GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

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GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

Date: 28 October 2016

Subject: Assurance Framework (including Performance Dashboard)

Report of: Jon Rouse and Nicky O'Connor

PURPOSE OF REPORT:

As part of the successful devolution of statutory responsibilities to Greater Manchester, an accountability framework was agreed between NHS England and Greater Manchester which amongst other things, sets out a responsibility to manage and improve system performance and a specific duty to conduct an annual performance assessment of each CCG. The responsibility to undertake this within GM was delegated to the Chief Officer of the Greater Manchester Health and Social Care Partnership.

The report provides an overview of proposed scope of the Assurance & Delivery Framework

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

(i) Note the report and Assurance Framework

(ii) Endorse the Framework as the basis for undertaking assurance on behalf of the Partnership

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Assurance Framework

Version 1.2

3rd October 2016

1. PURPOSE

This report has the following key purposes:

(i) To set out the scope of the proposed Assurance & Delivery Framework.

(ii) To provide an overview of the method by which assurance will be fulfilled on behalf of GMHSC Partnership

2. CONTEXT

2.1 As part of the successful devolution of statutory responsibilities to Greater Manchester, an accountability framework was agreed between NHS England and Greater Manchester which amongst other things, sets out a responsibility to manage and improve system performance and a specific duty to conduct an annual performance assessment of each CCG. The responsibility to undertake this within GM was delegated to the Chief Officer of the Greater Manchester Health and Social Care Partnership.

3. ASSURANCE PRINCIPLES

3.1 Following the successful agreement of Greater Manchester devolution it was acknowledged that there is a need to construct a new assurance framework to recognise the devolved powers to the Partnership team and which takes account of the broader place-based planning beyond the NHS.

3.2 The core principles by which the assurance framework should be constructed were agreed at a GM Assurance session led by GM system leaders in May 2016. This includes the commitment to an assurance process that reflects place-based leadership and single, integrated locality plans.

3.3 The session considered the vision, principles, strategic aims and outcomes for place-based assurance as:

Vision: GM to be assured, regulated and performance-managed as a PLACE. This would mean that:

- GM is responsible for its own performance;
- Principal accountability sits locally, not nationally;
- Collective responsibility is accepted for performance of the system as a whole;
- GM infrastructure should develop and provide appropriate tools and support.

3.4 The principles for place based assurance, regulation and performance management would be:

- Subsidiarity
- Open, honest, transparent and comparable
- A problem / issue anywhere in our system is all of our problem
- Peer challenge, review and support

- Manage the GM and locality reputation
- Identify and manages risk
- Objective and measurable
- Approach to be able to be modified to situation – support and constructive criticism through to intervention
- Ensure political, clinical and managerial leadership across the programmes
- Facilitate good practice learning and network development.

3.5 The objectives of place-based assurance, regulation and performance approach would be:

- Establish a system which owns the process of assurance and performance improvement, driven by GM determined and owned priorities.
- Enable greater and faster improvement through delivery across all parts of the system, which is engaged in the development and delivery of the process.
- Develop a culture and approach where system peers and partners proactively challenge and support delivery at all levels of the GM system.
- A shared agenda for operational delivery which acknowledges, but is not limited to the requirements of the Mandate and Constitution;
- Immediate means for GM to respond to key areas of delivery risk and use those responses to inform a GM improvement methodology for ongoing application;
- The importance and urgency of GM establishing a competent system dashboard to inform discussion and provide timely oversight of delivery risks.

3.6 The paper - '*GM Taking Responsibility – Recovery, Improvement and Delivery'* was constructed by senior leaders within the GM system which outlines the intent to work as a GM system to design an approach for GM internal assurance that would satisfy the national NHS England requirements, but would also allow our system to design a new approach that ensured that as a collective system we were able to identify our system challenges, collectively agree how we would address those challenges to recover our performance and ensure a sustained improvement and delivery of the agreed outcome. It introduced the idea of a common methodology that could be used at any level (neighbourhood, locality / district, cluster or GM

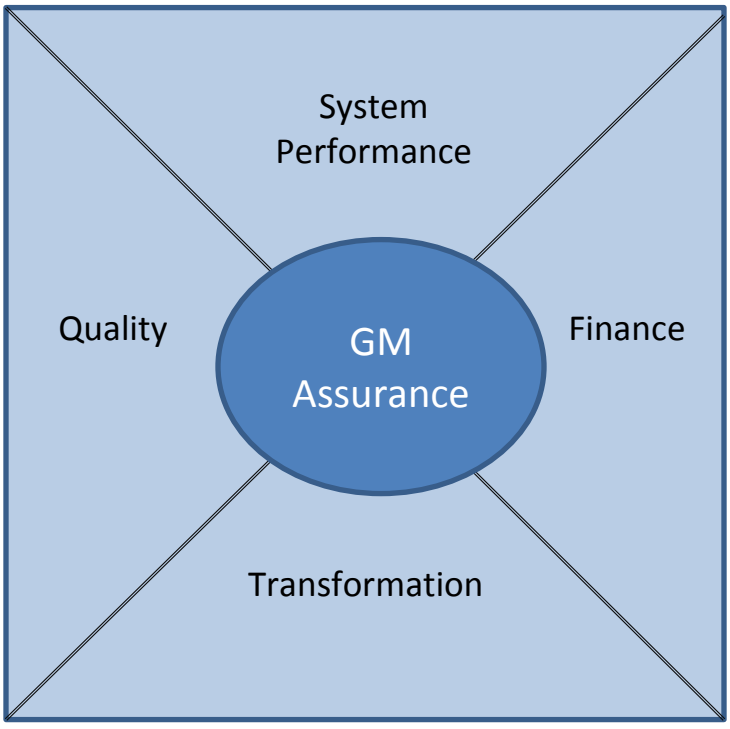
3.7 The paper described the vision, principles and outcomes that a GM methodology would deliver and that the governance we have developed since the signing of the MoU has enabled the GM HSC system to start to work together in a way that has previously proved too challenging on issues such as:

- Connecting the joint work of GM social care Directors to efforts to improve A&E performance;
- Providing for more focused risk based engagement to support safeguarding and failure risk in the care market;
- Recognising the opportunity of the Provider Federation to direct the GM response to key access targets as has been successfully demonstrated on cancer waiting times and survival rates; and
- Supporting greater insights into system delivery by sharing intelligence and developing reports which better illustrate root causes of poor performance.

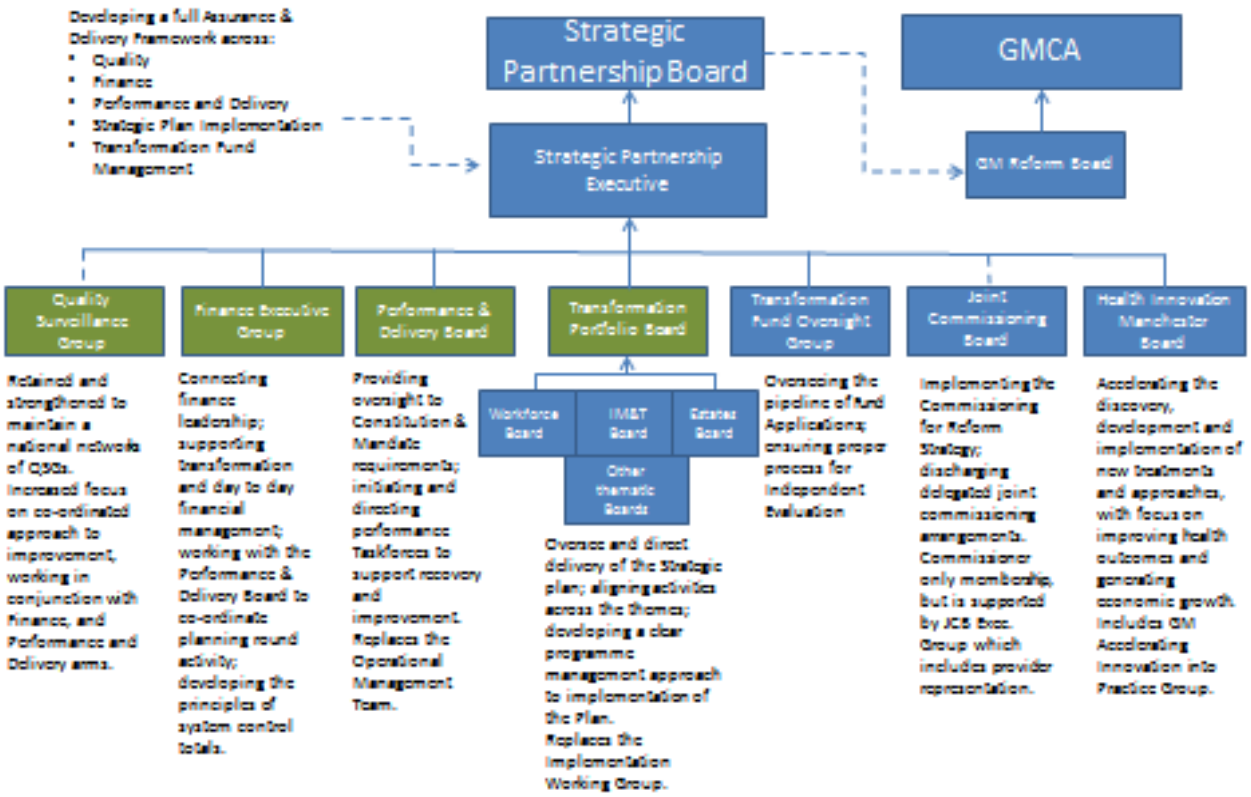
4. THE ASSURANCE STRUCTURE

4.1 The diagram below provides a summary description of the key functions of the assurance and delivery components. The groups and boards have been established with agreed Terms of Reference and appropriate GM system level membership (reflecting the governance considerations in terms of commissioner and provider functions). This is the structure for providing effective assurance and delivery of the Partnership's objectives and will provide the structural context for related work to define operational functionality and reporting mechanisms across individual teams.

4.2 The development of the governance components relating to delivery and assurance aims to ensure a co-ordinated approach towards improvement, performance and delivery. This is reflected in the renewed emphasis placed on the Quality Surveillance Group to work in conjunction with the Finance and Executive Group and the Transformation Portfolio Board, all feeding into the Performance and Delivery Board. This will ensure that the Strategic Partnership Executive will have a comprehensive and timely overview of issues and system support activities in these key areas. The Performance and Delivery Board will have ownership of the assurance framework which will provide a shared source of intelligence to drive the work of the related assurance and delivery groups, this will be supported but a balanced scorecard which will focus on the key areas of system performance, finance, transformation and quality.



Assurance & Delivery



4.1 Quality

4.1.1 Quality Surveillance Groups (QSGs) are a requirement of the National Quality Board and allow system oversight and identification of thematic issues across a health economy. The purpose of the QSG is to not only meet the requirements of the Francis Inquiry but also to ensure that "quality is systemic" for patients. This is done by assuring the complex set of interconnected roles, responsibilities and relationships that exist between professionals, provider organisations, commissioners, and regulators.
Within GM the QSG is chaired by the Exec Lead for Quality of the Partnership,(who is also the MD); membership includes Chief Operating Officers of CCGs, CQC, NHSI, HEE, PHE and Healthwatch.

4.1.2 The QSG acts as a virtual team across a health economy, bringing together organisations and their respective information and intelligence, gathered through performance monitoring, commissioning, and regulatory activities. By collectively considering and triangulating information and intelligence, QSGs work to safeguard the quality of care that people receive.

4.1.3 Once a Quality Surveillance Group identifies concerns about the quality of care being provided in their area, members can take contractual action, regulatory/enforcement action and/or provide improvement support in line with their existing responsibilities. QSGs are not statutory bodies: they have no legislative status or formal powers. QSGs are a forum through which different organisations who do have statutory powers and responsibilities can come together to discharge their responsibilities in a more informed and collaborative way.

4.1.4 Their purpose is not to performance manage Clinical Commissioning Groups (CCGs) or any other organisations, and they should not interfere with the statutory roles of constituent organisations e.g. contractual powers or regulatory responsibilities. They will not substitute the need for individual organisations to act promptly when pressing concerns become apparent.

4.1.5 Local QSGs can take action in the following form:

- investigations by individual member organisations, e.g. the commissioner(s), CQC, Public Health England, NHSI
- triggering Risk Summits (which may include the provider(s) in question) – where there are concerns that a provider is potentially or actually experiencing serious quality failures;
- deciding to keep the provider under review – where there are concerns about a provider that do not yet merit triggering a risk summit.

4.1.6 Single Item QSG Triggers include:

- Lack of confidence in the providers ability to improve
- Serious patient safety concerns
- Serious contract breaches/Contractual notices
- Issues outside of providers' control
- Persistent failure to meet CQC standards
- CQC Special Measures

4.1.7 Risk Summit Triggers

- serious failings within a provider
- a need to act rapidly to protect patients and / or staff
- a single, material event

4.1.8 Information gathered at QSG will form part of the Assurance framework: triangulated data from members will give insight into the quality of services commissioned. Whilst QSGs have not previously considered the quality of commissioned social care, under the GMHSCP, this, along with ownership of the overall framework for quality improvement in GM, will be reflected in new terms of reference to be agreed 6th October 2016.

4.2 Transformation

4.2.1 The Transformation Portfolio Board is responsible for the oversight and direction of the delivery of The Greater Manchester strategic plan – Taking Charge.

4.2.2 The Transformation Portfolio Board will bring together locality leadership with the GM transformation theme and programme leads to oversee and drive delivery of the GM transformation portfolio, direct and prioritise key GM level programmes of work and resolve key delivery issues/risks that are GM wide. It will be responsible for overseeing the implementation, delivery, alignment and prioritisation of the transformation portfolio and ensuring progress is being made across all areas.

4.2.3 The Board will ensure that risks and issues and pro-actively identified and managed. The members will model the system impact of the transformation portfolio in the context of wider public sector reform and delivery of business as usual. There will be a focus on the delivery of benefits realised as a result of plans being implemented, especially as Transformation Funds are allocated.

4.2.4 The Transformation Board will provide a monthly report into the Strategic Partnership Board Executive to provide assurance on the management of risks and issues, as well as progress of critical activities. This report will be considered as part of the locality assurance process.

4.3 Finance

4.3.1 The Executive Lead for Finance and Investment will be reviewing the relevant governance of the Partnership. However, what we know is that there will be a dedicated Board (currently called the Finance Executive Group) that will provide a forum for the consideration of strategic financial issues and assessment of associated financial risks, and, to coordinate and lead action where appropriate of the GMH&SC agenda. The table below outlines the proposed reporting and assurance processes to be undertaken by FEG, yet to be finalised.

Area	Comments	Recommendation
Reporting		
1. To include financial assurance ratings under the locality reporting arrangements that are being developed	A separate work stream is underway to develop a monthly financial locality report for GM. An initial plan locality report has been taken to FEG, and a month 2 in-year report will shortly be shared. Develop from this an understanding of the ability of the GM economy to meet planned financial targets.	It is proposed that assurance ratings from existing assurance regimes will be added to this locality report from month 3 Out of this, work with NHS England / NHS Improvement to understand and influence the treatment of CCGs' 1% uncommitted reserve
2. Locality plans	Assurance ratings are currently given to 5 year locality plans in terms of being ready to bid against and access the Transformation Fund. Consider the relationship between these ratings, and ratings from the existing financial assurance regimes	Look to add locality plan updates and ratings to the monthly locality report
3. Consider a new single composite financial assurance rating at locality level		Propose a review to develop a financial assurance scorecard by locality with a single combined assurance rating
4. Reporting of other financial metrics	QIPP / CIPs will be included in the proposed monthly locality report. Consider reporting other metrics such as the use of cash; run rates; underlying positions and capital, as a means of improving overall assurance. This would all based on information that is already available from existing returns	Propose a review of other metrics, including suitable explanations where metrics need interpretation (for example where different definitions apply between sectors)
5. Self-reporting at a locality level	Consider longer term options for localities to self-report	Review work in Tameside in particular on locality reporting to promote good practice
6. Link with other areas of assurance	Link the reporting of financial assurance with ongoing discussions	Link in with wider devolution work to develop a consistent

	on future assurance arrangements in other areas of performance	assurance regime across GMH&SC
Interventions		
7. Principle that existing assurance regimes apply unless otherwise agreed	For the sake of clarity; • Share details of existing assurance regimes • re-iterate that all existing assurance guidance and regimes continue to apply unless or until new local guidance is approved	Suggest update from the FEG group
8. Recovery plans	To recognise the dynamic that; • NHS England / NHS Improvement remain statutorily responsible for assurance of individual organisations • The recovery plan of an individual organisation affects other local organisations and sectors	Work up guidance on how organisations that need a recovery plan should work within the context of a locality wide recovery plan Consider how GMH&SC / NHS England / NHS Improvement can work together over joint solutions to the recovery plans of individual organisations
9. "Step-in rights"	To note that discussions are ongoing with the NHS England regional team over "step-in rights"; ie what are the relative roles of the regional team and the GMH&SC partnership on financial assurance, and being "assured, once as a place"	To note and feed into local reports once agreement has been reached. Consider the impact of other sectors
10. Cross sector assurance	Clarify how communications can work across the sectors of CCGs, providers and LAs to help achieve performance targets	Develop proposals such as quarterly tripartite assurance meetings, recognise capacity constraints in how this is progressed
11. Self-assurance within sectors	At one stage of the 16/17 planning process, GM CCGs were failing collectively to meet their drawdown control total. GM CCG CFOs discussed how CCGs could collectively manage situations like this. Ie to review flexibilities around individual organisation / collective control totals to ensure the GM-wide	Sectors, particularly CCGs, to consider whether any principles can be developed for self-assurance within sectors

	position can be managed. Agreement was subsequently reached over how this could be managed.	

4.4 System performance

4.4.1 Within existing GMHSC partnership governance arrangements the Performance and Delivery Board will be the Board where all performance requirements are considered together. It is also, however, the monthly forum where constitutional mandate standards are specifically reviewed along with the appended partnership outcomes; this includes the CCG Improvement and Assurance Framework metrics. The emphasis of the meetings is to evaluate performance and delivery at a GM level, and whilst recognising different priorities exist in the partnership organisations it is essential that GM works as a collective system to achieve the common goals and ambitions of the partnership and provide peer support and challenge. The Performance and Delivery Board may initiate and direct performance taskforces to provide support where appropriate (see below).

4.4.2 Members of the Performance and Delivery Board are nominated system representatives from within each sector of the partnership to enable a genuine multi-sectorial approach, the members act in an advisory capacity and make judgements in relation to system challenges and risks. This will included directly commissioned services and primary care.

4.4.3 The Performance and Delivery Board reports into the Strategic Partnership Board Executive (SPBE) enabling the SPBE & Strategic Partnership Board to take a more holistic view of the 'state' of the place.

4.5 The performance dashboard

4.5.1 A performance dashboard (Appendix Two) is being developed to provide oversight to the Performance and Delivery Board. The dashboard is intended as a focal point for joint work, support and dialogue between the Partnership and localities. Data will be updated monthly for the constitutional standards whereas many of the other indicators are updated on a quarterly, or in some cases, annual basis. This will enable everyone to see, in-year, what is working well and what is off-track. The Partnership will work together to ensure that the breadth of the dashboard is discussed with all stakeholders and it will form part of the Assurance Framework during the year, through a rolling programme of local conversations, drawing on expertise and insight from all sectors.

4.5.2 The CCG Improvement and Assessment Framework dashboard was used as the starting point for the dashboard. It has been built upon to incorporate further appropriate indicators which will help drive and monitor the success of the partnership. The dashboard includes indicators representing all partnership organisations to ensure a comprehensive lens which encapsulates the interdependencies of each sector. As outlined in the assurance process below, the dashboard will encompass the four elements of system performance, quality, finance and transformation. It will cast across public health, NHS and social care.

4.5.3 The performance dashboard must flow from the agreed outcomes framework and plans are in place to broadly align the outcomes with the performance metrics. The outcomes framework will be a value measure to the progress and impact of transformation schemes and act as a longer term indicator of the success in achieving the ambition of improving the health, wealth and wellbeing of the population of Greater Manchester.

4.5.4 The appended Performance Dashboard is currently in draft format and subject to further development and change. We are open in this development phase to views on choice of indicators and there is work to be done to turn the dashboard into a proper balanced scorecard that creates the right conversations. We also need to develop the right presentational form that communicates progress to wider groups of stakeholders, including elected representatives and the wider public.

4.6 Taskforce Groups

4.6.1 System performance issues will at times require focussed attention to enable a multi-sectoral approach to generate sustainable solutions. By working together, NHSE and GM will be able to fully understand and manage risk together and take more control of its own future and responsibilities

4.6.2 Urgent care is an example whereby it has been possible to make use of the new governance available to the devolved system in GM by establishing an Urgent Care Taskforce. The Taskforce is responsible for making links with and ensuring alignment between a range of programmes and initiatives that will support improved access and experience for people requiring urgent or emergency care.

4.6.3 Progress will be monitored by the Performance and Delivery Board along with input from NHS Improvement.

4.6.4 A similar approach can be adapted to other specialist areas where a cohesive response is required.

5. THE ASSURANCE PROCESS

5.1 It is proposed to undertake CCG Assurance within the context of locality planning by holding quarterly meetings with the executive leads of GMHSC and the leaders of the localities. There is a requirement for the CCG executive team to be represented at these meetings to satisfy the statutory requirement. However, there is also an intention to use these meetings to signal how we do assurance differently in GM, providing the opportunity to take a holistic approach that is cross-sectoral and covering all the bases of the Locality Plan, whilst still enabling the discharge of statutory functions. All partners have joint responsibility for helping each other transform and sustain the GM health and social care systems. The purpose of engendering mutual assistance and taking timely action where needed, should be as valuable as the formal act of annual assessment.

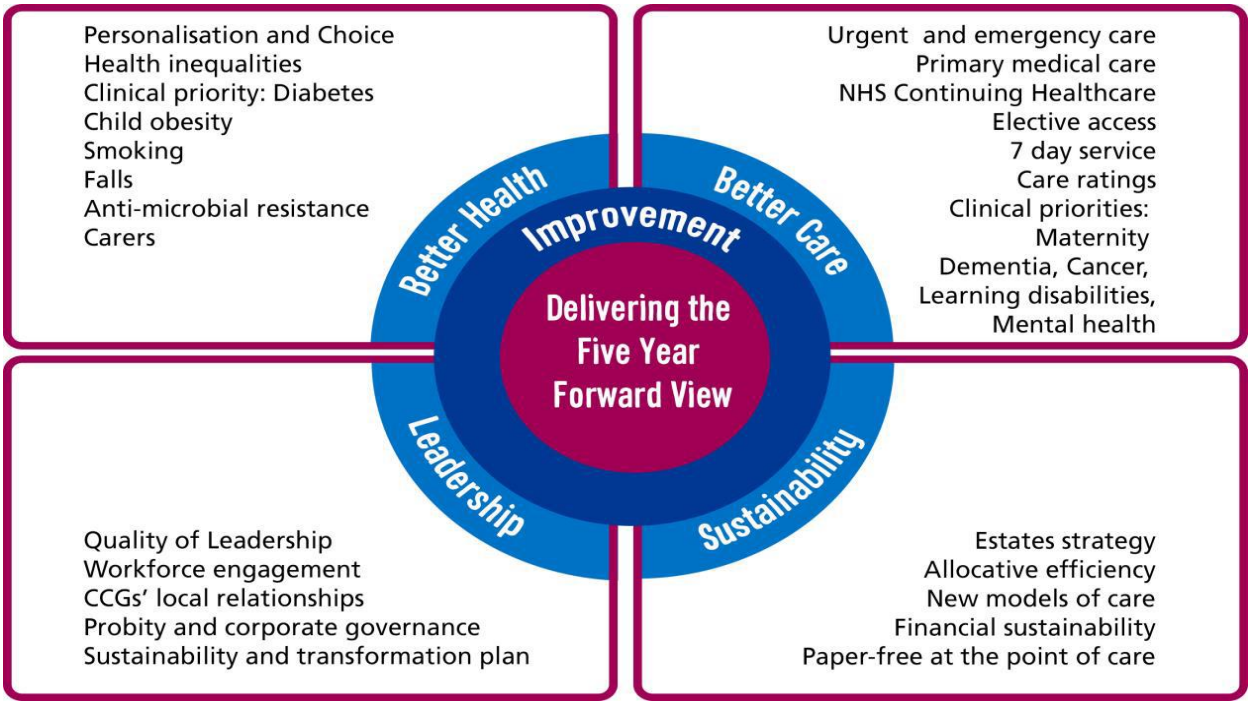
5.2 The assurance process will support conversations with other boards and allow for co-ordinated conversations to take place and avoid the need for multiple conversations, it will allow for a holistic approach whilst still enabling the discharge of statutory functions.

It is our intention under the new arrangements to involve NHS Improvement in these meetings, as well as receiving support and input from other national bodies as required in order to prevent contradictory support/guidance.

5.3 The process will recognise the Partnership's duty to provide accountability to the population of Greater Manchester that transformation is being carried out on their behalf.

5.4 The meetings will need to cover the Improvement and Assessment Framework (IAF) which encompasses the four elements of Better Health, Better Care, Sustainability and Leadership, along with delivery, quality, finance and transformation.

- Better Health: this section looks at how localities are contributing towards improving the health and wellbeing of its population, and bending the demand curve;
- Better Care: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
- Sustainability: this section looks at how localities remain in financial balance, and is securing good value for patients and the public from the money it spends;
- Leadership: this domain assesses the quality of the localities leadership, the quality of its plans, how the system works in partnership, and the governance arrangements that the locality has in place to ensure it acts with probity, for example in managing conflicts of interest.



5.5 But wherever relevant we will consider these issues on a cross-sectoral basis. Thus, the meetings will recognise joint responsibility and focus on mutual assistance and practical support where needed

5.6 Topics for discussion will include:

- Operational performance
- Quality of care
- Finance and use of resources
- Transformation fund metrics
- Leadership
- Improvement support requirements
- Success stories and areas of best practice; and, crucially
- Progress towards Improved Outcomes

5.7 These meetings will be supported by business intelligence including performance against constitutional standards and mandate commitments, IAF and quality indicators, outcomes framework and financial position. Transformation fund metrics will provide the generation of good evidence to track the impact of investments and support on levels of demand within the system. It is also an opportunity for the locality partners to say what more they need from the GM Partnership and national bodies.

5.8 These meetings will help inform the assessment of the non-data driven indicators within the IAF for which the GMCO is responsible.

5.9 Greater Manchester Quarterly Performance Meetings with NHS England

5.9.1 Within the Accountability Agreement in place between NHS England and Greater Manchester there is a continuing responsibility, through the GM Chief Officer (GMCO), for NHS organisations to deliver the NHS Constitution, observe statutory requirements and account to national Arm's Length Bodies where appropriate for the outcomes achieved on improving health and wellbeing, quality, performance and finance.

5.9.2 NHS England and the GM Chief Officer meet on a quarterly basis to assess the position of the NHS in Greater Manchester. Assurance discussions recognise the first accountability of public services is to the populations they serve and are undertaken in the context of the 'place'. They recognise that the GM Health & Social Care Partnership has formal accountabilities to the population of Greater Manchester as well as statutory accountabilities for NHS bodies to national Arm's Length Bodies.

5.9.3 Formal assurance of Greater Manchester is undertaken in aggregate but there is opportunity for discussion about individual places or organisations where warranted by the thresholds in the Accountability Agreement.

6. INTERVENTION AND ESCALATION

6.1 The Accountability Agreement says that in the first instance where GMH&SC is not delivering the requirements of the NHS Constitution, mandate, finance business rules and agreed finance control totals at an aggregate level the GMH&SC team will set out

for NHS England's regional team its proposal for improvement. The required actions could include:

- an improvement/recovery plan
- monitoring of the standard at a different frequency (eg monthly)
- a requirement for GM to seek further prescribed support to secure recovery
- NHS England exercising its powers of intervention with an individual CCG

6.2 Included in the agreement are thresholds where improvement plans are required and also for what are described as step-in rights on behalf of NHS England. These potential responses are seen as being part of a spectrum of activity through potential levels of escalation if this is agreed to be necessary. Escalation can be seen as working both ways, for example the GMCO may wish to ask NHS England to use its formal powers of intervention or NHS England stepping in might lead to escalation within GM. Where NHS England is considering whether to exercise its step in rights there will be a discussion with the GMCO. The concept of step in is based on NHS England working through the GMCO and then both parties agreeing how to work to address the issues that have been identified. An example would be where individual CCG/place performance is below the threshold described in the Accountability Agreement or agreed financial control total then in the first instance an Improvement Plan will be requested from the GMCO that will set out how the position with the organisation/place will be returned to the required standard. Where individual CCGs are consistently outside the thresholds in the Agreement or agreed financial control total then GM Health and Social Care Partnership. will manage improvement in partnership with the regulatory bodies. In cases where improvement has not been realised then GM Health and Social Care Partnership. can seek additional improvement support from NHS England's regional team.

6.3 Where individual CCG performance is outside of agreed tolerances within the Accountability Agreement the GMCO has an obligation to provide assurance on behalf of GM in the form of improvement plans and recovery trajectories. Powers of intervention are retained by NHSE for sustained non-delivery.

6.4 CCG Escalation and Intervention

6.4.1 A CCG assessment moving down to limited assurance or not assured in a particular component would signal the need for an improvement plan. An improvement plan could form part of the application of special measures or legal directions. The CCG improvement and assessment framework does not make in year assessments to provide these triggers. However, the process remains the same. If the data, or wider sources of insight, raise concerns that initiate a discussion between GM Health and Social Care Partnership in conjunction with NHS England and a CCG, the outcome could be an improvement plan. If the circumstances match the description of special measures or the statutory definition of directions, these actions may also be taken.
NHS England is supported by legislation in exercising formal powers of direction if it is satisfied that a CCG is (a) failing or (b) is at risk of failing to discharge its functions.
Formal intervention action would be proposed, as laid out in section 14Z21 of the NHS Act 2006 (as amended)

6.4.2 Since the use of direction affects CCG autonomy, careful consideration is required before this course of action is implemented. Any proposed such intervention should be

appropriate to the risk identified. When considering the use of intervention powers, a number of steps need to have been taken in order to establish whether the use of such powers is proportionate and appropriate.

6.5 Provider Escalation and Intervention

6.5.1 **NHS Improvement** support foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

6.5.2 Providers are segmented based on how closely they meet NHSI's single definition of success. Higher performing providers are allowed greater freedoms, including fewer data and monitoring requirements and simpler processes for transactions. More challenged providers will be given more direct and tailored support to help stabilise and improve their performance.

6.5.3 **CQC** are the independent regulator of health and adult social care in England. The role of CQC is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

6.5.4 CQC work to ensure that services found to be providing inadequate care do not continue to do so. Therefore they have introduced special measures. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which is used for enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration.

6.5.5 There are some differences in the process CQC use for special measures in different sectors including primary medical, independent healthcare and adult social care services.

6.5.6 Special measures apply to NHS trusts and foundation trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Special measures consist of a set of specific interventions designed to improve the quality of care within a reasonable time.

6.5.7 In this approach the Care Quality Commission (CQC) will focus on identifying failures in the quality of care, judging whether improvements have been made and, where necessary, using its enforcement powers to ensure that providers who are unable to meet required standards of quality and safety are not allowed to continue indefinitely. NHS Improvement uses their respective powers to support improvement in the quality.

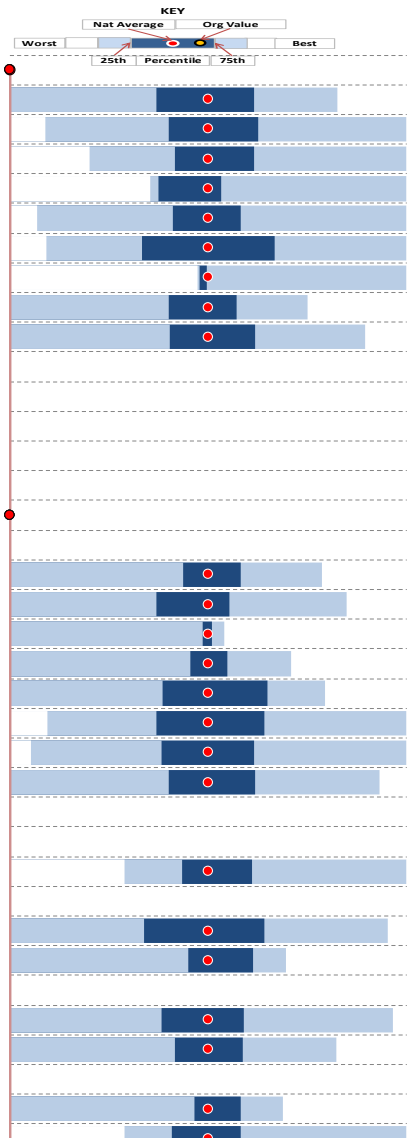
6.6 **Local Authority Escalation**

6.6.1 Local authorities are autonomous elected bodies operating under a separate statutory framework. Serious failure to fulfil statutory duties will be a matter for the Secretary of State for Local Communities or, in the case of care commissioning functions, could also be a matter for the Secretary of State for Health under section 48 procedures following a requested CQC review.

6.6.2 With respect to the Partnership's work we would seek to rely wherever possible on mutual support mechanisms, and also the local scrutiny function, including, at GM level, the Joint Health Scrutiny function that has the ability to call in anything that impacts residents on a pan GM footprint.

APPENDIX

	Improvement and Assessment Indicators	Latest Period	GM / STP	England	Trend	Better is...
	Better Health					
▲	Maternal smoking at delivery	15-16 Q3	12.8%	10.6%		L
◀▶	% children aged 10-11 classified as overweight or obese	2014-15	34.6%	33.2%		L
▼	Diabetes patients that have achieved all three of the NICE-recommended treatment targets	2014-15	41.8%	39.8%		H
▲	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	1.9%	5.7%		H
◀▶	Injuries from falls in people aged 65 and over per 100,000 population	01-Nov-15	0	2027		L
◀▶	Personal health budgets per 100,000 population (absolute number in brackets)	15-16 Q4	34	14		H
▲	% deaths which take place in hospital	15-16 Q3	50.5%	46.9%		L
▼	People with a long-term condition feeling supported to manage their condition	2015	0.0%	64.4%		H
◀▶	Inequality in avoidable emergency admissions	15-16 Q2	0			L
◀▶	Inequality in emergency admissions for urgent care sensitive conditions	15-16 Q2	0			L
	Medicine Optimisation **(Place Holder)**					
	Better Care					
◀▶	Cancers diagnosed at early stage	2014	0.0%			H
	People referred by their GP with suspected cancer within two weeks	Jul-16	95.5%	94.4%		H
	People referred by their GP with suspected cancer (breast symptoms) within two weeks	Jul-16	86.9%	92.1%		H
	People receiving first definitive treatment within 31 days of a cancer diagnosis	Jul-16	99.2%	97.8%		H
	People receiving subsequent cancer treatments -surgery within 31 days	Jul-16	96.1%	96.0%		H
	People receiving subsequent cancer treatments -anti cancer drug regimens within 31 days	Jul-16	100.0%	99.4%		H
	People receiving subsequent cancer treatments - radiotherapy within 31 days	Jul-16	100.0%	97.4%		H
▼	People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral	Jul-16	89.2%	82.2%		H
	People receiving first treatment for cancer following a consultant's decision to upgrade the patients priority within 62 days	Jul-16	85.9%	89.3%		H
▲	One-year survival from all cancers	2013	0.0%	70.2%		H
	Improving Access to Psychological Therapies access rate					
▲	Improving Access to Psychological Therapies recovery rate	Jun-16	45.5%	48.8%		H
	Improving Access to Psychological Therapies seen within 6 weeks	Jun-16	74.4%	88.5%		H
	Improving Access to Psychological Therapies seen within 18 weeks	Jun-16	94.7%	98.5%		H
▼	People with 1st episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referr	Jul-16	84.7%	74.6%		H
▼	Estimated diagnosis rate for people with dementia	Aug-16	77.0%	67.3%		H
◀▶	People with a learning disability and/or autism receiving specialist inpatient care per million population	Mar-16	0	58		L
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	0.0%	47.0%		H
◀▶	Neonatal mortality and stillbirths per 1,000 births	2014-15	8.0	7.1		L
◀▶	Emergency admissions for urgent care sensitive conditions per 100,000 population	15-16 Q2	0			L
▲	% patients admitted, transferred or discharged from A&E within 4 hours	Jul-16	87.7%	90.3%		H
▲	Delayed transfers of care attributable to the NHS and Social Care per 100,000 population	Apr-16	13.6	13.0		L
◀▶	Emergency bed days per 1,000 population	15-16 Q2	0.0			L
◀▶	Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population	2014-15	0.0	811.8		L
▼	Patients waiting 18 weeks or less from referral to hospital treatment	Apr-16	93.2%	91.7%		H
	Diagnostics Test Waiting Times	Jul-16	2.6%	1.8%		L
◀▶	People eligible for standard NHS Continuing Healthcare per 50,000 population	15-16 Q3	54.9	47.9		H
	C.Difficile (YTD Var to Plan)	Jul-16	-8.9%	-5.4%		L
	MRSA	Jul-16	4	32		L
	Primary Care (Place Holder)					
	Primary care access					
	My NHS					
▼	People offered choice of provider and team when referred for a 1st elective appointment	Feb-16	0.0%	50.0%		H
▼	Cancer patient experience	2014	89.8%	89.0%		H
◀▶	Patient experience of GP services	Jan-00	0.0%	0.0%		H
▲	Quality of life of carers - health status score (EQ5D)	2015	1.9			H
◀▶	Women's experience of maternity services	Jan-00	0.0	0.0		H
◀▶	Choices in maternity services	Jan-00	0.0%	0.0%		H



	Sustainability				
◀▶	Financial plan	2016			H
◀▶	Digital interactions between primary and secondary care	15-16 Q4	0.0%		H
◀▶	Local strategic estates plan (SEP) in place	2016-17	0.0%		H
	Activity v Plan: Total Referrals (Specific Acute)	July-16 (cum)	0.0%	2.3%	-
	Activity v Plan: Total OP attends (Specific Acute)	July-16 (cum)	-3.9%	-0.7%	-
	Activity v Plan: Total Elective spells (Specific Acute)	July-16 (cum)	-0.4%	-2.4%	-
	Activity v Plan: Non-elective spells complete (Specific Acute)	July-16 (cum)	-0.4%	1.1%	-
	Activity v Plan: Attendances at A&E (All Types)	July-16 (cum)	1.7%	3.3%	-
	Well Led				
◀▶	Staff engagement index	2015	0.0	3.8	H
◀▶	Progress against Workforce Race Equality Standard	Jul-05	0.0	0.2	H
◀▶	Effectiveness of working relationships in the local system	2015-16	0.0		H
◀▶	Quality of CCG leadership	2016-17			H
	Social Care				
	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	Ap15 - Mar16			L
	Proportion of people using social care who receive self-directed support, and those receiving direct payments	Ap15 - Mar16			L
	% of people aged 65+ discharged direct to residential care	Ap15 - Mar16			L
	Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population	Ap15 - Mar16			L
	No of bed days - delayed transfers of care aged 18+ per 100,000 pop	Apr-16			L
	Worforce (Placeholder)				
◀▶	Primary care workforce - GPs and practice nurses per 1,000 population	2015	0.0		H