clinically and financially sustainable GM health and social care system. There will be a detailed work programme for each of the transformation themes described in chapter 4, outlining specific deliverables in years one and two and higher level deliverables for years three to five This will ensure we can continue to review, refine and if necessary refresh our work programme to reflect our system needs.

To find out more or get in touch with us please go to:

Website: **www.gmhealthandsocialcaredevo.org.uk**
Email: **gm.devo@nhs.net**
Twitter: **@GMHSC_Devo**

Implementing the Plan

We have a bold, clear and ambitious plan for GM. All partners are working together to understand how we can begin to deliver this plan.

Engaging people

Between January and March 2016, the partners across the ten localities of GM will be talking to their staff and local people about these plans. At the same time we plan to run events and talk to people about what would help them take charge of their own health and wellbeing – and get views on how we might support people to do this.

We will be doing this under our Taking Charge theme, which sets out the idea that GM is taking charge of a significant opportunity, as well as a significant challenge, and that as well as taking charge the people of GM must also take responsibility – at an individual, community and wider level.

Thousands of conversations about health and social care, preventing ill health and integration of services have been held in GM over recent years. They have included roadshows, citizen's panels, workshops, online forums and many other outlets and events, organised by public bodies and the voluntary and community sector. The ideas set out in this Plan are the culmination of those conversations – and we will continue to build on them.

Examples include:

- In Bolton, the CCG launched "Let's make it" with 120 events to give a voice to those who find it hard to get heard
- In Manchester, the voluntary sector has led 22 workshops on improving mental health services
- In Rochdale 225 people have helped shape the locality plan, covering children's services and end of life care
- In Trafford, local people have been involved in creating a one-stop Care Co-ordination Centre for booking appointments, patient transport and learning about services

The people of GM recognise the challenges facing the health and social care services from an ageing population, advances in medicine and growing financial pressures. They accept that the rising demand for services must be slowed, and say the way to achieve this is for people to take more responsibility for their health.

Their priorities for the future, in relation to health and care services, include to:

- get appointments promptly and be seen within a reasonable time
- tell their story once and receive co-ordinated multidisciplinary care – with a single key worker
- have their families and carers involved
- have things explained, their questions answered and given choices about their care
- be supported to manage their own care
- have emotional and practical support recognised as important as medical treatment
- not to be blamed when costs and competing priorities interfere with their ability to look after their health
- have everything in place when they are discharged from hospital
- be treated with dignity and respect

We will build on this engagement with people – at a local and GM level - to continue to better understand what people need to take charge of their health and wider wellbeing in different places across GM.

As well as using traditional engagement approaches we are also exploring a web-based, crowdsourcing platform, and will link with national and potentially commercial partners, to ensure our engagement is as broad and deep as possible.

Engaging with Staff

There are approximately 100,000 staff working in health and social care services in GM and they are a critical group who are crucial to the success of our ambitions. Staff engagement will be led by their own organisations so they are able to put the wider GM work in the context of what's happening in their own organisations and are able to understand what this means for them, their families and the people they help care for.

Starting the work

Alongside the work we will be doing with people, we will also be working across public sector services in GM to begin to work through how we implement the changes described in this Plan.

Changes will happen across all parts of our health, care and support services. We are already starting to make some of these a reality as we begin to deliver different service models which are described in locality plans and to make better use of the resources we have to save across health and social care.

We know that we need to begin work now on some areas that will take time to change and deliver.

We will focus on in the next three months the following areas:

- Local health and social care system engagement
- Public engagement
- Locality and GM implementation planning
- LCO characteristics
- The application of the TF

The timescales for this work are mapped out below in a high level plan.

The implementation plan will describe the key deliverables for each part of the work that we are aiming to deliver by April 2016 and then years one and two, with an outline for years three to five.

Work to deliver this plan is happening now across our GM services. As we progress through the next three months of this work, we expect our plans to be built on, expanded and improved based on the views of people who use services across health, social care and support services.

A significant proportion of delivery activity will take place within our localities, working with our staff and our people to implement the reform in the context of local needs. Each locality will develop a Locality Implementation Plan by April 2016. Localities will be responsible for ensuring they have the capacity and capability to implement their reform plan, drawing on local and national expertise as appropriate.

We recognise the value in collaboration across GM, so in partnership with NHS England, we will create the GM health and social care team. This team will be small in number and flexible, with the ability to source expertise from within and out of GM to support delivery in the localities and at a GM level. It will be responsible for driving the devolution, reform and transformation agenda for the integration of health and social care services between 2016 – 2021.

Transformation initiatives	Jan – Mar '16	Apr – Sep	Oct >
	Design	Mobilise	Implement
1. Population Health Prevention	• Agree programme of prevention activity		
2. Community based care & support	• Create Local Care Organisations (LCOs) • Primary care at scale • Place based commissioning • Mental Health strategy		
3. Standardise Acute Hospital care	• Acute care collaborations • Clinical engagement • Early planning		
4. Standardise Clinical support & back office	• Shared services • Response to Carter • Staff engagement		
5. Enablers	• Agree HinM priorities • Pricing & contract model • Common approach to IM&T, Estates, Workforce		
Programme Implementation	• Establish GM H&SC Team • Governance • Communications Plan		

Full Implementation Plan to be drafted in January taking each initiative through from Design to Implementation.

Final plan to be agreed in March.

From April 2016, the team will:

- Ensure delivery of the GM Financial Plan
- Oversee and drive governance across GM
- Enable the implementation of locality plans and ensure they support the direction of GM health and social care
- Assure the operational delivery of health and social care, in line with the devolved functions from NHS England, such as CCG assurance, plus specialised and primary care commissioning.
- Lead GM commissioning where agreed and endorsed by the SPB and JCB
- Sponsor, drive and facilitate GM transformational projects
- Facilitate GM population and cross sector involvement in health and wellbeing improvements
- Understand the overall performance and delivery of services across the whole system within GM and therefore, identifying and managing risk
- Establish effective working arrangements with health and social care regulators
- Lead on the development and delivery of public and political engagement

We will produce a refreshed version of the Plan at the end of March 2016 that includes more details of how we propose to change our services over the next five years.

Assurance, accountability and implementation

Greater Manchester is our 'unit of planning' and we are working to the principle that GM is assured once by national bodies as a place.

This approach does not compromise the statutory responsibilities of the 37 health and social care organisations in GM to the national bodies. However, as all of our ten localities are moving towards the establishment of pooled commissioning budgets, management arrangements, governance structures and the development of LCOs, they will operate in a different way and the assurance and accountability processes will need to support these developments.

It is recognised that further work is required to understand and agree what this means for each of the national bodies and how the individual processes could be brought together to achieve assurance of GM as a place. This will be worked through as part of the implementation planning and listening phase from January to March 2016.

Staying in touch and getting involved

We already have a range of ways to stay in touch with this work. These are:

Website: **www.gmhealthandsocialcaredevo.org.uk**

Email: **gm.devo@nhs.net**

Twitter: **@GMHSC_Devo**

Opportunities to engage in the work will be widely advertised following the publication of the Plan.

This five year Plan for the reform of health and social care in GM has been developed in consultation with and approved by the GM SPB. This board is chaired by Lord Peter Smith, the leader of Wigan Council and through the membership of that board it has support of the 37 statutory organisations in GM, listed below:

- Bolton Clinical Commissioning Group
- Bolton Hospital NHS Foundation Trust
- Bolton Metropolitan Borough Council
- Bridgewater Community Healthcare NHS Trust
- Bury Clinical Commissioning Group
- Bury Metropolitan Borough Council
- Central Manchester Clinical Commissioning Group
- Central Manchester NHS Foundation Trust
- Greater Manchester West Mental Health Foundation Trust
- Heywood, Middleton and Rochdale Clinical Commissioning Group
- Manchester City Council
- Manchester Mental Health and Social Care NHS Trust
- North Manchester Clinical Commissioning Group
- North West Ambulance Service NHS Foundation Trust
- Oldham Clinical Commissioning Group
- Oldham Metropolitan Borough Council
- Pennine Acute NHS Hospitals Trust
- Pennine Care NHS Foundation Trust
- Rochdale Metropolitan Borough Council
- Salford City Council
- Salford Clinical Commissioning Group
- Salford Royal NHS Foundation Trust
- South Manchester Clinical Commissioning Group
- Stockport Clinical Commissioning Group
- Stockport Metropolitan Borough Council
- Stockport NHS Foundation Trust
- Tameside and Glossop Clinical Commissioning Group
- Tameside Hospital Foundation Trust
- Tameside Metropolitan Borough Council
- The Christie NHS Foundation Trust
- Trafford Clinical Commissioning Group
- Trafford Metropolitan Borough Council
- University Hospitals of South Manchester NHS Foundation Trust
- Wigan Clinical Commissioning Group
- Wigan Borough Metropolitan Borough Council
- Wrightington, Wigan and Leigh NHS Foundation Trust
- 5 Boroughs Partnership NHS Foundation Trust

Wider partners in the GM Plan:

- Greater Manchester Police
- Greater Manchester Local Medical Committee
- Greater Manchester Fire and Rescue Service
- Healthwatch
- Patient Groups
- Social Care and Residential Providers
- Voluntary Groups
- 3rd Sector Providers

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

#takingcharge

Website: **www.gmhealthandsocialcaredevo.org.uk**
Email: **gm.devo@nhs.net**
Twitter: **@GMHSC_Devo**

Report to :	**HEALTH AND WELLBEING BOARD**
Date :	21 January 2016
Executive Member / Reporting Officer:	Steven Pleasant, Chief Executive Tameside Council Cllr Brenda Warrington – Executive Member Social Care & Wellbeing (Lead) Cllr Gerald P. Cooney – Executive Member Healthy & Working Cllr Peter Robinson Children & Families
Subject :	**GOVERNANCE AND ACCOUNTABILITY FRAMEWORK FOR HEALTH AND CARE INTEGRATION**
Report Summary :	The purpose of this report is to seek approval to establish a governance and accountability framework to support the development and implementation of an integrated health and care system in Tameside whilst reflecting the wider Greater Manchester position.
Recommendations :	The Council is asked to support the proposals contained in this report: 1) Note the GM Devolution position. 2) Endorse the role of the Health & Wellbeing Board and keep under review; 3) Endorse the proposal to establish the governance arrangements in shadow form and the establishment in shadow form of the interim Single Commissioning Board and the terms of reference set out at **Appendix 1**; 4) Endorse the proposal to establish the governance arrangements in shadow form subject to review and individual engagement with partner organisations, including any necessary changes to constitutional arrangements, provisionally support formal introduction from 1 April 2016.
Links to Health and Wellbeing Strategy :	Integration has been identified as one of the six principles that have been agreed locally that will help to achieve the priorities identified in the Health and Wellbeing Strategy.
Policy Implications :	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. This meets the requirements of the NHS Constitution.
Financial Implications: **(Authorised by the Section 151 Officer)**	Section 5 of the Locality Plan provides details of the financial challenge to the Tameside Economy during the next five year period together with the associated proposals to finance the estimated £69 million gap. It is recognised that there is an estimated sum of £53 million transition funding (revenue £27m and capital £26m) required (phased over the five year period) to support the implementation of a financially sustainable integrated health and social care provision within the borough.

A supporting business case to request the transition funding is currently in development in advance of submission to Greater Manchester Devolution prior to the end of this calendar year. It is essential this sum is received over the timeline requested to ensure the projected financial gap is addressed.

In addition the Tameside Hospital Foundation Trust will require £71 million PDC funding over the five year period. This sum is being requested via the Department of Health.

Legal Implications:

(Authorised by the Borough Solicitor)

These are set out in the report.

Risk Management:

There are a number of key risks associated with this work. These are summarised as follows:-

- Management of organisational change is difficult and can be disruptive to delivery of work programmes.
- Cultural differences between organisations.
- Difference of working practices between organisations
- Lack of local focus and connection with stakeholders.
- Differing accountabilities and regulatory frameworks.

These risks will be mitigated through leadership of the change via senior officers of both organisations as well as bringing in additional organisational development to implement the change.

Access to Information:

The background papers relating to this report can be inspected by contacting Sandra Stewart, Executive Director for Governance & Resources by:


Telephone: 0161 342 3028


e-mail: sandra.stewart@tameside.gov.uk

1. INTRODUCTION

1.1 The purpose of this report is to set out proposals relating to governance arrangements for health and care integration in Tameside.

1.2 Across Greater Manchester and within Tameside, health and social care partners are working together to reform health and care services to support the shared ambition of improving health outcomes for residents as quickly as possible. At the local level revised governance arrangements are required to enable the ambition and vision contained in the Tameside and Glossop Locality Plan to be realised.

1.3 This paper sets out the proposals for governance in shadow form with immediate effect and subject to review formally from 1 April 2016.

1.4 The proposals are set within the framework of the Memorandum of Understanding and the governance and accountability arrangements agreed at Greater Manchester level where responsibility for the Greater Manchester Strategic Plan and Greater Manchester wide commissioning arrangements resides.

1.5 Additionally these proposals must take account of and interface with the governance arrangements of individual partner organisations. Over forthcoming months changes may be required to the constitutional arrangements of statutory organisations before these arrangements 'go live' in April 2016.

1.6 Finally it remains imperative that robust safeguarding arrangements remain at the fore. Strong links to both of the safeguarding boards for children and adults must be cemented in these new governance proposals with oversight by relevant scrutiny and audit/regulatory arrangements.

2. BACKGROUND

2.1 With the advent of health and social care devolution, the context within which Tameside & Glossop's Health and Wellbeing Board operates has changed significantly.

2.2 The Care Together Programme over the past couple of years has focussed on designing and testing models for improving health and social care services across Tameside and Glossop. This work culminated in the hospital regulator, Monitor, approving a plan for an Integrated Care Organisation (ICO) in September 2015 to bring together health and social care services to improve how these work collectively for the benefit of our population.

2.3 At a joint Board meeting between Tameside Hospital Foundation Trust, NHS Tameside and Glossop Clinical Commissioning Group (CCG) and Tameside Metropolitan Borough Council on 23 September 2015, all parties unanimously agreed to work together within the Care Together programme structure to implement the plan and agreed the following principles:

i. We agree that an integrated system of health and social care is the best way to ensure optimum health and care outcomes for our population and to ensure collective financial sustainability.

ii. We welcome the Contingency Planning Team's ('CPT') final report of 28 July 2015 and the assurances it provides as to the new model of care that the Tameside and Glossop Clinical Commissioning Group ('the CCG'), Tameside Metropolitan Borough Council ('TMBC') and Tameside Hospital Foundation Trust ('THFT') have jointly agreed to develop and operate to create a new integrated system of health and social care in Tameside and Glossop.

iii. *We acknowledge that creating a ICO will not resolve the significant budget challenges facing all organisations but it goes someway to reducing it and it will be necessary to continue to work closely together with all stakeholders to manage the deficit set out in the CPT report.*

iv. *We agree that a Tameside & Glossop Locality Plan setting out our vision to work together to reform health and social care services to improve the health outcomes of our residents and reduce health inequalities as quickly as possible, be considered and approved in due course at the statutory Health and Wellbeing Board, and that the model of care, which is as outlined in the CPT creating a new integrated system of health and social care in Tameside and Glossop report is a key component of that Plan.*

v. *We agree that THFT represents the best legal delivery vehicle for the integrated care system subject to an amended foundation trust licence and constitution to enable a new legal entity of an Integrated Care Foundation Trust to be constituted by the 1 April 2017. Such an organisation will need to be appropriately representative of all three bodies and other stakeholders including primary care and the voluntary sector, which will be reflected in its constitution. We agree to work together to support the THFT in this transformation with a view to be in the ICFT shadow form from the 1 April 2016.*

vi. *We agree that in working together to reform health and social care services to improve health outcomes for residents as quickly as possible and enable system wide change to take place transparently and clearly, robust and inclusive governance structures need to be developed and agreed. The key principles of any governance arrangements include:*

vii. *The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Tameside & Glossop; mutual co-operation; partnering arrangements, and added value in the provision of shared services.*

- *an acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability for their statutory functions.*
- *A commitment to open and transparent working and proper scrutiny and challenge of the work of the Programme Board and any party to the joint working arrangements.*
- *A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the Programme Board carry with them an obligation for the representative at the Programme Board to report these to their own constituent bodies.*

viii. *We agree to delegating our decision making power, regarding the implementation of the recommendations of the CPT report, to the Programme Board.*

ix. *We agree to develop a Memorandum of Understanding, the Programme Board Terms of Reference, and a detailed Scheme of Delegation for consideration and ratification at a future meeting.*

x. *To provide mutual assurance to the constituent bodies, we agree that there will be regular reports from the Programme Board to the Boards of the constituent bodies.*

xi. *We agree to the formation of a Programme Management Office to manage the implementation of the new Model of Care and will jointly look to resource this as appropriate.*

xii. *The Commissioners agree to deliver a joint commissioning function, to be in place by 1 January 2016.*

xiii. We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle.

2.4 An important initial step in the development of an Integrated Care Organisation is the transfer of the Tameside and Glossop community staff who are currently hosted by Stockport Foundation Trust into Tameside Hospital Foundation Trust. This process is now underway and will be completed on 1 April 2016.

2.5 Later this year, GM Devolution is submitting a five year comprehensive Strategic Sustainability Plan for health and social care in partnership with NHS England and other national partners. Each of the GM areas was required to submit a Locality Plan to provide a "bottom up" approach to the development of the GM Plan. The GM Strategic Sustainability Plan will be based on the following objectives to:

a) improve health and wellbeing of all residents of Greater Manchester, with a focus on prevention and public health, and providing care closer to home;
b) make fast progress on addressing health inequalities;
c) promote integration of health and social care as a key component of public sector reform;
d) contribute to growth, in particular through support employment and early years services;
e) build partnerships between health, social care, universities, science and knowledge sectors for the benefit of the population.

2.6 As such, the Tameside and Glossop Locality Plan addresses how we locally will meet these objectives and on the 12 November 2015, the Health and Wellbeing Board endorsed the Tameside and Glossop Locality Plan set out at **Appendix 2.**

2.7 The Tameside and Glossop Locality Plan is based on the following objectives to:

- improve health and wellbeing of residents with a focus on prevention and public health, and providing care closer to home;
- make fast progress on addressing health inequalities;
- promote integration of health and social care as a key component of public sector reform;
- contribute to growth, in particular through support employment and early years services;
- build partnerships between health, social care, and knowledge sectors for the benefit of the population.

2.8 Additionally, there needs to be a strengthened interface with the emerging governance arrangements within Greater Manchester, and furthermore it is imperative that the right governance and accountability mechanisms are in place to effectively drive and own implementation of Tameside & Glossop's Locality Plan.

2.9 On 18 December 2015, updated governance proposals were considered and approved by the Joint Meeting of The Greater Manchester Combined Authority and AGMA Executive Board, attached as **Appendix 3**.

2.10 At the local level we need to ensure that we have the right leadership for the pace of change required to deliver health and social care integration and that governance arrangements need to be 'strategically designed' to ensure fitness for purpose in the context of health and care integration and devolution; and the fast changing strategic environment associated with devolution and the need to be prepared to 'learn and adapt' within this context.

2.11 Such governance needs to:

- Ensure a strong clinical voice is secured in the governance arrangements
- Ensure commissioner/provider engagement
- Alignment to the pooled budget arrangements

- Securing appropriate primary care engagement within the governance structure, acknowledging the breadth and range of primary care including pharmacies, general practice, dental and optometry practices. Locally good engagement is developing across the wider primary care partners who are keen to play a full role in this transforming agenda.

2.12 Finally, the Governance and Accoutability Framework will be subject to further refinement and review throughout Spring 2016 with a further report to be considered by the HWBB in March to inform 'go live' arrangements from April.

3. PROPOSED ARRANGEMENTS

3.1 The proposed structure is set out in more detail below and has 2 requirements. Firstly, it must enable the Health and Wellbeing Board to fulfil its statutory duties. Secondly, it has to enable better lives for residents by ensuring implementation of the health and wellbeing strategy and, in particular the Locality Plan.

3.2 Tameside & Glossop's Locality Plan is the whole system plan outlining the partners (commissioner and providers) approach to improving the health outcomes of residents while also moving towards financial and clinical sustainability of health and care services.

3.3 Currently it remains a working draft with a final version to be considered by March 2016. Within this report it is proposed that the responsibility for finalising the Plan and for the delivery of the Plan will rest with the Health and Wellbeing Board, supported by an Executive, with implementation delivered through a Programme Board.

4. HEALTH AND WELLBEING BOARD

4.1 It is proposed that the Health and Wellbeing Board fulfills the functions of a strategic partnership board in relation to Tameside & Glossop's Locality Plan. The Health and Social Care Act 2012 introduced Health and Wellbeing Boards with the following responsibilities:

- To promote the integration of health, social care and public health;
- To promote joint commissioning;
- To lead on public health by aligning the various activities of the Local Authority behind an integrated health improvement approach;
- To Lead on the production of the Joint Strategic Needs Assessment (JSNA) – an analysis of local health and wellbeing needs across health, social care and public health; and
- To produce a Joint Health and Wellbeing Strategy based on the JSNA.

4.2 These functions align to the requirements of the Locality Plan which require representatives on the Board, and the Board as an entity to:

- Agree the health and social care priorities forTameside;
- Approve the content of the Plan;
- Ensure that there remains ongoing and significant organisational commitment across the health and care economy of Tameside & Glossop to the ambition and priorities contained in the Plan;
- To be responsible to residents and to each other for the financial and clinical sustainability of the health and care economy through the agreement and delivery of the Locality Plan;
- To provide a mutual assurance function over the outcomes linked to the commissioning decisions taken by members to deliver the Locality Plan.

4.3 Additionally it is expected that the Board will ensure that organisational interests of participating organisations, align with the ambition and vision agreed, and that there is a visible commitment from all agencies to authorising shared decisions made by the Board, and that these decisions are visible to regulatory bodies.

4.4 Functions to be undertaken by the Board will include:

- Receiving regular update reports from the Executive on the ongoing progress and delivery of the Locality Plan;
- Receiving regular reports from the Executive about the commissioning decisions of the Single Commissioning Board, and the performance linked to those decisions;
- Receiving regular reports from the Executive with respect to progression towards fiscal neutrality;
- To work within the assurance framework, developed jointly with regulators, that reflects the outcomes required by Greater Manchester and the Locality because the formal assurance that each individual party is delivering on their commitments to the Locality Plan will be provided in the usual way by the relevant statutory body.
- Receiving regular reports of Tameside & Glossop's performance against agreed assurance metrics;
- Receiving regular reports as appropriate on key quality surveillance issues as they relate toTameside & Glossop.

4.5 The terms of reference and membership of the Board will be kept under review to enure that it is able to deliver in the way required in the interests of residents.

5. JOINT COMMISIONING ARRANGEMENTS

Greater Manchester Joint Commissioning Board

5.1 Within Greater Manchester there will be Greater Manchester Joint Commissioning Board, which will also be a joint committee where each participant makes joint decisions which are binding on each other. It is important that there is clarity regarding the joint commissioning decisions to be taken at the local level and Greater Manchester level respectively.

5.2 Specialised Services Commissioning will take place at Greater Manchester level. As these services cannot be dealt with by way of s75 arrangements without a change in the s75 regulations, any joint commissioning of specialised services will need to be undertaken through a joint committee made up of NHSE, CCGs, GMCA, and local authorities.

5.3 The Greater Manchester Joint Commissioning Board will have significant commissioning decision making responsibility as the largest single commissioning vehicle in Greater Manchester.

5.4 In order to comply with regulatory requirements the Greater Manchester Joint Commissioning Board will function independently of providers.

5.5 Importantly, the key functions of the Greater Manchester Joint Commissioning Board are as follows:

- To develop a commissioning strategy based upon the Greater Manchester Strategic Plan;
- Be responsible for the commissioning of health and social care servcies on a Greater Manchester footprint;
- Have strategic responsibility for commissioning across Greater Manchester;
- Be responsible for the delivery of the pan Greater Manchester strategy via its commissioning decisions (local commissioning will remain a local responsibility)

- To operate within existing commissioning guidelines following key principles of co-design, transparency and broad engagement.

5.6 The Greater Manchester Joint Commissioning Board will only take on Greater Manchester wide commissioning decisions. Any decision that currently sits with the commissioning responsibilities of LAs and CCGs will stay with these organisations.

5.7 While the core principle of the Greater Manchester Joint Commissioning Board will be that those commissioning decisions which are currently made in localities will remain in localities, there will be mechanisms developed to ensure that the remit of Greater Manchester Joint Commissioning Board can be broadened should localities agree that it is in their best interests to do so.

5.8 It should be noted that Steven Pleasant, Tameside Council's Chief Executive has been appointed by The Greater Manchester Combined Authority and AGMA Executive Board as the co-chair of the Greater Manchester Health and Social Care Commissioning Board.

Criteria for Commissioning at a Greater Manchester Level

5.9 Work is currently underway to identify which services can be more effectively and efficiently commissioned on Greater Manchester footprint and therefore delegated to Greater Manchester. It will be for the Greater Manchester Health and Social Care Commissioning Board and local stakeholders to formally approve and agree what services these are.

5.10 Consideration is also currently being given to whether the commissioning of primary care should be undertaken at a Greater Manchester level, with the exception of General Practice which will be commissioned by CCGs. However, the Greater Manchester Health and Social Care Commissioning Board will have a significant role to play in developing and implementing a Greater Manchester wide framework within which general practice is commissioned.

5.11 The criteria by which existing activity would be commissioned at a Greater Manchester level will focus upon whether decisions taken on a broader footprint achieved a greater benefit for the population, e.g. increased value for money; greater levels of efficiency; or increased clinical sustainability.

Tameside & Glossop Care Together Single Commissioning Board

5.12 Across the Tameside & Glossop locality there will be single place based commissioning body comprising the Tameside & Glossop locality Clinical Commissioning Group and the Local Authority known as the Tameside & Glossop Care Together Single Commissioning Board. The proposals within this report have been developed by the Tameside & Glossop CCG and the Council as a means of effectively commissioning for the transformation programmes within the locality plan as well as gaining benefits from jointly commissioning existing services.

5.13 As part of previous work undertaken between the CCG and the Council we have defined the role of commissioning as follows:-

- To define the desired outcomes and service model led by a clear vision and strategy
- To create the environment for change
    - Soft factors e.g. culture, relationship management, values and behaviours.
    - Hard factors e.g. estates, IMT, finance, contracting, market management etc.
- To ensure standards are met and improvements are made

5.14 This approach fits with the emergence of an Integrated Care Organisation. The benefits we seek to gain from a single commissioning function are:-

- Common strategic and operational/business plans
- To make best use of our collective resources
- To have an effective means of jointly commissioning services

- To ensure effective governance within our organisations whilst generating stronger cross system governance arrangements.
- To retain key strengths of the CCG and the Council approaches to commissioning and local connections.

5.15 The aim of this work is not in the short term to merge organisations, formally restructure or transfer employment of staff from one organisation to another. It is aimed to formalise our working arrangements and organise our resources around key work programmes and work effectively together.

5.16 There are a number of key recommendations which will be taken through the formal governance processes of the CCGs and the council. The two organisations will establish a Single Commissioning Board as set out as follows:

5.17 There will be a single leadership team, which will be established as a committee of the two organisations with delegated decision making powers and resources. This will create a unifying group within both the statutory and collaborative governance arrangements for the first time. The key role of this Board will be:-

- To provide executive leadership for the locality plan from a commissioning perspective.
- Oversee the management of any delegated commissioning functions and pooled budgets.
- Lead the development of commissioning as part of statutory and HWB governance arrangements.

5.18 The Locality plan will be adopted as a shared commissioning strategy and should supersede the relevant parts of existing organisational strategies.

5.19 Together both organisations working with the hospital will develop a common operational/business plan for 2016/17. Led by the priorities for 2016/17 we will organise our teams around programmes of work with suitable operational leadership. These will include commissioning for the transformation programmes and also areas of operational commissioning where this adds value.

5.20 We will also develop and adopt a form of matrix working which will allow us to mobilise our workforce around work programmes in a way which makes best use of our resources, is suitably flexible but also retains a line of sight between commissioning activities and organisational accountabilities.

5.21 The Tameside & Glossop Care Together Single Commissioning Board is not a separate legal body but a Board where each participant makes joint decisions which are binding on each other.

5.22 It will be a Joint Committee and will be required to be formally constituted. This will require changes to the CCG's constitution to reflect powers to be delegated to the new Board. In the interim it is proposed that the Tameside & Glossop Care Together Single Commissioning board will operate on the basis of the terms of reference set out at **Appendix 3** to enable a period of further shaping and refining of these governance arrangements. Subject to review and appropriate engagement on changes to constitutional matters by individual partner organisations it is proposed that these arrangements are formally introduced from 1 April 2016.

5.23 The key role of the Tameside & Glossop Care Together Single Commissioning Board will be:

- to have regard to the Locality Plan and the recommendations of the HWBB;
- to act under the delegated authority on behalf of commissioning bodies.

5.24 The bodies delegating functions to the Tameside & Glossop Care Together Single Commissioning Board will remain accountable for meeting the full range of their statutory duties and together will:

- commission integrated health and social care services for community based locality teams; and
- commission services from the Integrated Care Organisation.

5.25 Key principles will include:

- a joint committee where decisions are binding on all parties;
- Members must have delegated authority;
- Must function independently of providers;
- Makes decisions to support the locality;
- Will develop a commissioning strategy based upon the agreed Locality Plan;
- There must be patient engagement on commissioning plans and all decisions must be transparent, reasonable, rational, defendable from Judicial Review challenge;
- Any decision currently within the commissioning responsibility of the Local Authority/CCG stays with those organisations with oversight by the shadow JCB;
- From April 2016 the JCB will hold a Tameside & Glossop locality wide pooled budget.

5.26 A scheme of delegation will need to be developed and agreed for the joint committee for the 1 April 2016.

6. POOLED BUDGET

6.1 The Tameside & Glossop Care Together Single Commissioning Board will be supported by appropriate financial governance arrangements. These will specify authorising officers to act on behalf of the CCG and Council with the appropriate financial scheme of delegation within defined permitted expenditure.

6.2 The Tameside & Glossop Care Together Single Commissioning Board will subject to Council and CCG approval need to

- Prepare a joint financial plan for the totality of the health and care resources including the pooled budget;
- Agree a joint approach to prioritisation and development of business cases to access transformation funding;
- Develop an appropriate and more progressive approach towards risk share arrangements, which make joint prioritisation of resources and spending decisions a necessity;
- Develop commissioner skills in readiness for the magnitude of the pooled budget envisaged;
- Sets tolerances to take amount of demand variations and agrees appropriate risk reserves; and
- Agrees the principles by which the financial savings and the impact of investment schemes will be tracked across partners and the whole resource quantum using cost benefit analysis (CBA) methodology and benefits sharing arrangements.

7. PROGRESS TO DATE

7.1 The Council and the CCG have made significant progress already in regard to the actions above. These include:-

- Development of the Tameside & Glossop Locality plan.
- Development of a single commissioning team drawn from the both organisations to take forward commissioning.
- Appointment of an Independent Programme Chair and Programme Director

- transfer of the Tameside and Glossop community staff who are currently hosted by Stockport Foundation Trust into Tameside Hospital Foundation Trust. This process is now underway and will be completed on 1 April 2016.
- Pooled budgets and associated financial plans relating to the Better Care Fund.
- Working groups in place to develop contractual arrangements for Single Commissioning and extended pooled budget arrangements.
- Organisational development work relating to commissioning with a focus upon movement towards outcome based commissioning.

7.2 By April we will have completed a first step towards the new commissioning system. We will continue the work programmes and seek to make this way of working more mainstream and more systematic.

7.3 In undertaking this work, we foresee will be able to engage better with the public, patients, communities and community group in our commissioning activities.

7.4 Commissioning across health and social care will allow benefits to identifying risks relating to quality and safety across providers and also to flag risks such as safeguarding incidents or other people in vulnerable positions and work across the public sector to achieve better outcomes efficiently and effectively.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.

APPENDIX 1

Interim Care Together Single Commissioning Board

Terms of Reference

Context

1 On 23 September 2015 the three Care Together partner organisation Boards met together to establish a set of principles for the development of the Integrated Care Foundation Trust and for the establishment of a single commissioning function. It was agreed that the Integrated Care Foundation Trust would be established from 1 April 2017, and that the Single Commission would be established from 1 April 2016 with interim arrangements in place from 1 January 2016.

2. The following document sets out the Terms of Reference for the Interim Care Together Commissioning Board to cover the period 1 January until 31 March 2016.

Statutory Framework

3. The Interim Care Together Commissioning Board is not a statutory body. It is not intended to replace any of the existing statutory bodies in the locality; instead it is to be an advisory group making recommendations to the two statutory organisations (Tameside Metropolitan Borough Council and NHS Tameside and Glossop Clinical Commissioning Group)

Role of the Interim Care Together Board

4. The Interim Care Together Commissioning Board has been established to enable members to make recommendations on the design, on the commissioning, and on the overall delivery of health and care services including the oversight of their quality and performance.

5. In performing its role the Interim Care Together Commissioning Board will exercise its functions in accordance with the Tameside and Glossop Locality Plan.

Geographical Coverage

6. The responsibilities for the Interim Care Together Commissioning Board will cover the same geographical area as of NHS Tameside and Glossop CCG (that is fully coterminous with Tameside Metropolitan Borough Council and the Glossop locality Tameside & Glossop Care Together of Derbyshire County Council).

Membership

7. The Interim Care Together Commissioning Board shall consist of the following members:

- The Chair of the CCG (Chair)
- The CCG Governing Body GP Lead for Urgent Care
- The Council's Executive Member for Healthy and Working
- The CCG Governing Body Lay Member with responsibility for Governance
- The CCG Governing Body GP Lead for Integration (Clinical Vice-Chair)
- The Chief Executive of the local authority
- The Council's Executive Member for Children and Families
- The Council's Executive Member for Adult Social Care and Wellbeing (Deputy Chair).

In the event of the Chair being unavailable for a meeting the Clinical Vice-Chair will assume the chairing of the Board meeting to maintain the meeting being clinically-led. In the event that both the Chair and the Clinical Vice-Chair are conflicted regarding an agenda item and leave the meeting then the Deputy Chair will assume the chairing of the meeting.

The following will have a standing invitation to attend the meetings of the Interim Care Together Commissioning Board:

- The Management team of the Care Together Commissioning function
- The Independent Chair and Programme Director of the Care Together Programme
- A representative of Derbyshire County Council or of High Peak Borough Council.

Meetings and Voting

8. The Interim Board will give no less than five working days' notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five days before the date of the meeting. When the Chair of the Interim Board deems it necessary in light of urgent circumstances to call a meeting at short notice this notice period shall be such as s/he shall specify.

9. Each member of the Interim Board shall have one vote. The aim of the Interim Board will be to achieve consensus decision-making wherever possible. However, should a vote be required it will be by a simple majority of members present but, if necessary, the Chair has a second and deciding vote. Tameside & Glossop Care Together

10. The Chair of the Interim Board shall manage all conflict of interest matters. The members of the Interim Board will be asked at each meeting to declare any new actual or perceived conflicts. In addition each member will be expected to declare any new or existing conflicts for any items of business for that meeting. The Chair will ensure that a Register of Interests for the members of the Interim Care Together Commissioning Board is established and maintained.

Quorum

11. The quorum will be five of the eight members to include both a member from the CCG and a member from the Council. There is always to be a statutory legal representative from each of the organisations.

Frequency of meetings

12. It is anticipated that the Interim Care Together Commissioning Board will routinely meet at monthly or six-weekly intervals.

13. The meetings of the Interim Care Together Commissioning Board shall not be held in public.

14. It is intended that, from 1 April 2016, the meetings of the Care Together Commissioning Board will:

a) be held in public, subject to any exemption provided by law as set out under 14(b)

b) from 1 April 2016 the Care Together Commissioning Board may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by both the Public Bodies (Admission to Meetings) Act 1960 (as amended or succeeded from time to time) and the Local Government Act 1972.

Additional requirements

15. The members of the Interim Board have a collective responsibility for the operation of the Interim Board. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

16. The Interim Board may delegate tasks to such individuals or committees as it shall see fit, provided that any such delegations are consistent with each Tameside & Glossop Care Together parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate, and reflect appropriate arrangements for the management of any actual or perceived conflicts of interest.

17. The Interim Board may call additional experts to attend meetings on an ad hoc basis to inform discussions.

18. The members and attendees of the Interim Board shall respect the confidentiality requirements of the two statutory bodies.

19. The Interim Board will present its recommendations to the two statutory bodies for ratification.

20. These Terms of Reference will be reviewed by 1st April 2016 and reflect the desired change from an Interim Board to a substantive Board and the need to fulfil its functions.

Version 2 (draft) 8 January 2016

A Place-Based Approach to Better Prosperity, Health and Wellbeing

Tameside and Glossop Locality Plan November 2015

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1. EXECUTIVE SUMMARY

We believe everyone living in Tameside and Glossop should be supported to live a long, healthy and fulfilling life. We are committed to changing the way we organise, provide and fund public services to ensure we achieve this aim.

It is a sad reality that people living in Tameside and Glossop have some of the worst health outcomes in the country. Not only does our population have a lower than average life expectancy, but the healthy life expectancy (HLE), the age at which one can expect to live healthily is also well below the England and North West average. For the period 2011-13, the England average for men was 63.3 years, the North West average was 61.2 years. Male Tameside residents on average have a healthy life expectancy of 57.9 years; the situation is similar in Glossop, a shocking statistic. Statistics for women also show healthy life expectancy as worse than the England and North West average. Obviously, this has a profoundly negative impact on the ability of residents to engage in work, support themselves and their families, and ultimately on the healthy and fulfilling lives they expect.

In Tameside and Glossop, we have set ourselves the bold ambition of raising healthy life years to the North West average by 2020. We then will continue to drive our ambition to ensure we achieve the England average over the next five years. This is a significant task especially considering we are a financially challenged economy, but it is an ambition behind which we can all unite.

This Locality Plan outlines how we will reorganise and energise our health and care services to contribute more effectively towards better prosperity, health and wellbeing. This starts by recognising and building on the strong voluntary, community and faith sector presence in our locality and ensures we continually hear the voice of our communities. We will strive to empower local residents, build community resilience by developing and delivering place based services and early intervention and prevention to keep people healthy and independent. When people do require health or social services, our single care provider which provides a fully integrated model of care, will ensure high quality locally based care including an enhanced integrated urgent care service. This aspect of our initiative was outlined in the recent Contingency Planning Team (CPT) report commissioned, published and endorsed by Monitor.

Tameside and Glossop have a significant financial challenge as evidenced by the estimated £69m gap in funding across the health and social care economy by 2020. Continuing with our current systems is not an option; we would run out of money long before the end of each financial year. Our proposals for a single health and care provider have been analysed and subjected to external financial scrutiny and once fully implemented, will reduce expenditure by £28m. Additionally, we have other key plans described within this Locality Plan to show how by leading together and pooling our resources, we can reach financial sustainability within five years. We require assistance to achieve this, both in terms of regulator support for the radical reform of our local health and social care system but also being able to access transitional funds to support a phased release of savings as we move from the present to new arrangements.

A clear vision and strong partnership in conjunction with the opportunities provided within Greater Manchester Devolution, provides us with the platform to drive forward our shared objectives. Working with local people across the statutory, private, voluntary, and community sectors will enable us all to achieve our ambition of prosperity, health and wellbeing for Tameside and Glossop into the future.

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2. STRATEGIC CONTEXT

2.1 Tameside and Glossop

Tameside and Glossop have a residential population density of approximately 21 persons per hectare and covers 40 square miles with a mix of urban and rural landscape. The area includes historic market towns, a canal network and industrial heritage areas as well as modern fast transport links (rail, motorway and tram). It is bordered by the metropolitan boroughs of Stockport to the south, Oldham to the north, Manchester to the west and Derbyshire to the east. Some parts of our locality are sparsely populated whilst areas of the main towns are highly populated (e.g. Ashton, Droylsden and Hyde).

Tameside and Glossop's local economy is interconnected with that of Greater Manchester. The workforce is well placed, particularly in the west of the borough, to benefit from the geographic concentration of economic activity and newly improved transport links. 6.2% of all jobs in Greater Manchester are in Tameside and the Tameside and Glossop share of Greater Manchester working age (16-64) population is circa 8.5%, which means that there is a net outflow of workers to other areas including to the regional centre, Manchester, itself.

A number of key challenges over the next decade are likely to impact on the lives of our residents and our communities. These include some significant social issues including continuing high levels of relative deprivation as well as the impact of being a financially challenged economy. As described by this Locality Plan, we intend to take positive action in favour of both deprived places and deprived people and achieve a financially sustainable economy within five years.

Given that the prevalence of many diseases is age-sensitive, changes in the population and age distribution within Tameside and Glossop will have important implications for the burden of disease and the demand for health services. Compared to England as a whole, we have a slightly lower proportion of people aged 20-39 and a slightly higher proportion of people aged 40-69. In addition, an increasingly ageing population is likely to increase the overall prevalence of limiting long term illness or disability and increase demand for health services and social service interventions.

2.2 Population and Public Health

Statistics relating to our population are stark. Healthy Life Expectancy (HLE) is significantly lower than the North West and England average for both men and women, this is shown for Tameside in Table 1 below and Glossop broadly mirrors this.

Table 1 - Healthy Life Expectancy in Tameside

	Men	Women
England	63.3	63.9
North West (NW)	61.2	61.9
Tameside	57.9	58.6
To achieve NW average need to increase HLE by (years)	3.3	3.2
To achieve England average need to increase HLE by (years)	5.4	5.3
To get to the England average, Tameside need to prevent the following number of premature deaths each year	105	71
To get to the Northwest average, Tameside need to prevent the following premature deaths each year	59	47

Source; PHE 2011/13
Analysis; Tameside Public Health Intelligence

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From the Tameside and Derbyshire Joint Strategic Needs Assessments (JSNA), it is clear approximately two thirds of the life expectancy gap between our average and that of England as a whole is due to three broad causes of death; circulatory diseases, cancers and respiratory diseases. Data also shows that across the whole life course there are problematic rates of obesity, alcohol misuse and smoking related conditions.

Poor mental health and wellbeing also has a significant impact on individuals, families and communities. Low mental wellbeing is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. A summary of key health challenges for Tameside can be found at **Appendix A** and Glossop (Derbyshire) at **Appendix B**. A full description of health needs can be found at:

Tameside JSNA
Derbyshire JSNA

2.3 Public Service Reform

The Greater Manchester Devolution Agreement (Devolution) brings opportunities, innovation and enthusiasm for changing current public sector policy and services for the rapid benefit of the Greater Manchester population. Tameside and Glossop is determined to work effectively within the Devolution construct to create the conditions for economic growth, connect more of our residents to the opportunities of that growth and create attractive places for people to live and work. We also will ensure this is underpinned by good quality, universal services including health and social care.

In line with the aspirations of Devolution, our public service reform principles are:

- using evidence-based interventions to improve outcomes
- integration and co-ordination of public services
- whole family / whole person approach to changing behaviour
- developing new approaches to investing and aligning resources from a range of partners on joint priorities
- robust evaluation of what works to reduce demand on public services

Devolution offers the opportunity to overcome many of the barriers to integrating public services, particularly for those residents and communities who will most benefit from an integrated response from public services.

2.4 Contingency Planning Team

In November 2014, Monitor appointed Price Waterhouse Cooper (PwC) as a Contingency Planning Team (CPT) to test the financial and clinical sustainability of Tameside Hospital NHS Foundation Trust (THFT) following a number of critical reports. The CPT report was supported and published by Monitor on the 17th September 2015 **(See Appendix C).**

The publication of the CPT report feeds directly into the work which has been on-going for the past two years to develop integrated health and social care across Tameside and Glossop. The CPT process provided considerable assurance on our plans for a new model of integrated care and gives us access to levers of national significance in terms of creating an Integrated Care Organisation (ICO). We have an opportunity to be at the forefront of the national drive to integrate health and social care, allowing us to collectively deliver better outcomes for local residents.

The CPT report concluded that THFT should become the delivery vehicle for the integrated health and social care system. As a locality, we have agreed with this recommendation and will be supporting THFT as they transition into a representative integrated care organisation. The CPT estimates that by implementing the proposed model of care, we will save £28 million a year across health and social care by 2020. Although this is significant, it does not solve the whole financial gap. The detail of how we will meet this gap is contained within Chapter 5.

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However, financial reasons are not the main reason why we believe health and social care services in Tameside and Glossop will need to look very different in the future. Integrating preventative and proactive care, GPs, social care and the services provided in the hospital will deliver better health and social care service for local people. Those in need of support will receive it in a more co-ordinated way, without having to work their way through a complex system of multiple organisations and teams. Care will, wherever possible, be provided closer to home (preferably in people's homes) and we will do all we can to keep people out of hospital and where effective, provide early support to prevent a stay in hospital.

Two important aspects of the new model of care are the creation of Locality Community Care Teams (LCCTs) in five localities and the Urgent Integrated Care Service (UICS). The LCCTs will bring together health and social care delivery and dramatically improve coordination of care through individual care plans and the sharing of expertise. The UICS will have responsibility for looking after local people who are in social crisis, or who are seriously unwell. There will be a range of services sitting under the UICS including A&E, a rapid response team, a discharge team and intermediate care.

The CPT report proposes Tameside Hospital will continue to provide planned surgery and A&E care (as part of the UICS) but will have a reduction in beds for patients needing medical care of 18% due to the positive impact of integrated care providing services in the community.

The report represents a significant step forward but does not provide us with all of the answers. The proposals are unfunded and discussions are taking place around how the required transformation funds can be obtained in the economy to drive forward our plans for an integrated health and social care system at scale and pace. The CPT report is available at **Appendix C**.

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3. OUR AMBITION

3.1 Our focus

Our ambition for the public sector across Tameside and Glossop is bold. We aim to raise healthy life expectancy to the North West average within five years. By 2020, a male in Tameside and Glossop can expect to have an additional 3.3 years of healthy life expectancy and women an additional 3.2 years. We then will continue to drive our ambition to achieve the England average within the subsequent five years.

We do not underestimate this challenge and the significant changes this will require in the planning and delivery of services across the public sector to deliver this. This Locality Plan describes how health and social care services will contribute towards our ambition by creating a fully integrated health and social care system which:

- creates resilient and empowered residents and communities as well
- improves health and wellbeing outcomes with a focus on early intervention and prevention
- provides high quality, safe, clinically effective and local services meeting NHS constitutional standards
- delivers long term financial sustainability.

3.2 Our principles and values

We will ensure that the way in which we take forward this Locality Plan is based on a number of important principles and values. We are committed to:

- ensuring the interests of the people of Tameside and Glossop are at the heart of everything we do
- valuing and building upon the skills and assets we already have in our local communities
- tackling inequality in our community wherever we can, particularly if this means some people get a better health and social care service than others
- creating a person-centred culture where the care delivery system is designed around the individual and not the system
- ensuring that local people and staff working in our organisations have the opportunity to participate as equal partners in taking forward this plan
- promoting social value in all our work, meaning we will look to invest in local businesses, not for profit businesses and community organisations to provide the services we need
- providing the best quality care that we can, within the available resources
- supporting healthy behaviours across our communities both through a focus on high risk behaviour and longer term lifestyle changes
- supporting people with long term conditions or on-going care needs, and their carers, to self-care more effectively and engage proactively in their own health and care
- providing an integrated health and social care service that is based on supporting people to live healthy, independent lives in their own homes wherever possible, with the support they need close at hand. Where people need to travel for more specialised care or treatment we will ensure that services are in the most appropriate location to deliver good quality care.
- develop strong working relationships with Devolution to ensure our plans compliment the work for the wider conurbation and that Tameside and Glossop residents benefit from the wider work across Greater Manchester.

3.3 Our determinants of success

By 2020, the people of Tameside & Glossop will be living longer, healthier and more fulfilled lives. Healthy life expectancy will be increasing, health and social care will be delivering services in a different way including a significant shift towards prevention of illness and a focus on wellness, and the economy will have a robust financial platform.

The population of Tameside and Glossop will feel and understand the transformed system and will be engaging with services differently. This change will be described as:

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- Tameside and Glossop being a place where people choose to live as it is safe, provides the opportunity to work, gives access to affordable housing and leisure and offers a wealth of opportunities to enjoy a good quality of life
- the lives people have, the employment they are in and the skills they have developed give them a real sense of purpose and the confidence and aspiration to achieve and believe in themselves
- regardless of age or ability, people feel they are making a positive contribution to their family and community, have a sense of belonging and take a pride in their community
- people are using information, advice and taking the opportunities to help them make the best choices about how they live their lives and stay fit for work and recreation
- people can see the benefit of being independent with less focus on public services but the knowledge that, when needed, they will be supported
- people understand what to expect from public services and are using them in a responsible way
- people have trust and confidence in the services provided, knowing that they are accessible and right for them and their families as they have been engaged by services and involved in their co-design
- their symptoms and problems are diagnosed early and they receive the best interventions from the right people, in the right place, at the right time
- children in the very earliest stages of their lives are getting off to a good start because their parents have the right skills, knowledge and support
- children and young people are making the most of opportunities that education, training and leisure offer them and are already adding value to their community with their skills and experience
- older people are treated with dignity and respect, are able to live safely and independently and continue to add value to their community with the skills and experience they have
- good mental health is valued equally as much as good physical health by our communities and by our services.

Tameside and Glossop example of current best practice - Charmaine

Charmaine is 14 years old. She had poor attendance at school and high levels of behavioural problems and incidents with staff and other young people. The school was very concerned about her declining academic performance and the impact of her risky social activities outside of school. She was putting herself in situations where she was at high risk of child sexual exploitation, including going missing from home.

Through mentoring support from a voluntary sector 'Achievement Coaching' programme, Charmaine was helped to improve her relationship with school, both physically and emotionally. She was also supported to access drugs and alcohol services and 'keeping safe work' was completed with her to improve her understanding of the risks she was putting herself in, and the potential consequences.

Charmaine engaged with the project for six months and in that time she progressed well during the programme. Her attendance improved and her behaviour incidents reduced by 70%. She submitted her course work on time, received a better grade then she was expecting and she plans to attend College. She has met several times with her Branching Out, drugs and alcohol worker (another voluntary sector provider) and her attitude towards risky behaviour has changed. Her assessments show that her knowledge on substance misuse has increased and her attitude towards legal highs is changing. School feels that she is less likely to be excluded due to the intervention.

Using the Troubled Families Cost Saving Calculator it has been calculated that an investment of £1000 for this intervention has saved the Public Sector £13256.

3.4 Partnership and participation

In line with our principles and values, we will ensure local people who use services and the staff who provide them are actively involved in further developing and delivering this plan. In order to ensure we design services that meet the needs and expectations of local people, we will invite people as individuals and part of community groups to be involved and help us shape our plans for how integrated health and care services will be delivered. In doing so, it will be important for us to hear the voice of all parts of our community so we develop services and community support networks that are attractive and accessible for all residents.

To help us take forward the co-design of this plan, and co-production of new care and support models and services, we will build strong working partnerships with a wide range of organisations that represent the interests of different parts of our local community, as well as those who provide support and services. We will develop the concept of relevant local organisations coming together to create community based consortiums to shape and deliver services. This will include organisations providing health and care services, but it will go much wider to include areas such as housing, education, transport, leisure facilities, employment and welfare. We also will develop our partnership approach to include local community organisations, charities, social enterprises, businesses and other parts of the public sector. We are committed to being open and clear in our communications, so that people know how and where they can get involved. We are not just looking to run a one-off exercise to take people's current views on integrated health and care, but to establish processes that will enable on-going participation and partnership working which stands the test of time.

Tameside and Glossop example of current best practice - Engagement

Community and Voluntary Action Tameside (CVAT) and their counterparts in Derbyshire, High Peak CVS and Glossop Volunteer Centre carried out engagement activities on behalf of the partners involved in developing the Care Together Programme.

Learning from previous engagement events, an asset based approach to engagement was developed. This meant working with existing 'assets,' in this case Voluntary, Community and Faith Sector (VCFS) groups already working with people from protected characteristic groups alongside traditional deliberative events. Through the in-reach, skills (e.g. interpretation support) and enthusiasm (in getting their member's voices heard) of these groups and the trust that they have from their members, it was possible to see additional opportunities to engage with over 220 local people, many of whom were from potentially marginalised communities. The approach has subsequently been used to engage with approximately 70 Children and young people around the re-design of Emotional Wellbeing services.

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4. OUR APPROACH

The future health and social care system we are striving to develop for Tameside and Glossop is one where people are supported to be well, independent and connected to their communities. When people do need to access health and care services, they will be delivered locally in a joined up way with an emphasis on addressing the wider factors of the individual's health and wellbeing, including work, housing and access to leisure. We know this requires fundamental change in the way we work together and also in how services are delivered.

Delivering our ambition will be enabled through six priority transformation programme areas. Together these six areas will create a fully integrated, person-centered system of health and care support and treatment. The aim of each is to provide the care and support people need so they do not have to escalate to the next stage unless absolutely necessary. This chapter explains these six programme stages of the model of care in detail.

- **Healthy Lives (early intervention and prevention):** a focus on education, skills and support for people to avoid ill-health, including lifestyle factors but also employment, housing, education and income inequalities.
- **Community development:** this will strengthen and sustain community groups and voluntary sector organisations' work to provide the necessary support in the community.
- **Enabling self-care:** improving skills, knowledge and confidence of people with long-term conditions or with on-going support needs to self-care and self-manage.
- **Locality based services;** for people who need regular access to health and social services, these will be fully integrated in localities, offering services close to, or in, people's homes. They will be supported by multi-disciplinary teams (MDT) with a named care co-ordinator, based on a personalised care plan which focuses on the individual's life goals and aspirations, not just health and care needs. This will involve identifying upfront those people most in need of this care co-ordination.
- **Urgent integrated care services:** for people in crisis or who need urgent medical attention, other health or care support, and a single urgent care hub will align a range of urgent and out of hours care services around A&E to make it easier for people to access the most appropriate service.
- **Planned care services:** to ensure the provision of planned (elective) care in line with the Devolution and Healthier Together programmes.

4.1 Healthy Lives (early intervention and prevention)

Our ambition for our population is to be independent and in control of their lives. The Marmot Review into health inequalities "Fair Society, Healthy Lives" 2010 is very clear about how to improve health and wellbeing for all; employment, planning, transport, housing, education, leisure, social care are all interlinked and have an impact on physical and mental health. Further detail can be found via the link below:
http://www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE

Delivery requires a greater focus on prevention, early intervention, shared decision making, supported self-management and self-care. Our Health and Wellbeing Strategy, which we are currently implementing, aims to deliver this as well as tackling unfair disadvantage and inequality through early intervention and prevention across the life course. This is described below.

4.1.1 Starting & Developing Well

Encouraging healthy lifestyles and behaviour and thereby enabling all children and young people to maximize their capabilities is at the heart of our transformation work. We will achieve this through the continuing development of high quality services encouraging and promoting healthy habits. This includes preventing/reducing harmful alcohol consumption, substance misuse, obesity, physical inactivity, smoking and improving sexual health, so that individuals and communities are equipped and empowered to make healthy choices and live healthy lives.

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Focusing healthy lifestyle messages on young people is likely to also have a long term effect on our Healthy Life Expectancy (HLE). A new generation can more easily break the unhealthy lifestyle choices that their family has traditionally made and thus reduce their risk of developing life limiting long term conditions later in life. There is also evidence that children can influence the behaviours of their parents, if they understand from an early age that they can encourage and support their parents to change their lifestyles.

We will intervene early where our children, young people and families need help and we will strengthen the support provided during pregnancy and the first five years of a child's life to ensure every child is given the best start in life, is fit to learn and able to fully develop their potential, communication, language and literacy skills. A key priority is to increase the proportion of children who are 'school ready' by continuing the implementation of the Greater Manchester Early Years new delivery model to improve early intervention and prevention for children and families in need.

- **Healthy Schools Programme**

The Healthy Schools Programme ceased in 2011. Our aim going forward is to develop a Health and Well Being offer for Children and Young People (CYP) to improve health outcomes for children, young people and their families. This will be achieved by working in partnership with the School Health Service and others organisations to tackle health inequalities and contribute to key public health priorities for the 5-25 year old age range.

The core public health offer for school-aged children, which encompasses the Healthy Child Programme (5-19), includes:

- Health promotion and prevention by the multi-disciplinary team;
- Defined support for children with additional and complex health needs;
- Additional or targeted school nursing support as identified in the JSNA

We are taking a whole school approach i.e. one that goes beyond the learning and teaching in the classroom to pervade all aspects of the life of a school. Key to this will be to work collaboratively with schools to help their children and young people to grow healthily, safely and responsibly and to become active citizens who proactively contribute to society and the environment.

Tameside and Glossop example of current best practice - Jade

Jade started experiencing difficulties after the birth of her second child. Her family was experiencing significant stress which was linked to domestic abuse, substance misuse, mental health needs and financial difficulties. These, combined with isolation and lack of support networks began to affect the children's development and attachment. Jade was reluctant to work with social care and support services due to her own childhood experiences, so for a short time the children were taken into care.

Different organisations came together in partnership with Jade and her family to work through their issues. They made sure the children were at the centre of the picture. A Family Intervention Worker from Jade's local children's centre supported the family to manage debt and access benefits. Jade was supported to allow her older child to access a free 2 year old place and speech and language therapy at a local nursery. She built good relationships with the Health Visitor and Early Attachment Specialist who supported Jade with parenting, and enabled the family to get back on track. Both parents accepted the help and support they needed to make changes and the children were returned to the family. They continue to make significant progress. Jade is very proud of her children and is keen they have a positive childhood experience. Jade no longer needs a Family Intervention Worker but often pops into the children's centre to attend the groups where she has built confidence and made new friends.

- **Child and Adolescent Mental Health Services (CAMHS)**

The early detection of mental health problems through all stages of a child's life is crucial. Intervention making a difference both for individuals and populations at this time can help avoid social and health problems in later years. The antenatal period and early years represent vital development stages when emotional wellbeing issues and problems with child development, speech and behaviour can arise. We are improving emotional and mental health services for children and their parents by delivering an integrated parent infant mental health pathway.

As one of only eight pilot sites nationally, NHS Tameside and Glossop Clinical Commissioning Group (CCG) is devising and implementing a transformational approach to CAMHS to better integrate care and support for our children and young people. The Children and Young People's Emotional and Mental Well-being Transformation Plan 2015-2020 sets out our partnership plans to improve prevention, early intervention and increase access to specialist CAMHs practitioners.

4.1.2 Living & Working Well

- **Stronger families**

Strengthening all generations of the family, leading to active residents with responsibility for their own health and wellbeing needs will be delivered by our Stronger Families programme, an integrated approach to working with families with complex needs. A central aim is to ensure we champion early intervention to prevent issues escalating downstream and later in the life course. In addition, this model ensures that we take a 'whole-family' approach when working with families rather than a simple single child, single adult response.

This model has proved to be one of the most successful nationally with some of the best outcomes for families ranging from reductions in anti-social behaviour, improvement in school attendance and some of the highest rates of moving adults into employment. As the model works closely with the multi-agency Public Service Hub, families and services have been able to pull on a range of agencies and voluntary sector provision to address the whole needs of the family, this has included better management of adult mental health and substance misuse, better coordination with Health Visiting teams and reductions in domestic violence.

Our plans include providing all children and adults with a learning disability with support from an integrated all age learning disability service, proactively managing a programme budget to meet the needs of those with complex needs, those within the Transforming Care cohort and those, including children and young people, at risk of requiring out of area packages of support.

- **Housing**

Using an approach that builds on existing community strengths, we aim to increase opportunities for residents in Tameside and Glossop to live in a safe and healthy home and community.

We know that the area where people live and the quality of their housing can have a major impact on their health and well-being and that poor housing and environment cause ill health. We welcome the mandate set out in the "Memorandum of Understanding to Support Joint Action on Improving Health Through the Home", December 2014 and will be working at pace and scale to create communities and neighbourhoods as well as the identification and management of housing related issues using the local community asset base. We will be training and developing our collective workforce to work in partnership to increase community resilience as well as provide a preventative approach in areas such as fuel poverty, accident prevention, financial resilience, homelessness, adaptations and assistive technology, to ensure residents have a home which promotes wellbeing.

- **Physical inactivity**

Investment in encouraging and enabling participation in physical activity is a cost effective method of increasing population health and reducing avoidable demand and expenditure. Physical inactivity is directly correlated to deprivation levels, meaning that it is a significant factor in maintaining health inequalities.

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Increasing the level of physical activity amongst our local population is a fundamental aspect of our transformational work to improve overall health and wellbeing, enable economic growth, and to reducing demand for health and social care services.

- **Mental health and wellbeing**

Creating parity of esteem between mental and physical health is pivotal to our overall well-being. Within Tameside and Glossop, this concept is embedded across health, social care and wellbeing work streams such as health improvement, skills and employment, early help and substance misuse. Our strategic approach is being refreshed to maximise the new opportunities approaching with the NHS England Access and Waiting Times' standards, the Greater Manchester Mental Health Partnership and the forthcoming NHS England Task Force work.

Access, integration and recovery models underpin our transformational work. This work will ensure our mental health services are effective, efficient, based on 'best practice' and outcome focused to ensure services are sustainable and are provided as close to the users' community as possible. This will include integration with targeted and broader based voluntary, community and faith sector services to build on community assets.

- **Work and Health**

Improving the economic prosperity of local residents is another key driver for our reform work with specific outcomes focused on reducing worklessness, improving adult skills and improving household income. Our collaborative multi agency approach is tackling the multiple and complex barriers which can prevent people from accessing and progressing in work e.g.: mental and physical health, skills, addiction, housing, lack of affordable child care and debt. We are exploring a local "Fit to Work" pilot for out of work benefit claimants, which could establish GP referral routes into a work/health management service and increase activation of patients in self-management. Additionally, we will focus on prevention programmes to improve physical health and reduce our high rates of vascular dementia.

- **Transport and Health**

To sustain and improve our economy and enable our communities to flourish and prosper, good transport provision is crucial. This enables access to employment, healthcare, education and link with the benefits associated with tourism and leisure. Transport is a catalyst in underpinning investment opportunities in developing run down areas and improving housing provision in our local area.

Our public health approach to transport is to move away from cars and towards walking, cycling and public transport. This reduces the harms of the road transport system, enhances benefits to individuals, society and the environment by helping carbon reduction. To achieve this shift, our services will be restructured so that more of our population find, and are supported to see, the most convenient, pleasant and affordable option for short journey stages to be walking and cycling, and for longer journey stages to be cycling and public transport. We will be encouraging this via our plans to ensure people can easily access local services on foot or bicycle, and ensure new developments prioritise physically active lives, including walking and cycling.

4.1.3 Ageing & Dying Well

Our work to reduce loneliness and social isolation, particularly amongst older people, has been recognised nationally as best practice. Our approach aims to reduce chronic emotional loneliness which otherwise can lead to people leading lifestyles that result in poor health and premature death.

With a focus on promoting independence and by making Tameside and Glossop a good place to grow old, older people are helped to participate fully in community life. In our commitment to ensuring we provide high quality care to all that need it; we will ensure sources of support are joined up. We will build on the capacity of services and communities to know how to help and access this.

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- **Increased Life Expectancy**

Improving the healthy life expectancy of our local population is key to improving the experiences of people in older age. Our whole sector proactive and preventative approach will connect people with their local communities, work with people to manage their health and will encourage and support people to access local community groups and resources. Along with the emotional impact on people and their families, dementia has a huge financial impact and reflects one of the biggest public health, NHS and social care challenges.

There are approximately 3,483 people with dementia living in Tameside and Glossop and the estimated total cost to the economy is £112m with long term institutional social care costs making up the majority of this. Our ambition locally is to ensure individuals and their carers have an early diagnosis of their dementia and quality post diagnostic support which meets their needs and is integrated within our Local Community Care Teams. As we have an above average rate of preventable dementia, caused predominantly by unhealthy lifestyle behaviours (the local rate of vascular dementia is 42%, more than double the national rate of 20%), we will build on keeping brains healthy within our Wellness Offer.

Our local strategy and action plan is ambitious. We want to ensure local people and their carers are able to live well with dementia, at home wherever possible, with resources available to support them throughout their journey, including in crisis situations. This supports the overarching aim of the Greater Manchester Strategic Plan for Dementia, which is to improve the lived experience for people living with dementia and their carers, whilst determining how to reduce dependence on health and care services. In line with this our local strategy will be refreshed against the five domains identified:-

- **Preventing Well:** reducing the risk of dementia in the local population, particularly vascular dementia
- **Diagnosing Well:** developing a robust seek and treat system that offers early, comprehensive, evidence based assessment for all
- **Living Well:** establishing dementia friendly communities, networks and support and ensuring that every person has access to tailored post diagnostic advice/support
- **Supporting Well:** regular access to health and social care services which reduce the number and duration of emergency admissions, re-admissions and care home placements. Ensuring care continuity, irrespective of the location of the individual.
- **Dying Well:** Focusing on understanding where people living with dementia are dying and striving to ensure the place of death is aligned with the person and family preference.

- **Housing**

Working with local partners – care homes, registered social landlords and private landlords, we will ensure that the quality of housing for older people is aspirational and supports good health. Assistive technology, telecare and telehealth are key factors in people remaining safely at home. Over 4,000 people are supported by our Community Response Service which offers a physical response within 20 minutes where necessary, in the majority of cases. Our Housing Strategy is being refreshed, with a greater emphasis on the needs of older people to ensure locally there is sufficient appropriate housing.

- **Urgent Integrated Care Services**

The vast majority of hospital attendances and admissions locally are older people. It is critical that we ensure we deliver a responsive community based integrated intervention that supports an individual to remain at home. Our ambition, as described in our Care Together programme, is to ensure we offer a professional response within one hour, where this is appropriate, with professional triage and support to offer a short term intervention to stabilize and refer on where required. Considerable benefits will be derived from this approach, not least that the individual remains in the comfort of their own home, wherever possible, and timely, appropriate interventions manage and minimize the acuity.

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- **Palliative and End of Life Care Services**

The vision for palliative and end of life care services is to ensure the wishes of those in the final months of their life are met and also to improve the percentage of deaths occurring in the usual place of residence. Patients perceived to be in their last 12 months of life are already proactively monitored using the Gold Standards Framework and end of life care information is appropriately shared to improve co-ordination. We will be working through our locality teams to develop improved links with voluntary and community services and thereby further support patients and their families to self-care and prevent crises.

Tameside and Glossop example of current best practice - Grace

Grace is a recently retired French teacher who had surgery for bowel cancer five years ago. She is very private person, but after reading several newspaper articles and watching a documentary on-line, decided to be as open with family, friends and work colleagues as she could. She found many of them very supportive and encouraged by their response became a volunteer with a local cancer awareness programme and helped with community events encouraging people to take up screening for bowel cancer. She also gave several talks to patients at her GP practice about the importance of screening.

A year ago her cancer recurred, treatment was unsuccessful, and she started to find she had a lot less energy and lost weight. Her daughter who lives locally asked to stay with her as often as she could, and friends and family made sure that she had visitors every day. She continued to walk her dog three times a day and pick up her newspaper from the local shops.

Grace is currently in bed at home, receiving daily visits from the local Macmillan Community Palliative Care Team, District Nursing Team and overnight support from Marie Curie Cancer Care. She has indicated that she would like to spend her final days at home, and made a plan for her funeral with her sister. Her daughter and two of her friends visit every day. An Advanced Care Plan has been agreed, and her GP has visited three times in the past week.

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4.2 Community Development

Our local communities have a vital role in delivering our ambitious plans as social connections and having a voice in local decisions are all factors that underpin good health. Understanding, building upon and utilising the rich and diverse assets within our community can provide a significant impact on health and wellbeing. This approach is known as Asset Based Community Development (ABCD) and has been summarised by Alex Fox, CEO of Shared Lives Plus in this way: “If all you look for in an individual, family or community, is need, that is all you will find and you will always conclude that an outside agency or expert is needed to fix them. It suggests that anyone offering support should always look first for what someone can or could do and should think about how to support them to maximize their capabilities and potential, drawing on their natural support networks.”

Our intention is to examine how local assets, including the community itself, can be used to meet identified needs and enable local residents to achieve and maintain a sense of wellbeing by leading healthy lifestyles, supported by resilient communities. Our approach is based on enabling the many strengths that already exist in our communities to thrive and as such will focus on supporting communities to develop and use their own assets to tackle the issues that affect their lives.

Tameside Council is currently developing and testing out approaches to working with local communities who want to contribute to the development of community asset based approaches. These pilot programmes will form the basis for developing future approaches and commissioning strategies and the focus has been to understand the specific facilities, activities and assets that are used and valued by communities and residents. This has involved working closely with our third sector support and development agency, Community and Voluntary Action Tameside (CVAT), to develop a strategic approach to ABCD and includes working with Manchester Metropolitan University to strengthen our understanding. The learning from this programme has formed the foundation of our Asset Based approach going forward.

A large part of this programme has been learning from and supporting our assets in terms of those already delivering community development work and providing opportunities for them to share learning and best practice, support one another and identify opportunities to work together. We created a 'Community Development Workers Network' for employees and volunteers from any organisation which has a community development aspect to their work. These bi-monthly network meetings include the key element of peer learning; Community Development workers have led sessions with their peers on several topics including monitoring and evaluation. We also have provided a three day practice based course on Appreciative Inquiry for frontline workers, some of whom are using this approach to facilitate community gatherings in their area.

The benefits of Asset Based Community Development include enhanced community and individual resilience, reduced isolation, and associated reductions in the demand for crisis care, such as for: dementia, falls, mental health crises, self-harm, substance misuse, CVD, cancer and end of life care. The type of approaches promoted through ABCD are usually based on social and community support for individuals who need it, and include approaches such as peer-to-peer support networks, befriending services, advocacy and sign-posting people to the most appropriate places for help. These approaches can include community based activities focusing on improving exercise, better diet, talking therapies for people suffering from depression or anxiety, social activities for people who are lonely or isolated, advice and support with understanding healthcare information and conditions, activities such as creative and performing arts which help build self-esteem and many more.

Tameside and Glossop example of current best practice – Jill

Jill is 79 and lives alone following the death of her husband, Harry 12 months ago. He was her main carer as Jill was diagnosed with vascular dementia whilst Harry was with her. Since his death Jill has been lonely and frightened, in spite of her daughter Ruth's help. She often calls her GP Surgery worried about her health.

The GP informed Jill and Ruth about "The Storybox Project". This provides participatory performing arts activities for older people with memory problems, providing opportunities for expression through alternative means of communication. The approach is participant-led, valuing each person's contribution equally, and fosters the development of personal relationships through engaging in a shared expressive activity. It has seen good outcomes, including improved relationships between participants and carers, who are invited along too. Jill's GP and Ruth have noticed an improvement in Jill's wellbeing since she started to attend Storybox. Jill loves it. She's sleeping better and is making new friends. She is realising that there is still much to enjoy in life and is talking with Ruth about attending a swimming session for people with memory problems and their carers too. Jill's GP has embraced an asset based approach to their practice and this is only one of many projects/schemes that they encourage their patients to enjoy and develop.

4.3 Enabling self care

We want to empower people to stay healthy. We also want to support those people with long term conditions to develop confidence, knowledge and skills to manage their condition and to make informed decisions and choices about their treatment and care. We will promote local self-care courses for anyone diagnosed with a long term condition to improve understanding on how their condition impacts on their life, job and relationships and thereby enable them to know more about and improve their health outcomes. This is an essential element of our plans if we are to reduce the demand for health and social care resources and thereby move to a financially sustainable position.

The internet and other technology improvements mean that people who have traditionally needed regular contact with health and care professionals are now in a much stronger position to manage long term conditions safely themselves. Tameside and Glossop has a long history of using assistive technology on social care provision and developing empowerment tools to enhance the skills and confidence of people to care for themselves. We also have one of the UK's leading GP practices in terms of empowering patients to access their own medical records and use this knowledge to research and manage their long term health conditions. In our GP practices, we have professionals keen to test out new ways of supporting patients where a face to face consultation is not necessary. We will build on the experiences and enthusiasm to develop new ways across our integrated care system to ensure people are empowered by information and can effectively judge when they can manage their own health and when they need a specific intervention or support.

As part of our work within Devolution, we will work in partnership to support the development of a social movement for change which promotes people making informed lifestyle choices and based on "bottom up" community leadership. This will create a fundamentally different relationship between public services, residents and local communities and support a shift towards people being empowered around responsibility for their own health, proactively supporting people to strengthen connections with their communities and enabling a focus on community and service user generated outcomes which shape local services. This will link to work on social value based commissioning and evaluation models and include targeted work on areas such as Social Impact Bonds.

4.4 Locality Based Services

Our vision for integrated health and social care services, and tested via the CPT process, is to provide an effective and efficient care system. To do this, we are developing a single integrated care provider, using the Foundation Trust delivery model to provide improved access to services, dramatically reduce artificial organisational boundaries, and greatly enhance the experience of using services.

The introduction of five Local Community Care Teams (LCCTs) will support residents in choosing healthy lifestyles, encouraging them to take more control and responsibility for their own health. They will also enable care to be given in the community, where possible in the persons' home and people will get a named staff member to co-ordinate their support. The LCCTs will have unequivocal responsibility for the health and wellbeing of the populations which they serve. This will be achieved through a co-ordinated approach with primary care, mental health including dementia services, social care services and voluntary, community and faith sector services. These teams will use the risk stratification tools currently available to identify those people most at risk of needing services in each locality with a view to using earlier intervention techniques to manage demand for longer term services. People with long term conditions will be supported by a named care coordinator.

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We have invested in the core infrastructure and in primary care services to provide support and built additional capacity and capability into our practices to meet future challenges. We have co-designed and implemented a new local Quality and Performance Framework, complementary to the GM standards, which has standardised and stretched the contracted quality indicators. Practices are incentivised to achieve these outcomes and are supported through investment in a team of quality improvement and data quality experts to improve systems, processes and bring capacity into practice management and GPs.

We have already implemented coordinated CQUINS across our local community and acute providers to ensure quality and outcomes are aligned across clinical pathways. This includes general practice, primary care services, e.g. GP Out of Hours, Ashton Walk in Centre and extended access arrangements to ensure services are aligned and not operating as stand-alone providers. We are further developing this work to review how QoF (Quality Outcomes Framework) could be re-designed and negotiated into our local model of quality for primary care. We will include GPs in this via the 2016/17 contract negotiations as we continue to engage practices in the design of the future model of care.

The current funding and make-up of the GMS and PMS contractual models are being reviewed as Phase 3 of our GP investment plan. All GP commissioned services are being reviewed to ensure they remain relevant and contribute to the wider system challenges. We will ensure the GP budgetary allocation are place based and locally discretionary, including nationally commissioned services for GPs. We will listen to Healthwatch feedback from detailed local survey work to help design the specification to meet the needs of these populations and ensure we build on the assets in communities. We are also researching models used nationally and internationally to understand and develop the most effective ways of encouraging GPs to work in an aligned and ever increasingly integrated way with, and/or as part of, the future Integrated Care Organisation (ICO).

Primary Care based around the role of the GP service will be at the heart of the new LCCTs. Our new primary care strategy will invest in general practice to:

- strengthen Primary Care Infrastructure
- develop models of care that are meaningful to patients and practices, including access
- develop relevant and meaningful outcomes and quality indicators
- develop our membership and their relationship with the public.

We are looking at an outcomes based commissioning and contracting model to align incentives across pathways, contracts and providers. We will be working with Greater Manchester to ensure our plans complement those of Devolution. We are keen to test opportunities and be an early adopter of new models of primary care delivery and form. We also are keen to work with Devolution to develop transformational opportunities with pharmacies, dentists and optometrists.

4.5 Urgent Integrated Care Services

When people need support in the event of a crisis, this will be managed by one cross Tameside and Glossop wide urgent integrated care service (UICS). It will have clear responsibility for looking after local people who are in social crisis, or who are seriously unwell. The UICS will act as a single point of access and will be able to mobilize all relevant assets and resources across the health and care system to help get people well and back in the most appropriate care setting as quickly as possible. There will be clear accountability between the LCCTs and the UICS.

The UICS will provide one seamless service that supports people from the moment they have an urgent need, irrespective of whether this need is met in their home, by a short-term placement or in hospital to the point they are ready to resume independent living. We envisage the UCIS will comprise:

- a single point of access for people and their carers
- one single assessment process to ensure people only need to tell their story once
- care co-ordination
- an urgent response team

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- co-ordination of all hospital discharges, including discharge planning to ensure no-one is discharged without the necessary community health and social care support in place, ensure no-one is in hospital longer than necessary and help improve the flow of individuals in and out of hospital
- bed and home-based intermediate care
- on-going support by a multi-disciplinary team until a person is stabilised and ready to return to independent living, or living with support from LCCTs.

Our integrated urgent care service will reduce demand for acute services and crisis care. We have already developed a new Urgent Integrated Care Service discharge and admission avoidance team which co-ordinates the intermediate tier of services in hospital, social and community health to manage patients home as quickly and safely as possibly. Our approach to urgent care is to ensure patients are not confined to a waiting room, chair or bed in an acute setting any longer than they need to be. People should get care in the most appropriate setting for their needs – often this will not be a hospital based urgent care service.

Attendances and admissions to hospital will reduce as individuals, and professionals access the right care, interventions and support at the right time, in the right place. This will also allow the hospital to operate effectively and safely. Where appropriate, the Urgent Integrated Care service will ensure discharge from hospital is safe and prompt, with an appropriate level of support to ensure recovery is maximised and the individual maintains their independence. This may involve community based intermediate care services which will aim to achieve maximum potential and recovery.

We will create an integrated urgent care front door/hub from where A&E is currently located. This will relocate the Walk in Centre, GP Out of Hours and the GP (registered list) from Ashton Primary Care Centre and provide wrap around advice and care from integrated acute, mental health, social and community health services all to be located at the urgent care hub. This will ensure the new discharge and admissions avoidance service and the acute/urgent support through the LCCTs is co-ordinated in one place.

4.6 Planned Care Services

Our ambition for planned care is for when people need pre-arranged treatment, they will have access to care that delivers the best health outcomes and returns them to independence as quickly as possible.

In line with the recent Healthier Together consultation and Greater Manchester Devolution plans, we will ensure our patients have access to the very best clinical support. This will be through ensuring our local hospital works with other hospitals to provide consistently high quality treatment and care which meets best practice standards and provides the best outcomes and experience for patients. We will share services across a number of hospitals and ensure concentrated expertise in clinical teams delivering the “once-in-a-lifetime” specialist care. This may mean that for some services, people will have to travel further for particular types of treatment but we will continue to develop opportunities for day case treatment by reducing overnight stays in hospital and increasing the amount of outpatient care in our communities.

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5. DELIVERING OUR AMBITION

5.1 Leading the change

Tameside and Glossop health and social care leaders are determined to improve healthy life expectancy and also create an affordable health and social care system. Chapter 4 describes the detailed approach to our challenges and this chapter will focus on how we will achieve this.

The Care Together Programme is a joint programme between Tameside Metropolitan Borough Council (TMBC), Tameside Hospital NHS Foundation Trust (THFT) and NHS Tameside and Glossop Clinical Commissioning Group (CCG) and has a clear governance structure, led by an Independent Chair. The programme also has a Programme Director, a small Programme Support Office and a dedicated budget in 2015/16 to start our transformation plans. Transitional funding from 2016/17 needs to be secured to continue the process of transformation.

From the 1st January 2016, Tameside will have a single commissioning function operating under a single leadership and supported by one cohesive management team. The current pooled commissioning budget will be considerably expanded to provide a single pooled budget of circa £360m from 1st April 2016 which will include all health and social care expenditure. Once this is embedded and if desirable/appropriate, the remaining elements of public sector expenditure may also be incorporated. We are developing a single commissioning strategy to result in an outcomes based contract for implementation in April 2016.

Comprehensive engagement continues with Derbyshire County Council regarding how to ensure parity of service provision for Glossop residents. Although there are no plans to fully integrate social care and health services formally, discussions are on-going regarding how closer working can be achieved to ensure improved health outcomes and financial efficiencies where possible. Glossop will therefore continue current arrangements for the time being.

There will also be a single integrated provider progressively from 1st April 2016 delivered by the current THFT on its transition to becoming an Integrated Care Foundation Trust. As part of this journey, the Tameside and Glossop Community Services currently hosted by Stockport Foundation Trust will be transferred to THFT from 1st April 2016. The development of local primary and community care services will commence in earnest once the transaction is safely completed.

The Care Together programme expects to deliver the new legally constituted and representative Integrated Care Foundation Trust by 1st April 2017. The Care Together Programme Board will then cease as it hands over accountability for further development of the organisational culture and model of care to the ICO. There may, in time, be opportunities to identify further system wide benefits in Accountable Care Organisational models.

In order to achieve this ambition and to ensure that local people and staff working in our organisations have the opportunity to participate as equal partners in taking forward this plan, we will develop robust, consistent and effective channels for local people to inform and direct the services they receive through timely consultation, and meaningful engagement. We will do this by developing our existing best practice as individual organisations and committing to meaningful and timely engagement with system and organisation leaders, clinicians, staff, voluntary/community organisations and the public. This will be resourced and supported throughout our development to ensure that we meet our ambition of the interests of the people of Tameside and Glossop being at the heart of everything we do.

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5.2 The financial challenge

Under a "Do Nothing" scenario, our financial gap is projected to be £69m across health and social care by 2020. Table 2 demonstrates the total deficit growing from £23m in FY15 to £69m by FY20.

Table 2 - System-wide position in the "Do Nothing" scenario[1]

Source: PwC Contingency Planning Team Report: 28 July 2015

Health and social care system	Do nothing					
£'m	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**
System income						
T&G CCG allocation	332	343	341	346	352	358
Trust income from other CCGs	23	23	23	23	24	24
Other Trust income	13	11	11	11	11	11
Social care allocation	66	60	52	47	41	41
Total income	**433**	**436**	**427**	**427**	**427**	**434**
Cost of provision						
Trust expenditure	-173	-179	-180	-182	-184	-185
Commissioning of other services	-210	-223	-219	-223	-227	-231
Social care expenditure	-74	-79	-82	-84	-87	-87
Total expenditure	**-456**	**-481**	**-481**	**-489**	**-497**	**-503**
System deficit	**-23**	**-45**	**-54**	**-62**	**-69**	**-69**

Following two years of intense analysis, review and planning across the health and social care economy, we have identified the appropriate strategies to close the financial gap and deliver a balanced economy over the course of the next five years. However, there are four critical and fundamental conditions to achieving successful delivery of our plans. These conditions are:

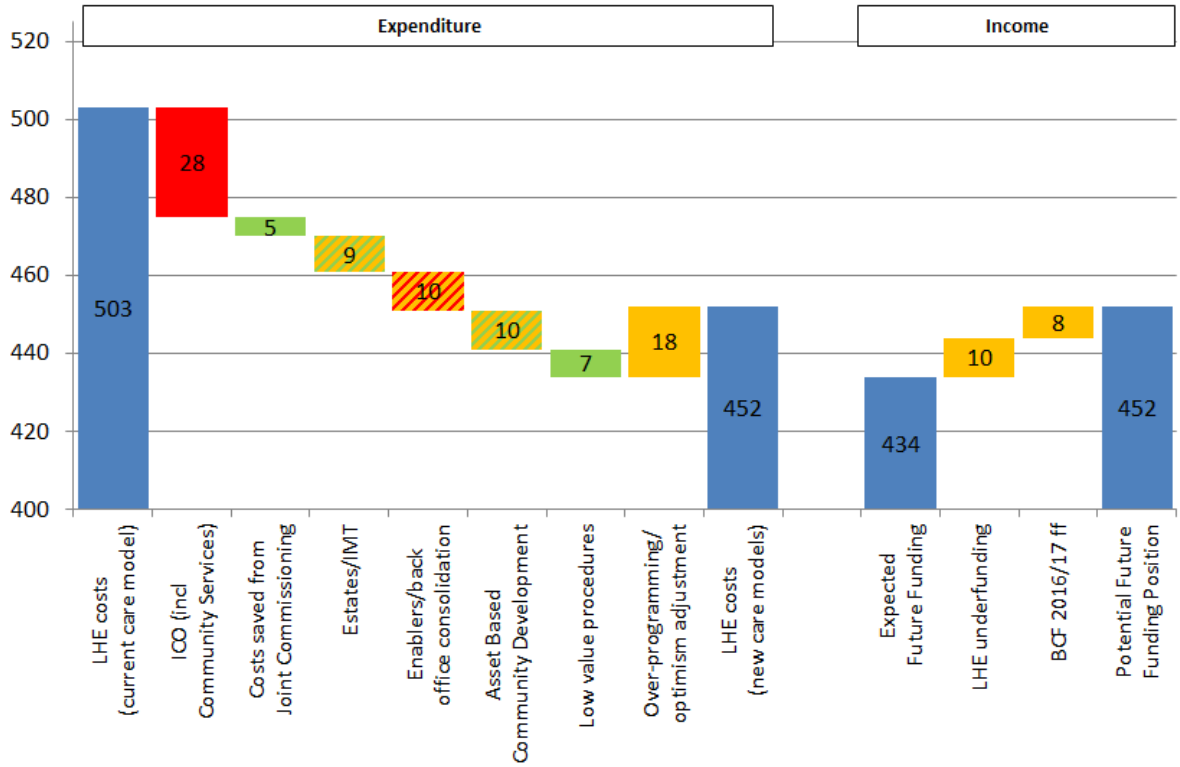
- The economy receives the required revenue and capital transitional funding to deliver the ambition. A robust coherent business case is currently being prepared outlining the request to Devolution
- Department of Health financial support (i.e. public dividend capital), for THFT continues to be received over the course of the next five years
- Social care funding is protected at 2015/16 levels to ensure stability and;
- The CCG is able to drawdown all its £6.746m cumulative carried forward surplus in 2016-17 from NHS England.

5.3 Closing the financial gap

Our plan to close the £69m financial gap is summarised in Table 3 below. The table shows the projected balanced economy in 2020 with the reduced level of expenditure and increased income across the different areas. Each of the components are risk rated to highlight those areas where transitional support is fundamental to delivery, (i.e. Red risk), to those areas where plans are already in an advanced stage of implementation using existing non-recurrent funding streams, therefore minimal risk (i.e. Green).

[1] The system deficit position in FY15 is being addressed through Public Dividend Capital (PDC) funding and therefore reporting a balanced cash position across the health and social care economy.

Table 3 - Closing the financial gap by 2020



The different components of the above table and the way in which they contribute to the balanced Local Health Economy (LHE) by 2020 are as follows:

5.3.1 Expenditure Components

£503m – Cost of the local health and social care economy
This represents the total value of the current cost of delivery of our health and social care model.

£28m – Integrated Care Organisation (including Community Services)
This is the reduction in annual costs identified by the CPT's recommendations for THFT through adopting a fully integrated model of care including the provision of community services. These cost reductions arise mainly from a reduction in demand for expensive inpatient services, a resulting reduction in estate use at Tameside Hospital and managing the demand increase with the same financial envelope of community care, social care and mental health services in a new integrated model.

The recommendations were published by Monitor in September 2015 and we are keen to drive through the implementation of these recommendations at pace and scale. The finance and activity modelling underpinning the CPT's recommendations is both sophisticated and thorough. The modelling uses granular level data to inform the proposals, correlate with activity projections within Healthier Together and also support the Locality Specific Services (LSS) analysis undertaken as part of the CPT's strategic review of a financially distressed FT.

The prevalence of various long term conditions have been considered and the numbers of hospital admissions these have historically caused. This has enabled an estimate of the impact of integrated care on a specialty and points of delivery basis which can be performance measured and provide critical success factors for delivery of our vision.

The modelling also demonstrates how general practice is at the heart of our plans for integrating care across primary, community, social and secondary care services for Tameside & Glossop. As described in Section 4.4 of this Locality Plan, general practice is the cornerstone of plans to reform local health services and improve health and outcomes for local people.

Our new models of care are focused on delivering as much care as is safe and appropriate in primary and community care and our aspiration for level 3 co-commissioning of primary care budgets from the 1st April 2016 is testimony to this. Benchmarking data suggests Tameside & Glossop are below average in investing funds in primary care and we recognise the urgent need to address this historic imbalance. We have already launched the first two phases of our Primary Care strategy by investing substantial recurrent and non-recurrent monies in primary care to get these programmes underway.

£5m - Costs saved from joint commissioning

As referenced previously, there will be one single commissioning function from 1st January 2016 by one cohesive management team. This will realise efficiencies and synergies which could not be achieved if operating as two independent commissioning teams. This fully integrated approach will ensure a cohesive function intent on securing the best possible outcomes for the residents of Tameside and Glossop. To this end, the pooled budget established in 2015-16 will be extended to include the full scope of health and social care expenditure and an aligned budget totalling circa £360m.

Further evidence of our vision is demonstrated within our commissioning intentions for 2016-17 contracts. We will work with partners to develop a model of contracting which reflects the changes in service provision and provides a methodology for funding to enable a long term development and a sustainable financial position. We are working towards a fully inclusive contract with our providers with pre-determined outcome based measures. We acknowledge a lead time is required in developing an outcome based contract model and therefore provider income will be relatively guaranteed in year 1 with minimal exposure to risk. However, this income guarantee will reduce incrementally year on year whilst exposure to risk will incrementally increase until such a time as a true outcomes based contract is in place which we would expect to be no later than 2020-21.

£9m – Estates, Information Management and Technology (IM&T) and Shared Intelligence

Estates: Rationalisation of the public sector estate in Tameside and Glossop will improve efficiency and reduce running costs. It is also hoped that, through Devolution, capital receipts can be retained within Greater Manchester to support the capital costs of transforming from the current health economy to one fit for the future, optimising running costs and securing transformation. We are also reviewing opportunities to increase business rates receipts to help contribute to closing the financial gap for social care.

IMT: We are developing an economy wide IM&T strategy and implementation plan to underpin the Shared Intelligence Service. Subject to receiving the required transitional funding, this work stream will achieve:

- One data set to move towards an outcome based contract
- Shared care record, ultimately to be owned and managed by the individual
- Procurement discounts due to increased purchasing volumes
- Improved efficiency as a result of the co-location of health and social care functions
- Reduced complexity of processes to increase quality and reduce costs
- Standardised desktop infrastructure, support and remote access, thereby improving quality and reducing costs and;
- Provide economies of scale in the application of IM&T.

£10m - Enablers/back office consolidation

Across our health and social care system, there are a number of services and functions required to support any type of organisation and economies of scale can become available by combining these services/ functions. We will be looking to consolidate these to maximise this opportunity whilst recognising there may be further opportunity by collaborating with other partners across Greater Manchester. We believe that shared services at scale provide the best opportunity to drive efficiencies and reduce corporate costs. The scope of transactional type services to be included has not yet been finalised but potentially include Procurement, Payroll, Finance, Transactional HR, IT and Estate Management.

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Whilst we have agreed a £10m savings target across the economy, we will develop a gain share agreement to ensure all organisations benefit from the proposals and that quality of service is at least maintained. We recognise that automation of processes and reduction in transactions are what will drive the reduction in costs and will focus on these to achieve our savings.

£10m - Asset Based Community Development
As specified previously, we are committed to providing an integrated health and social care service based on supporting people to live healthy, independent lives in their own homes wherever possible, with the support they need close at hand. We value the skills and assets we already have in our local communities and will build on these. We want to build strong working partnerships with a wide range of organisations which represent the interests of different parts of our local community, as well as those who provide support and services. This will include organisations that provide health and care services, but it will go wider to include issues such as housing, education, transport, leisure facilities, employment and welfare. This extended collaboration will reduce costs and drive longer-term benefits by improving the health and wellbeing of our citizens.

A number of recent national pieces of work by leading experts have demonstrated the benefits of the kind of approach outlined in this initiative. Nesta's People Powered Health report and business case, published in 2013 estimated a national saving of £4.4billion could be achieved by taking community based "more than medicine" approaches. This would typically involve savings of 20% of spend for people with long-term conditions, who themselves account for 70% of the NHS budget – a saving of 14% of our total NHS spend. Earlier this year Public Health England and NHS England published a study by Professor Jane South of Leeds Metropolitan University, A Guide to Community Centred Approaches to Health and Wellbeing, which brought together all the key evidence of the effectiveness of community based approaches and mapped a "family of interventions" to demonstrate the range of approaches possible. The Kings Fund 2013 report Volunteering in Health and Care presents a compelling argument about the untapped potential in our communities and how that can work effectively with healthcare services. So, making greater use of the assets, skills and capabilities people in our communities already have will both save money and improve people's health and wellbeing. An efficiency saving of £10m for Tameside and Glossop by 2020 is a conservative estimate given the evidence presented in the research cited above.

£7m - Low Clinical Value Procedures
Low clinical value procedures are those deemed to be clinically ineffective, not cost effective or only meeting cosmetic rather than a clinical need. In line with our principle of using evidence-based interventions and not wasting tax payers' money, we will continue to review our "Effective Use of Resources" policies against national evidence to identify procedures which should not be carried out at all or only for the specific cohorts of patients who will derive sufficient clinical benefit. We will work with local residents, GPs and providers to ensure that only patients who meet the necessary criteria for these procedures receive them and others are supported in a more cost effective way.

£18m - Over-programming/optimism adjustment
Our plans are bold, show significant ambition but are also challenging. To mitigate the risk of any delays in delivery and/or additional costs from new emerging risks, we have incorporated an adjustment of circa 4% of the future expected funding which equates to £18m.

£452m – Cost of the New Care Models
This represents the £452m revised cost of providing the new care models, a reduction of £51m from the opening cost as a result of deploying the above strategies.

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5.3.2 Income Components

£434m - Expected Allocations
As projected as at October 2015.

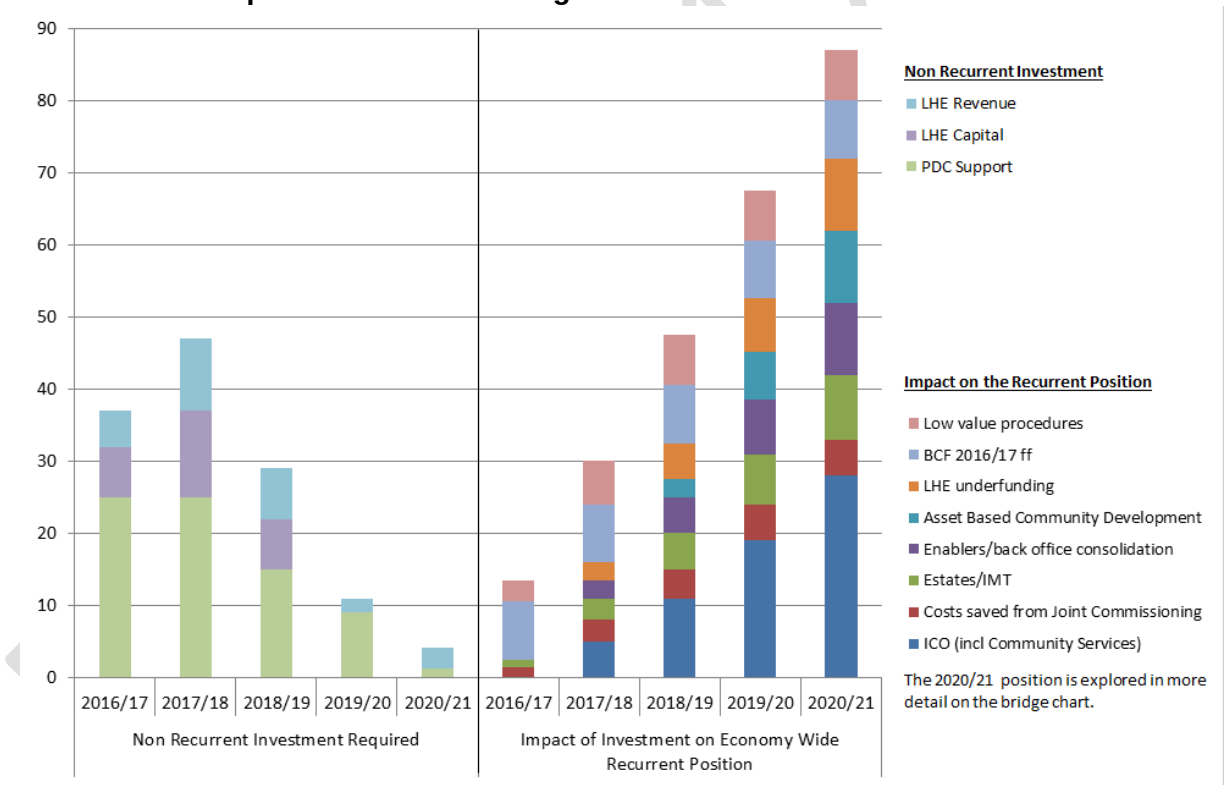
£10m - LHE Underfunding
Government data for CCG distance from target and Local Government financial settlement figures highlights that Tameside and Glossop is underfunded by approximately £14m. Therefore, if fair shares were applied, we should receive circa £14m more than we do currently. However, being conservative, we have assumed a material value of £10m which would reduce the overall financial gap requiring addressing in this Locality Plan.

£8m - BCF 2016-17 funding
This funding has now been confirmed nationally. This represents a financial benefit to the future economy closes the financial gap by matching income with expenditure.

5.4 Profile of Implementation

The implementation of the different strategies will be phased to ensure each of the actions are in line with the strategic vision of delivery being clinically safe, financially sustainable and integrated. The estimated phasing of the income and expenditure across the five year period until 2020 is shown in Table 4 below:

Table 4 - Phased implementation of strategies to deliver a balanced LHE



5.5 Costs of Implementation

The implementation/transition costs for delivering a financially balanced health and social care system are estimated to be in the region of £53m, combining capital and revenue requirements. These transition costs are vital to fund double running and pump priming of services whilst the transformation is being undertaken. There is also a requirement for continued public dividend capital to THFT to provide the essential working capital to run the hospital until efficiencies are released to fund the fully integrated, clinically safe and financially sustainable ICO. Although a significant level of transitional funding is necessary, the CPT report demonstrates that this would provide a good return on investment (Appendix C).

Implementation costs are summarised in Table 5. It is expected that the majority of these costs will be incurred in the first three years of implementation. It is imperative that external funding is made available to allow time for efficiencies to be released and facilitate the transition to the financially sustainable economy.

Table 5 - Transition/Implementation Costs

Area	Description	Capital	Revenue	Implementation/ Transition
		£ m	£ m	£ m
Public sector estate re-design	Reconfiguration of the Trust's estate as per the CPT's report comprising: - assessment, planning and design of the new estates, - moving services within the estate, - development of premises for LCCTs, - building work around the new front end of the hospital and demolition costs associated with the Charlesworth building.	6.5		6.5
Workforce costs/organisational leadership development	Requirements for cultural and associated workforce changes to support the new ICO and the development of the ICO leadership team.		6.3	6.3
Implementation management and professional costs	External/temporary support for: - Implementation support, programme management, communications/engagement, contracting; and - Due diligence, actuarial advice, legal advice and other transaction costs.		5.5	5.5
Double running costs	Where services are to be replaced with services in alternative settings, or where facilities are closed to new patients but need to retain staffing for a period while existing bedded patients are cared for until discharge/transfer, there will be some need for overlap of services.		4.3	4.3
Investment in integrated IT and communication systems	Set up cost and capital investment in new IT including community migration, equipment to support community diagnostics, gap modelling, and infrastructure investment.	19.5		19.5
Contract terminations	Transfers of services between organisations or changes to where and how services are delivered may mean that some support contracts need to be terminated, modified or transferred. There could be financial costs and penalties associated with this.		5.8	5.8
Contingency	In developing a model which is a first of its type in the UK, it is important to ensure there is a contingency to mitigate risk.		5	5
	TOTAL TRANSITION/IMPLEMENTATION FUNDING REQUIRED:	26	26.9	52.9

The above values are taken directly from the CPT report and are uplifted by 10% to cover contract termination costs which had not been adequately reflected. However, these values are being further reviewed and developed as part of the preparation of the business case and the composition is likely to change and the values revised downwards.

5.6 Profile of transition costs

The profile of the above transitional investment over the course of the next five years is shown in Table 6 below. These are currently being tested through the development of the robust and comprehensive business case for transitional funding and hence may change.

Table 6 – Profile of transition costs[2]

Transitional investment:	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total
	£m	£m	£m	£m	£m	£m
Capital	7	12	7	0	0	26
Revenue	5	10	7	2	2.9	26.9
PDC support	25	25	10	10	1	71

The majority of transitional funds are required to take forward change in the system at scale and pace. It should be noted that these figures do not include the full £6.746m cumulative carried forward surplus in 2016-17 from NHS England which we will be requesting in Year 1. Should these not be forthcoming, the revenue ask from Devolution will rise accordingly.

[2] The Department of Health have recently informed THFT that only £20m PDC support can be made available in 2016/17. The ramifications of this are currently being worked through.

5.7 Moving forwards

New financial pressures and risk will always emerge and financial plans will be continually reviewed and updated. We have therefore factored in some contingency for such items and recent examples worthy of consideration comprise:

- Transfer of specialist services back to CCGs will inevitably represent some financial risk to the economy
- The impact of the living wage following the Chancellor's 2015 budget statement, which will impact on the social care costs, and;
- The financial contributions required to support Greater Manchester wide early implementation priorities as outlined in the Programme approach to the Health and Social Care Devolution Programme.

We believe our plans are significantly advanced based on our vision for providing integrated health and social care at pace and scale to deliver our ambition of dramatically improving healthy life expectancy. Our plans have been scrutinised by external parties in depth and have now been endorsed by Monitor as being an absolute necessity for the future of Tameside Hospital and the population we serve, some of the most deprived in the country. We will ensure that wherever possible, the people of Tameside and Glossop receive the very best start in life with the best possible outcomes for health and care by investing funds wisely and ensuring effective stewardship of the public purse.

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APPENDIX A

Summary of Tameside Health and Well Being

Within Tameside there are significant inequalities in health outcomes. Whilst the wards of St. Peters, Ashton Hurst, Ashton St. Michael's and Hyde Godley have the worst outcomes in the Borough, the overall Tameside position for health and social care outcomes is poor.

Key statistics (compared to the England average)

- Highest premature death rate for heart disease in England
- For premature deaths from heart disease and stroke, Tameside is ranked 148th out of 150 Local Authorities in England
- For overall premature deaths, Tameside is ranked 142nd out of 150 Local Authorities in England (<75 years)
- For premature deaths from cancer, Tameside is ranked 133rd out of 150 Local Authorities in England
- Life expectancy at birth for both males and females is lower than the England average (76.9 years males, 80.3 years females)
- Life expectancy locally is 8.7 years lower for men and 7.4 years lower for women in the most deprived areas of Tameside compared to the least deprived areas.
- Healthy life expectancy at birth is currently 57.9 years for males in Tameside and 58.6 years for females in Tameside. This is significantly lower than the England averages.
- In year 6, 33.3% of children are classified as being overweight or obese, under 18 alcohol specific hospital admissions, breast feeding initiation and at 6 to 8 weeks and smoking in pregnancy are all worse than the England average.
- In adults the recorded diabetes prevalence, excess weight and drug and alcohol misuse are significantly worse than the England average
- Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average and many of our statistical neighbours
- Life expectancy with Males in Tameside living 3 years less than the England average and nearly 7 years less than the England best.
- Females live on average just over 2 years less than the England average and 6 years less than the England best.
- Healthy life expectancy for women is nearly a year less than for men, and close to the worst in England.
- Premature mortality for women has not improved as fast as the NW and England.
- Circulatory diseases including heart disease are the commonest cause of early death and rates are 55% higher than the national average.
- Disability free life expectancy at 65 years is significantly worse than the England average (6.8 years compared to 10.2 years in England (males)) and 7.1 years compared to 10.9 years (females))
- Nearly 20% of Tameside residents are living in fuel poverty compared to the 16% England average
- Significantly higher emergency admissions for both males and females
- People returning to their own homes after a stroke is significantly worse than the England average, 28% less people return to their own homes after a stroke compared to the England average.

Source; Tameside JNSA 2015-16

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APPENDIX B

Summary of Glossop Health and Well Being

The High Peak is a Borough Council area in the North of Derbyshire. It has a population of about 91,000 distributed across 208 square miles. The largest town is Glossop (population 33,000) and the second largest is Buxton (population 25,000).

Key statistics (compared to the England average)

- Two lower super output areas (LSOA) in Glossop (Gamesley and Hadfield North) fall within the 10% most deprived in England and are the third and fourth most deprived LSOAs in Derbyshire (IMD 2010)
- Male life expectancy in these areas is 69 and 73 compared with 78 for both Derbyshire and England (ONS). For females the figures are 72 and 78 respectively compared with 82 for both Derbyshire and England.
- The most recent ONS figures for Jobseekers allowance claimants (Nov 2013) show that Gamesley in Glossop has the highest level in Derbyshire with a rate of 6.6%. Whitfield ranked 15th worst (4.3%). The comparable figures for High Peak are 2.1% Derbyshire 2.1% and England 2.9%.
- In the High Peak, a higher percentage of Jobseekers allowance claimants are long term unemployed (over 12 months) compared to county or national rates (34.5% in High Peak equating to 430 people compared to 31.8% in Derbyshire and 31.2% England).
- Derbyshire had a significantly smaller proportion of children living in poverty.
- The rate of low birth weight births is significantly lower.
- Population vaccination coverage in childhood immunisations is significantly higher and, in the case of most vaccinations, rising.
- A smaller proportion of children are achieving a good level of development at the end of reception, and this is even lower in those entitled to free school meals.
- A smaller percentage of mothers are initiating breastfeeding of their babies and this appears to falling.
- By 6-8 weeks the percentage of breastfeeding mothers is even smaller and again appears to falling.
- A higher proportion of mothers are smoking at the time of delivery of their child.
- The percentage of young people who are not in education, employment or training is significantly lower and falling.
- The proportions of teenage girls conceiving, both under the age of 18 and under the age of 16, are significantly lower.
- The proportions of children recorded as carrying excess weight, in both reception (4-5 years) and Year 6 (10-11 years) are significantly lower.
- The rates of hospital admissions caused by unintentional and deliberate injuries in children, aged 0-4 years and aged 0-14 years, are significantly lower and falling.
- Cancer screening coverage – both breast and cervical – is significantly higher, though falling.
- The proportion of adults in Derbyshire who are overweight or obese is significantly higher.
- The percentage of people recorded as having diabetes is significantly higher and is increasing.
- The proportion of households living in fuel poverty is significantly higher, but falling.
- The hospital admission rate for injuries due to falls for 80+ year olds is significantly higher.
- Premature mortality from cardiovascular disease considered preventable is significantly higher.

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APPENDIX C

Contingency Planning Report -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

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8b.

JOINT GREATER MANCHESTER COMBINED AUTHORITY
& AGMA EXECUTIVE BOARD MEETING

Date: 18th December 2015

Subject: Updated Governance Proposals

Report of: Councillor Peter Smith, Portfolio Lead for Health & Social Care and Liz Treacy, Monitoring Officer

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PURPOSE OF REPORT:

This paper builds upon the governance principles that were agreed by Greater Manchester in September 2015 and sets out proposals and recommendations from the governance focus session held with representatives of all stakeholders on 17th November. In particular it sets out a role for primary care providers in the governance structure, it confirms the process for agreement of the Strategic Plan and it sets out progress on GM wide joint commissioning arrangements.

The paper was taken to the Strategic Partnership Board on Friday 27th November, where its contents and recommendations were agreed.

RECOMMENDATIONS:

1. Members are asked to agree the GMCA and AGMA representation on the Strategic Partnership Board Executive. AGMA have four seats, these are currently occupied by members from Cllr Peter Smith (Wigan), Cllr Cliff Morris (Bolton), and Cllr Sue Murphy (Manchester). Members are asked to appoint one further representative.

2. The AGMA Executive Board is also requested to endorse the recommendations agreed by the Strategic Partnership Board on 27th November. As follows:

   i. To agree that primary care providers will receive four seats on the Strategic Partnership Board, and have one seat at the Strategic Partnership Board Executive.

ii. To agree that voting arrangements for the Strategic Partnership Board and Strategic Partnership Board Executive are revised to reflect those set out in the report.

iii. To agree that the Terms of Reference for the Strategic Partnership Board and Strategic Partnership Board Executive are amended to reflect (1) and (2).

iv. To agree that the Governance Sub Group work with Primary Care partners to develop their governance arrangements.

v. To agree the Strategic Plan approval process.

vi. To agree the role of the Strategic Partnership Board in respect of the Transformation Fund, and to instruct the Strategic Partnership Board to develop the criteria by which such funding will be accessed.

vii. To agree the role of the Strategic Partnership Board in shadow form.

viii. To agree the principles of the conflict resolution process for the Strategic Partnership Board, and instruct the Governance Sub Group and Strategic Partnership Board Executive to further develop.

ix. To agree the functions and form of the GM Joint Commissioning Board.

x. To instruct the Governance Sub Group to develop terms of reference for the Joint Commissioning Board.

xi. To agree that a GM Commissioning Strategy is developed aligned with the Strategic Plan.

xii. To instruct the Governance Sub Group to develop the criteria by which NHSE could exercise its ability to request that decisions are not considered at the Joint Commissioning Board.

xiii. To agree that the Joint Commissioning Board be supported by smaller Executive Group.

xiv. To agree that the GMJCB establish a research and innovation board to inform its decisions.

xv. To agree that existing scrutiny arrangements are reviewed, and request that a report be brought to a future meeting.

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1. INTRODUCTION

1.1 Across Greater Manchester, we are working together to reform health and social care services. To support Greater Manchester achieve its ambition of improving heath outcomes for its residents as quickly as is possible, robust and inclusive governance structures need to be developed and put in place.

1.2 This paper builds upon the governance principles that were agreed by Greater Manchester in September 2015 and sets out proposals and recommendations from the governance focus session held with representatives of all stakeholders on 17th November. In particular it sets out a role for primary care providers in the governance structure, it confirms the process for agreement of the Strategic Plan and it sets out progress on GM wide joint commissioning arrangements.

1.3 The principles that were agreed in September 2015 were set within the context of the MoU signed in February. This update is provided within the context of those principles:

- GM NHS will remain within the NHS and subject to the NHS Constitution and Mandate;
- Clinical Commissioning Groups and local authorities will retain their statutory functions and their existing accountabilities for current funding flows;
- Clear agreements will be in place between CCGs and local authorities to underpin the governance arrangements;
- GM commissioners, providers, patients and public will shape the future of GM health and social care together;
- All decisions about GM health and social care to be taken with GM as soon as possible;
- Accountability for resources currently directly held by NHS England during 2015/16 will be as now, but with joint decision making with NHSE in relevant areas to reflect the principle of "all decisions about GM will be taken with GM.

2. FUNCTIONS OF STRATEGIC PARTNERSHIP BOARD (SPB)

2.1 GM has agreed that the SPB will be responsible for setting the overarching strategic vision for the Greater Manchester Health and Social Care economy.

2.2 As it is not a legal body, its decisions are not binding decisions of its members, but it will make recommendations for its members to formally adopt following their own governance procedures.

2.3 Its primary responsibilities were set out in the report of 25th September and include:

- To set the framework within which the Strategic Partnership Executive will operate.
- To agree the GM Health and Social Care Strategic priorities in accordance with the NHS five year forward view.
- To endorse the content of the GM Strategic Plan for financial and clinical sustainability.
- To agree the criteria that determine access to the Transformation fund.
- To ensure that there remains ongoing and significant organisational commitment across the GM health economy to both the devolution agenda and a devolved health system.
- To agree an assurance framework, developed jointly with regulators where required, that reflects the outcomes required by Greater Manchester.
- To provide leadership across the GM health economy to ensure that the key strategic priorities for a GM health system are achieved.

3. SPB MEMBERSHIP AND VOTING

3.1 As previously agreed the membership of the will include:

- Independent Chair
- GMCA (The Chair of the GMCA)
- 10 AGMA authorities (Leaders or Lead Members)
- 12 Clinical Commissioning Groups (Chairs or Chief Officers)
- 15 providers - all acute NHS Trusts and Foundation Trusts, mental health and community providers and NWAS (Chairs or Chief Officers)
- NHS England (as they determine).

3.2 Monitor/TDA (NHS Improvement), CQC, Public Health England, Health Education England, Greater Manchester Fire and Rescue Service (Chair), and Greater Manchester Police and Crime Commissioner will also be invited to attend as non voting members of the Board.

3.3 In shadow form, the voluntary and community sector will be represented by GMCVO. This is an interim solution which recognises further work will be undertaken to ensure that Greater Manchester is able to appropriately engage the VCS within the new governance structures; across both the Strategic Partnership Board and as part of the Provider Forum.

3.4 In shadow form patient voice representation in the governance structures will be through an agreed Greater Manchester Healthwatch representative. Further work is being developed to ensure that the patient voice is appropriately represented within the new governance structures, and as part of the public's engagement on the Strategic Plan

3.5 There is a report elsewhere on this agenda recommending that primary care providers have four representatives on the SPB, one for each of the principal disciplines: General Dental Practice; General Medical Practice; Optometry; and, Pharmacy. This is reliant on primary care providers developing governance structures that will support representation in this way.

3.6 It is proposed that a Greater Manchester Health and Social Care Workforce Engagement Forum is developed as a joint Greater Manchester wide forum for employers and trade unions to discuss at City Region level matters arising from the planning and implementation of devolution in health and social care across Greater Manchester.

3.7 Over the coming weeks discussions with Trade Union Representatives and Employers will take place to identify the role and remit of such a Greater Manchester Health and Social Care Workforce Engagement Forum. The forum would seek to ensure that the principles of meaningful partnership working operate effectively throughout Greater Manchester and will promote good practice in all areas of staff engagement, development and management.

3.8 The SPB will be supported by an SPB Executive. The SPB Executive will have membership that is representative of the key stakeholder groups, and will work within a framework that is set by the SPB. The form and function of the SPB Executive was agreed by the SPB in September 2015 and consists of 4 representatives of CCGs, Providers, and local authorities. It is proposed that primary care have one place on the Executive.

3.9 The SPB and the SPB Executive will have the same independent Chair. The process for recruiting the Chair will begin in January 2015. As interim measure the SPB and SPB Executive will be chaired by the AGMA/GMCA Portfolio Leader with responsibility for Health and Social Care. The Chair of Association of Greater Manchester CCGs will deputise.

VOTING ARRANGEMENTS

3.10 It was previously agreed that the voting arrangements for the SPB would be the with the four principal stakeholder groups: CCGs; Providers; NHSE; and, AGMA/GMCA. For any vote to carry, it was agreed that 75% of the four membership groups eligible to vote must vote in favour of the proposal, with each of the four membership groups holding one vote apiece, and the person with that vote being accountable to their constituent stakeholder group.

3.11 However, due to primary care accounting for approximately 90% of contact across the health and social care system; and having agreed, in principle, to put in place accountable governance arrangements, the voting arrangements will be revised. As such it is proposed that primary care will receive one vote, and therefore become the fifth stakeholder group with voting rights.

3.12 The amendment in voting rights is reliant on primary care partners developing the necessary governance structures to support representational aggregated voting.

3.13 As a result of the amendment to voting rights, it is proposed that for any vote to carry at the partnership Board 80% of those eligible to vote, must vote in favour of a proposal.

3.14 As a result of the amendments to the membership and voting arrangements for the SPB, the voting arrangements for the SPB Executive will also be revised to replicate those set out above. Primary Care will continue to have one place on the Executive. These amendments are conditional on Primary Care developing governance arrangements to support representation in this way.

3.15 Meetings of the SPB will be quorate if each of the vote holding stakeholder groups are represented. Attendees with voting rights will be expected to attend with the authority to vote on behalf of the stakeholder grouping the represent.

4. APPROVAL OF GREATER MANCHESTER STRATEGIC PLAN

4.1 The GM Strategic Plan will be recommended to the Board by the Executive in December.

4.2 The role of the SPB is not to agree the plan, but to provide endorsement at a Greater Manchester level, and recommend that it be taken for approval by CCG governing bodies, Council cabinets, and NHS Trust Boards.

5. DECISION MAKING CAPABILITY – TRANSFORMATION FUND

5.1 It is likely that any transformation funding received by Greater Manchester will be channelled from Treasury to NHSE and, it is anticipated, delegated to the commissioners to allocate in line with recommendations from the SPB Executive which will ensure that GM is able to direct and agree its usage.

5.2 The SPB will determine the criteria for access to the fund, and will receive assurance from both the Chief Officer and SPB Executive on the

application of transformation funding, and delivery of expected outcomes from investments made.

5.3 The SPB Executive will review proposals received against the criteria agreed by the SPB, and will recommend the distribution of transformation fund to commissioners.

5.4 The SPB Executive will receive assurance on the outcomes relating to the activities commissioned by commissioners from the transformation fund.

6. ROLE OF THE SPB IN SHADOW FORM AND NEXT STEPS

6.1 In shadow form, the SPB has the following functions:

- To endorse the Strategic Plan, and recommend it for approval by the 37 organisations in Greater Manchester.
- To endorse the ten locality plans as part of the Strategic Plan
- To agree the criteria that determines access to the transformation fund and request that these be developed by the SPB Executive.
- To agree the criteria for judging whether organisational reform or reconfiguration needs Greater Manchester sign off
- To endorse the Greater Manchester joint commissioning strategy, which will be constructed in line with the Strategic Plan.

6.3 The SPB will also hold a system management function. That is, it will be responsible for ensuring that the Strategic Plan is delivered, and that the component parts of the Greater Manchester health and social care economy i.e. the ten localities; and 38 organisations (including NHS England), continue to work within the parameters set by the Plan, and continue to work toward the aims objectives of the Plan.

6.4 The SPB will have clear regard for Vanguard applications both on a Greater Manchester basis, but also at a locality level. The SPB will also provide assurance of the Greater Manchester health and social care system, ensuring that the Plan is delivered. Work is required to further develop the assurance framework for Greater Manchester.

6.5 It is proposed that the SPB will be informed of any applications by organisations and localities in Greater Manchester for additional funding outwith that already in Greater Manchester. It is proposed that such applications will meet the requirements of the Strategic Plan. Any GM wide applications for additional funding will be agreed by the Board.

7. CONFLICT RESOLUTION

7.1 In the event of dispute at Board or Executive level; or in the event that one or more organisations do not approve the plan, a dispute resolution process will be implemented. The focus of this process will be three fold:

to understand why dispute has occurred; to determine/understand the potential implications of the dispute; and to resolve where possible.

7.2 A key principle of the dispute resolution procedure is that disputes will be resolved at the most appropriate place level, i.e. for organisation with a singular district footprint the issue will be resolved at a locality level following consideration by the Chairs and Leaders of all of the stakeholders in the locality.

7.3 Where disputes cannot be resolved at place level, a group comprised of an agreed number of Chairs and Leaders from each stakeholder group outside of the locality representing each of the stakeholder groups will be formed to arbitrate and make recommendations to the parties in dispute. It is intended that the recommendations made by the dispute resolution group are binding on those parties in dispute, however work is ongoing with regulators to confirm the detail of how this could be made to operate.

7.4 A detailed procedure will be drafted through the Governance Sub Group and SPB Executive based on these principles and referred back to the Board for endorsement.

8. JOINT COMMISSIONING BOARD

8.1 The GM Joint Commissioning Board will be a Joint Committee where each participant makes joint decisions which are binding on each other.

8.2 As Specialised Services Commissioning cannot be dealt with by way of s75 arrangements without a change in the s75 regulations, any joint commissioning of specialised services will need to be undertaken through a joint committee made up of NHSE, CCGs, GMCA, and local authorities.

8.4 The GMJCB will have significant commissioning decision making responsibility as the largest single commissioning vehicle in GM.

8.5 In order to comply with regulatory requirements the GMJCB will function independently of providers.

8.6 The key functions of the GMJCB are as follows:

- To develop a commissioning strategy based upon the agreed Strategic Plan.

- Be responsible for the commissioning of health and social care services on GM footprint
- Have strategic responsibility for commissioning across GM
- Be responsible for the delivery of the pan GM strategy via its commissioning decisions (local commissioning will remain a local responsibility).

- To operate within existing commissioning guidelines following key principles of co-design, transparency, and broad engagement.

8.7 The GMJCB will only take GM wide commissioning decisions; any decision that currently sits with the commissioning responsibilities of LAs and CCGS will stay with these organisations (or at a locality level where new commissioning arrangements are being developed)

8.8 Whilst the core principle of the GMJCB will be that that those commissioning decisions which are currently made in localities will remain in localities, there will be a mechanisms developed to ensure that remit of the GMJCB can be broadened should localities agree that it is in their best interests to do so.

8.9 It is accepted that there are certain specialised services that would be impractical to commission on a Greater Manchester footprint. However, NHSE will work collaboratively with the GMJCB to ensure that these services are not commissioned in isolation of Greater Manchester.

8.10 The GMJCB will be required to produce a clear Commissioning Strategy that is aligned with aims and objectives of the Strategic Plan. The Commissioning Strategy will be reviewed periodically, or at times when the priorities for the Greater Manchester health and social care economy change; thus necessitating a shift in commissioning priorities. Any changes to the Commissioning Strategy would require agreement by the GMJCB in line with voting arrangements set out below (see 9.5).

9. JOINT COMMISSIONING BOARD: MEMBERSHIP AND VOTING

9.1 The membership of the GMJCB will be comprised of the 23 commissioning organisations in Greater Manchester, and the Greater Manchester Combined Authority:

- CA x 1
- NHSE x 1
- The CCGs x 12
- The LAs x 10

Total 24 representatives

9.2 It is anticipated that CCGs will be represented on the GMJCB by their accountable officer, NHSE will be represented by the GM H&SC Chief Officer, the Greater Manchester Combined Authority will be represented by the lead Chief Executive for Health and Wellbeing and local authorities will be represented by their Chief Executive.

9.3 However, organisations may nominate whomever they see fit to represent them. The representative must however attend with a delegated authority

and have an ability to participate fully in the decision making process. The seniority of the membership of the GMJCB should reflect both the size of the budget and the significance of the decisions taken.

9.4 The GMJCB will be supported by specialised officer groups such as the Cancer Board, Specialised Service Commissioning Oversight Group, and in recognition of the need for innovation a health research and innovation group will be formed to support the commissioning process.

9.5 The GMJCB will be jointly chaired by local authorities and CCGs. The GMCA, NHSE, CCGs and LAs will each have one vote (i.e. four votes in total). Decisions will require a 75% majority of the participant organisations.

9.6 NHSE will be represented on the GMJCB by the GM H&SC Chief Officer, however there may be circumstances where NHSE has no present interest in a particular matter e.g. where the matter relates to a function that NHSE has delegated to GMCA and/or CCGs. In such circumstances the Chief Office, who would cast the vote on behalf of NHSE, will pass the NHSE vote to CCGs or align their vote to that of CCGs. This will ensure parity across GM commissioning agencies

9.7 Due to the fact that NHSE commissions many services on a national basis, notably some very specialised services, there will be a proportionate ability for NHSE to notify the GMJCB where an item due for consideration could have significant ramifications for NHSE, eg proposed spending beyond existing budget(s); or potential and significant adverse implications for communities beyond GM.

9.8 The exact circumstances, in which these arrangements apply, have yet to be determined and further is required to develop such criteria. This will be taken forward by the Governance Sub Group. In these instances, any decision will need to be taken with the consent of NHSE.

9.9 NHSE also reserve a right of veto over certain commissioning decisions relating to specialised services. However this right of veto is not absolute, for it to be exercised it would need to satisfy clear and agreed criteria e.g. where the commissioning of services would give rise to a significant financial risk for NHSE. The exact circumstances, in which this would apply, have yet to be determined and further is required to develop such criteria.

10. CRITERIA FOR COMMISSIONING AT A GREATER MANCHESTER LEVEL

10.1 Greater Manchester will need to consider whether it is beneficial for certain services to be commissioned on a Greater Manchester footprint

and therefore by the GMJCB. Work is now underway to identify which services can be more effectively and efficiently commissioned on Greater Manchester footprint and therefore delegated to Greater Manchester. It will be for the GMJCB and local stakeholders to formally approve and agree what services these are.

10.2 It is also proposed that the GMJCB consider the commissioning of primary care at a Greater Manchester level; with the exception of general practice which will be commissioned by CCGs. However, the GMJCB will have a significant role to play in developing and implementing a Greater Manchester wide framework within which general practice is commissioned.

10.3 Greater Manchester has already agreed that those services currently commissioned at a local level, will continue to be done so (albeit under potentially significantly differing commissioning arrangements). However, GM will need to develop a clear mechanism to ensure that it is able to commission at both a cluster and GM level.

10.4 The criteria by which existing activity would be commissioned at Greater Manchester level will focus upon whether decisions taken on a broader footprint achieved a greater benefit for the population, e.g. increased value for money; greater levels of efficiency; or increased clinical sustainability.

10.4 The criteria will be designed by commissioners (the GMJCB), and kept under constant review to ensure that commissioning in Greater Manchester can be as efficient and effective as is possible.

10.5 It is acknowledged and recognised that commissioning organisations cannot be compelled to delegate a commissioning function up to the GMJCB against it wishes, as such each organisation currently responsible for commissioning a service/function will have to approve the proposal that is being identified to potentially fall within the scope of the GMJCB.

10.6 It is proposed that any health and social care commissioning activity currently undertaken on a GM footprint, whether it be by AGMA/GMCA, GM CCGs, or NHSE (subject to the general exclusion set out above) will now be commissioned by the GMJCB.

10.7 The GMJCB will need to agree a clear decision making process to ensure that it is able to take decisions about shifting commissioning activity into the GMJCB from localities.

10.8 Where agreement cannot be reached a dispute resolution process would be enacted, following the principles of that set out in section 7. Where the dispute related to the potential commissioning of services on a GM

footprint, the GMJCB will reserve the right to proceed and commission on a smaller footprint should it be beneficial (and agreed) to do so. However, the GMJCB can also draw upon the dispute resolution process which will broadly replicate that set out for the SPB (see section 7).

10.9 The dispute resolution procedure will be clearly set out in the written agreement that will be required to support the proposed joint commissioning arrangements; this will either be in the form of a s.75 agreement or follow the structure of such an agreement.

11. JOINT COMISSIONING BOARD SPECIALISED SERVICE COMMISSIONING

11.1 The key principle by which specialised services will be commissioned is that GM commissioners, providers, patients and the public will shape the future of health and social care provision in Greater Manchester. This is subject to Greater Manchester, via the GMJCB, formally agreeing to accept responsibility for commissioning those Specialised Services that are best served commissioned by Greater Manchester.

11.2 If it is agreed to commission specialised services the commissioning will be in line with the content and direction of the Strategic Plan. The GMJCB will produce a GM commissioning strategy to complement and deliver the Strategic Plan; this plan will require the endorsement of the SPB.

11.3 As part of the GMJCB commissioning process, the GMJCB will be required to clearly define the process that will be followed to commission a service. This process will need the support and approval of the SPB (including NHS Trusts).The process will be required to give due consideration and ultimately make provision for the co-design of services; the actual commissioning of service will remain the sole domain of the GMJCB which will operate fully independently of providers.

11.4 It is recognised that there is no mechanism that Greater Manchester can develop that will eliminate the risk of decisions being challenged, or subjected to a judicial review. However, the governance that is being developed by Greater Manchester and the process that is being outlined to commission services should reduce significantly the risk of decisions being challenged from within Greater Manchester. Where a commissioning process has been agreed by the Strategic Partnerhsip Board and subsequently followed, the GMJCB would not expect the outcome to be challenged by an organisation with Greater Manchester. As the regulatory bodies are SPB members it is anticipated that the outcome of commissioning decisions would be supported by regulators.

11.5 Greater Manchester has already committed to reviewing the existing scrutiny arrangements for health and social care. Scrutiny is recognised

as playing a vital role in supporting both service delivery and transformation. It is therefore proposed that prior to a decision taken being referred to an Independent Review Panel, that Greater Manchester reviews a decision at the SPB. However, this does not remove or replace the right of scrutiny committee to refer decision taken.

12. JOINT COMISSIONING BOARD – SERVICE RECONFIGURATION

12.1 The premise of the Memorandum of Understanding signed in February 2015 was two fold: that decisions about Greater Manchester will be taken with Greater Manchester; and that decisions on health and social care spend would be taken to benefit the residents of Greater Manchester not necessarily be taken based on the institution that serve them.

12.2 The GMJCB have a key role to play in commissioning services across Greater Manchester, as part of the transformation required this may result in significant organisational change.

12.3 The GMJCB will be required to consult with the public about proposals that could result in service reconfiguration, and work collaboratively with the regulatory bodies.

12.4 Any such activity will need to be delivered within the context of the Strategic Plan. Where a proposed change at a Greater Manchester level could potentially adversely impact the sustainability of a service or organisation; and or, have a material impact at a locality level or on the deliverability of a locality plan, the proposal will be referred to the SPB.

13. JOINT COMMISSIONING BOARD – OTHER SERVICES

13.1 There are a number of services that are currently commissioned at a locality level that may be best commissioned within a Greater Manchester framework of quality and standards. These include General Practice, a significant amount of social care services, and certain Public Health services. The GMJCB will consider the commissioning of such services within its Commissioning Plan.

14. JOINT COMMISSIONING BOARD SUPPORTING STRUCTURE

14.1 The GMJCB will be supported by a smaller executive, which will operate within a framework developed and agreed by the GMJCB.

14.2 The smaller executive will have responsibly for taking forward the next steps set out within this report (see section 15), and will be responsible for receiving clear updates from the commissioning advisory groups (see 8.4), making recommendations to the broader GMJCB as required.

14.3 The membership of the smaller executive will be drawn from the commissioning organisation across Greater Manchester, and be supported by members of the Greater Manchester Health and Social Care Team.

15. JOINT COMMISSIONING BOARD IN SHADOW FORM AND NEXT STEPS

15.1 The GMJCB will meet in shadow form and carry out the following functions:

- To agree the scope of its remit from April 2016, including agreeing line by line which Specialised Services will be commissioned by Greater Manchester.
- To have oversight and be cognisant of those services that will be commissioned on a Greater Manchester footprint from April 2016-17.
- In recognition that commissioning cycle may already be in train, the Joint Commissioning Board will therefore be required to be appraised of those take decisions that need to be taken, and make recommendations to the decision makers.
- To develop the Greater Manchester Commissioning Strategy.

16. RECOMMENDATIONS

16.1 See front cover of the report.

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 January 2016
Executive Member / Reporting Officer:	Cllr Brenda Warrington, Executive Member Adult Social Care and Wellbeing Chris Mellor, Chair, Care Together Programme Board Jessica Williams, Programme Director, Tameside and Glossop Care Together
Subject:	**INTEGRATION REPORT - UPDATE**
Report Summary:	This report provides an update to the Tameside Health and Wellbeing Board on the progress and developments within the Care Together Programme since the last meeting.
Recommendations:	The Health and Wellbeing Board is asked:- 1. To note the progress of the Care Together Programme including the strategic and operational aspects; 2. To receive a further update at the next meeting.
Links to Health and Wellbeing Strategy:	Integration has been identified as one of the six principles that have been agreed locally that will help to achieve the priorities identified in the Health and Wellbeing Strategy.
Policy Implications:	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. This meets the requirements of the NHS Constitution.
Financial Implications: **(Authorised by the Section 151 Officer)**	The Tameside Locality Plan was submitted to Greater Manchester Devolution in October 2015. The plan provides a supporting analysis of the estimated £69 million funding gap which is projected to arise within the economy by 2019/2020. The plan also explains the strategies required to deliver this projected gap. A supporting transformation fund business case is scheduled for submission to GM Devolution/Department of Health by end of January 2016. The business case will request a combination of revenue (£36 million) and capital (£13 million) funding (subject to revision prior to submission deadline) which is profiled over a five year period. The transformation fund will support the necessary transition within the economy towards the implementation of the new care delivery model. It is essential that the estimated funding gap is continually reviewed and updated to ensure additional savings strategies are implemented as appropriate.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model. However, the programme itself requires clear lines

	of accountability and decision making due to the joint financial and clinical implications of the proposals. It is important as well as effective decision making processes that there are the means and resources to deliver the necessary work. This report is to provide confidence and oversight of delivery.
Risk Management :	The Care Together Programme has an agreed governance structure with a shared approach to risk, supported through a project support office.
Access to Information :	The background papers relating to this report can be inspected by contacting Jessica Williams, Programme Director by:  Telephone: 0161 304 5342  e-mail: jessicawilliams1@nhs.net

1. INTRODUCTION

1.1 This report provides an update to the Tameside Health and Wellbeing Board on the developments within the Care Together Programme since the last meeting.

1.2 The report covers:

- Strategic Issues; External and Tameside and Glossop specific;
- Operational Progress;
- Next Steps;
- Recommendation.

2. STRATEGIC ISSUES

External Developments - National

2.1 Monitor has reported the combined deficit for Hospital Trusts in the six months to 30 September 2015 was £1.6bn with 182 out of the 241 Trusts in deficit at the end of Quarter 2. The projected full year deficit is now put at £2.2bn, which is the worst for many years. Social Care funding has fallen to its lowest level for 20 years and the Local Government Association in predicting a £2.9bn annual gap by 2020.

2.2 This evidence of severe demand side problems has caused the Chancellor in his Autumn statement to announce a £6bn (inflation + £3.8bn) cash injection into the NHS in 2016/17 and powers for Local Authorities to levy a 2% “Social Care Precept” in Council Tax next year.

2.3 The Kings Fund published a paper on 12 November 2015 entitled "Place-based Systems of Care" in which they said "NHS organisations need to move away from a "fortress mentality", whereby they act to secure their own individual interests and future, and instead establish placed based systems of care in which they collaborate with other NHS organisations to address the challenges and improve the health of the populations they serve". This validates the direction of the Care Together programme as it aims to deliver precisely this but goes further by also including integration with social care.

External Developments – GM Devolution

2.4 Discussions have taken place with the Greater Manchester Devolution team to confirm the plans for Tameside and Glossop are in line with those of the Greater Manchester work. This is borne out by the GM Strategic Plan published just prior to Christmas which includes significant reference to Place Based Commissioning and Place Based Care. Our developing plans to implement local community health and social care models and an evidence based standardised approach to population health prevention as reflected by the CPT report and the Tameside and Glossop Locality plan are all within the GM plans.

2.5 GM Devolution continue to receive invitations to the Care Together Programme Board and are interested to see the detailed delivery plans over the next 2-3 months as models for integrated care are developed across GM. Our progress is of course subject to obtaining the transitional funding identified in the CPT report and we are preparing a detailed Business Case, which will follow the Treasury/Department of Health protocols, for consideration at the end of January 2016.

3. OPERATIONAL PROGRESS

Model of Care

3.1 The initial Steering group to deliver the detailed model of care has been chaired by Karen James and terms of reference agreed for this and the four workstreams beneath it; Healthy

Lives, Locality Development, Urgent Care and Planned Care. Over the next few months, there will be a significant engagement programme with public, staff, voluntary, community groups as well as statutory bodies to ensure the detailed model of care in all workstream areas meet the needs for Tameside and Glossop and also, is widely understood and supported. This engagement programme will be presented for approval at the February Care Together and Health and Well Being Boards.

3.2 As outlined in the Locality Plan, the approach to integrated care is not limited to the Integrated Care Organisation model set out in the CPT report. This is evidenced by the "Healthy Lives" workstream, chaired by Angela Hardman, Director of Public Health which will take forward work focused on prevention and pro-active support for people to self-care and self-manage in their own communities, drawing on social models of support as well as statutory health and care services.

3.3 In doing this, we are adopting the underlying principles of Asset-Based Community Development in strengthening community capacity and capability, and developing a more structured and sustainable partnership with the voluntary / community / social enterprise sector. We have put ourselves forward to link with the GM Devolution Team, where there are particularly strong links with the themes of Prevention and Community Services.

Transfer of Community Services

3.4 This extensive and important project continues at pace as Community Services for Tameside and Glossop will transfer from Stockport Foundation Trust to Tameside Hospital Foundation Trust on 1 April 2016. This is a contract value of approximately £25m and involves approximately 600 staff all of whom remain committed to providing their high quality service through the transition. There remain some high level risks to the project, mainly due to the limited remaining life of the current IM&T system used but are being mitigated where possible.

Single Commissioning Function

3.5 Another vital and exciting project where Tameside and Glossop are leading the way to develop co-ordinated, integrated and effective outcome based commissioning for health and social care. The two commissioning teams in Tameside MBC and Tameside and Glossop CCG have agreed to work together under one leadership to determine their clinically led priorities, will have one decision making structure, one pooled budget and will be co-located to start to develop new ways of working together for the benefit of all residents.

3.6 The initial Shadow Single Commissioning Board, chaired by Alan Dow will be held on 12 January and will agree terms of reference, integrated and residual governance arrangements and the approach to the 2016/17 contract negotiations.

Programme Support Office and Programme Development

3.7 The revised structure to focus the Care Together programme on delivery has been implemented and communicated to staff. Administrative support is in place and project management recruitment is underway. The November Care Together Budget shows slippage against the planned year end financial position. This has been reviewed in depth to ensure a realistic financial outturn is projected which will be discussed at the Programme Board in January 2016.

3.8 PwC have been commissioned to develop a business case to be submitted to GM Devolution. This is fixed price contract and will build on the detailed work already carried out by PwC within the CPT process. The business case aims to secure the necessary transitional funding to enable our health and social care system to change to a financially and clinically sustainable model.

4. NEXT STEPS

4.1 As well as the continuation of all work above and especially the focus on the model of care, notable next steps are detailed below.

Primary Care

4.2 GM Devolution are seeking neighbourhoods / localities who wish to pilot the new national voluntary contract and develop integrated health and social care services. Tameside and Glossop has expressed an interest in working with GM Devolution to see how this potential new contract could stimulate discussions with a wide range of primary care practitioners on how to align health and social care pathways and services in the future.

Organisational form for the ICO

4.3 Terms of Reference for this workstream are currently being developed and will be presented at the Programme Board later in January 2016. A high level programme of work including timescales will also be described.

Single Commissioning Function Co-location

4.4 The aim is to bring the two commissioning teams in one building in February 2016 and start developing new ways of working, effective issue solving and foster relationships. The location will be New Century House, location of Tameside and Glossop CCG as well as some community services and detailed planning is underway to move and build the relevant teams.

Communications Strategy

4.5 Effectively communicating our vision and how those interested can become involved in its design and delivery is essential to the success of implementation and long term delivery of a clinically and financially sustainable system which dramatically improves healthy life expectancy across Tameside and Glossop. A communications strategy to demonstrate how we will do this is currently being developed and will be brought for discussion at the next Health and Wellbeing Board.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is asked:-

1. To note the progress of the Care Together Programme to date including the strategic and operational aspects in all areas and;
2. To receive a further update at the next meeting.

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Developing a Single Commissioning Strategy

Health and Wellbeing Board 21 January 2016

Background

- Approved integration of health and social care commissioning functions to facilitate the delivery of the Care Together Programme ambitions
- From 1 January 2016, the T&G CCG and TMBC commissioners are working together as an interim single commissioning function
- 1 April is the planned introduction of the substantive Care Together Commissioning function, Board and pooled budget

  Arrangements for joint commissioning with High Peak District Council and Derbyshire County Council being considered separately
- Responsible for the following areas of commissioning:
  - Adult and child social care and public health for Tameside;
  - Primary and all NHS Commissioning including individualised commissioning Finance
  - Professional nursing, quality improvement and assurance, patient safety and safeguarding
- To commission and provide a fully integrated health and social care system, a single agreed commissioning strategy which clearly sets out the vision, outcomes and commissioning priorities for residents of Tameside and Glossop is essential.

Content of the Strategy

- The strategy will:
  - Identify the commissioning priorities over the next 5- 10 years;
  - Promote place-based commissioning to deliver place-based systems of care;
  - Build on strategic intentions and ambitions already identified within the Health and Wellbeing Strategies and T&G Locality Plan
  - Build on best practice developments already implemented
  - Reference and incorporate innovative practice, where appropriate; and
  - Demonstrate significant ambition as well as deliverability.

Initial discussions with Councillors, GPs, partners and staff have indicated the strategy needs to:

- Contribute to the development of a ‘successful place’;
- Be brief but bold;
- Focus only on those priorities and outcomes that will make the biggest difference;
- Provide some detail on ‘how’ in addition to the ‘what’ it will deliver.

Process

- Clare Powell, independent contractor (former PCT Director of Commissioning) will support development of the Strategy over next 2 mths
- Jan – Feb 2016;
  - Meet key members of team to understand views on priorities and outcomes
  - Review background documentation
  - Research best practice in commissioning for outcomes
  - Work through the single commission executive management team to provide progress reports and seek advice on developing Strategy
  - Seek wider staff feedback through planned events on 19 January and 2 February.
- March - May 2016;
  - Extended engagement
  - Continued contract negotiations with THT and other providers alongside strategy development
  - Approval of Single Commissioning Strategy from Tameside Health and Wellbeing Board and Care Together Programme Board.
- May 2016; Review and development as system matures

Outcomes required

- Identifies commissioning priorities and key outcomes to be commissioned over 5 years;
- Includes an outcome framework which can be used as basis for contract and procurement discussions with providers;
- Enables development of an implementation plan and work programme for the single commission;
- Aligned with existing local plans and Greater Manchester devolution plans;
- Supports the development of the 5 year system plan (Sustainability and Transformation Plan) required by NHS England by June 2016;
- Developed with and by single commissioning function and is 'owned' by the team; and
- Approved by Health and Wellbeing Board and Care Together Programme Board in spring 2016.

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Health and Wellbeing Board

GM Devolution and Working Well

Damien Bourke

Assistant Executive Director (Development, Growth and Investment)

21 January 2016

GM Devolution and Working Well

- Background information to GM Devolution and Working Well

- Progress and future of the Working Well Programme

Devolution and Greater Manchester

Greater Manchester's ambition is to create an **integrated employment and skills eco-system** which has the individual and employer at its heart, and that better responds to the **needs of residents, business and contributes to the growth and productivity of the GM economy.**

This will be done by transforming services to better meet the needs of residents and becoming financially self-sufficient by recognising the role public service reform, as well as growth, will play in achieving this goal.

There are several agendas that align to the priorities highlighted in the Greater Manchester Strategy; GM's overarching strategy for the city region, these include:

Skills and Employment Partnership works with providers and employers to understand present and future growth, employment and skills needs

Greater Manchester Growth and Reform Plan sets out the aim of becoming a financially self-sustaining city region to secure Growth Deal funding

City Deal aligns mainstream skills funding with the priorities of the local economy and the GM Local Enterprise Partnership

Public Service Reform provides public services in new, sustainable and efficient ways to help working age adults to take up and retain employment

Devolution now gives Greater Manchester the impetus needed to achieve the ambition

Devolution & further GMCA/LEP funding provides a unique opportunity to begin addressing challenges posed by the currently fragmented employment and skills system

The current employment and skills landscape is complex and fragmented. Our implementation approach is putting in place the processes that will allow GM to achieve its vision, reforming a devolved skills and employment system that will have a significant impact on GM's residents, employers and its continued economic growth. Central to that it will:

- Reduce the fiscal gap and drive productivity in GM through a devolved, integrated employment and skills eco-system
- Create significantly enhanced performance and impact from the £3.97bn investment in GM
- Develop a future workforce with the skills to support growth and increased levels of productivity
- Shift the commissioning strategy to deliver what GM needs with GMCA able to drive performance through local accountability, including appropriate alignment of national and local priorities
- Ensure Government agencies and contracted services operating consistently on a GM footprint

What will the future Skills & Employment system look like?

Employers are able to grow, have access to, & invest in the skills they require, encouraging in work support & wage progression. Employers will be actively engaged in shaping GM's education & skills system and take responsibility in supporting residents back into work

Employment & skills initiatives will be developed and commissioned at a local level, providing unemployed residents and those furthest from the labour market with the right integrated support required to move them closer to work

Schools will ensure all individuals achieve fully functional maths, English and ICT to L2.

FE Providers will progress more individuals to Level 3+ qualifications in a vocational or technical area closely linked to GM's labour market

Residents will have the right support to make the best choices about their employment and skills options and have better access to the right integrated support at the right time to enter, progress or sustain employment.

Devolution Programme of Work

The GM Agreement includes a range of reforms across the work and skills landscape, enabling GM to directly control or influence over £500m of funding. These are:

1. The **staged expansion of Working Well** from Summer 2015. By the time it is fully rolled out, the programme will cover 50,000 individuals and have a £100m budget. This work will include a pilot **supporting older workers** with long-term health conditions back to work.

2. Government **designing the Work Programme in a way that allows GM to be a joint commissioner.** Work Programme contracts across GM are worth c£100m.

3. **Mental Health & Work** pilot to develop a service model which supports unemployed people who are finding it difficult to get in to work because of mental health issues.

4. **Reshaping and restructuring FE** (post 19 skills) **provision** worth £150m (including Apprenticeships) within GM and aligning to £170m of EFA spend.

5. **Devolution of the AGE Grant** to GM from April 2015.

Taken together, while only reflecting a proportion of the investments made in employment and skills within GM, these current devolved powers enable us to exert **significant influence** on the supply and demand dynamic. Through these reforms, GM will improve outcomes for residents, invest in innovation & prevention and create savings through better performance and improved use of resources

Progress so far

- Working Well expansion first phase is currently out to tender.
- Mental health provision: Talking therapies provision has been designed with close involvement of CCG's and is out to tender
- Adult Skills Budget 'other': funding and outcome models being developed linked to wider Outcome Framework for GM
- WP co-commissioning work in development with DWP.
- Delivery commenced on GM AGE grant with over 140 grants being paid to employers

Local Growth Fund

- £12m LGF from BIS to support unemployed residents
- GM has aligned with Working Well Expansion under devolution.
- Also enhanced through ESF to ensure maximum support