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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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
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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.

The Plan

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.

The Plan

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.

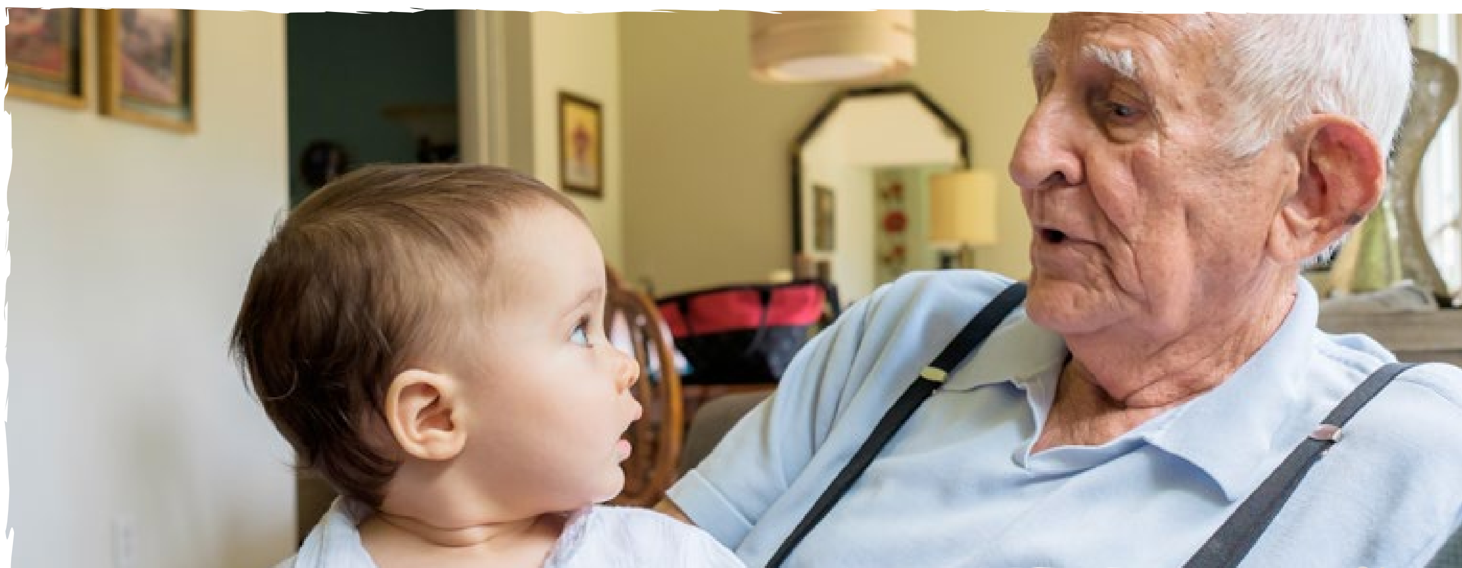
Each locality is putting the money we have for health and social care into pooled budgets, so we can buy health, care and support services once for a place in a joined up way.

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.

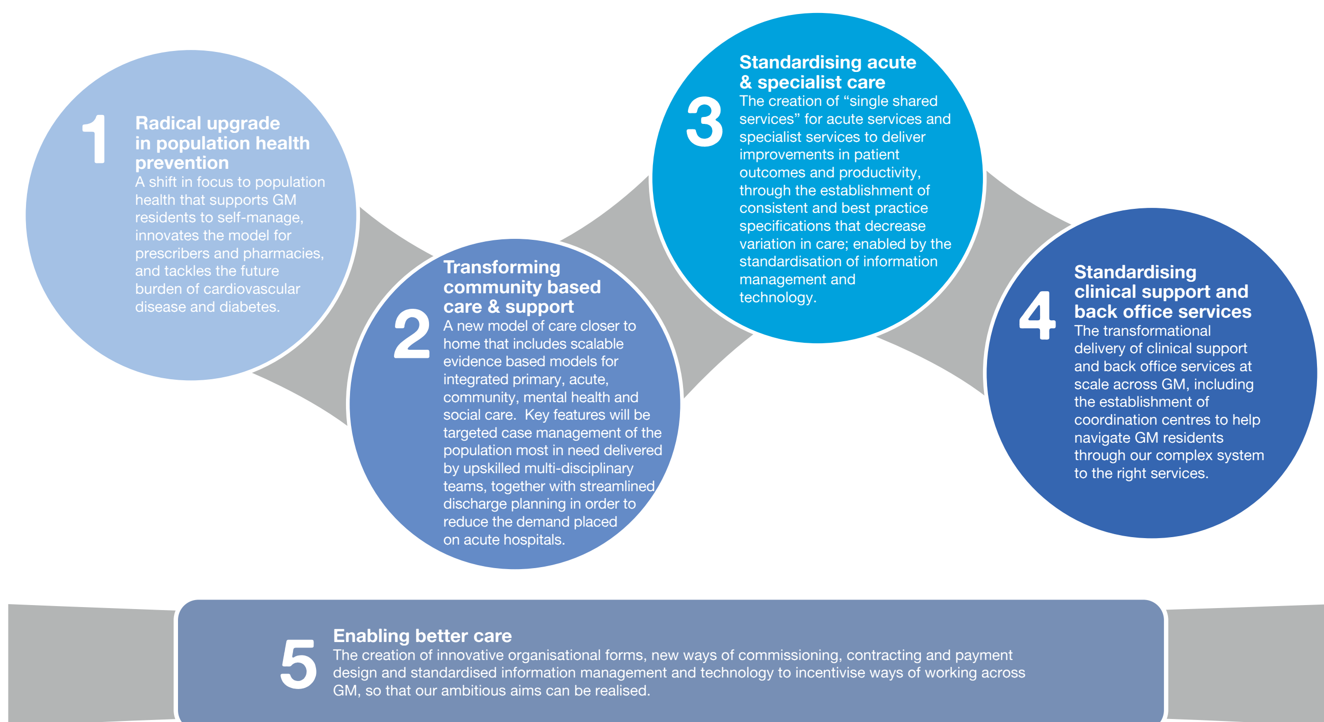
The Plan

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.

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.

CORTES

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

health prevention

- 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

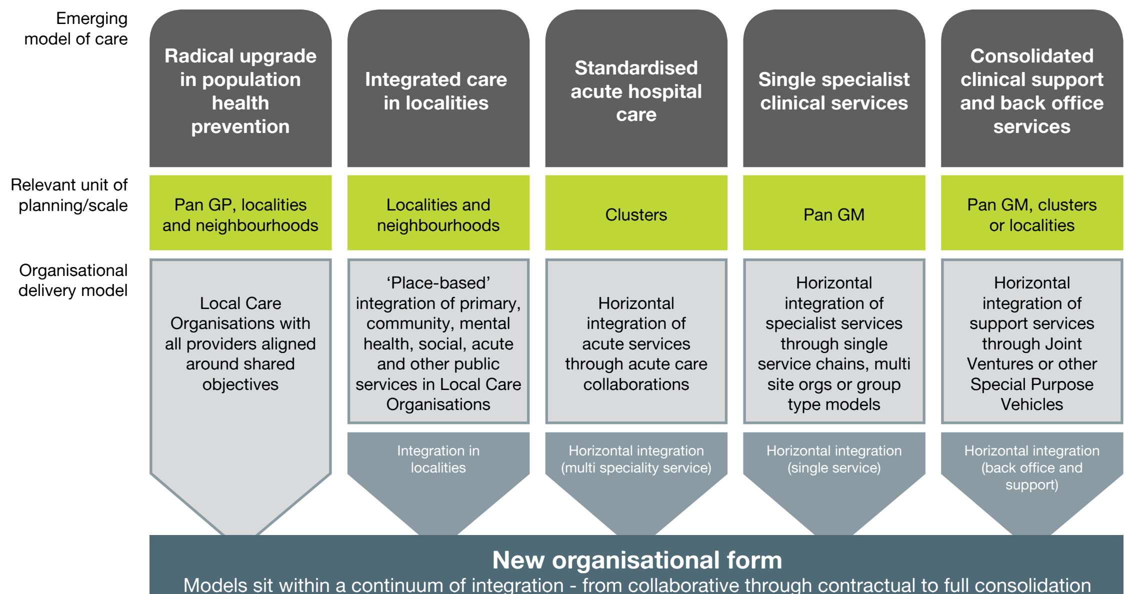
Health and social care providers in GM need to become more adept at standardisation and reliable implementation of best practice. Through our revised working arrangements, supported by our new governance structures, we will ensure that our new models of care remove tolerance to variation both in service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

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.

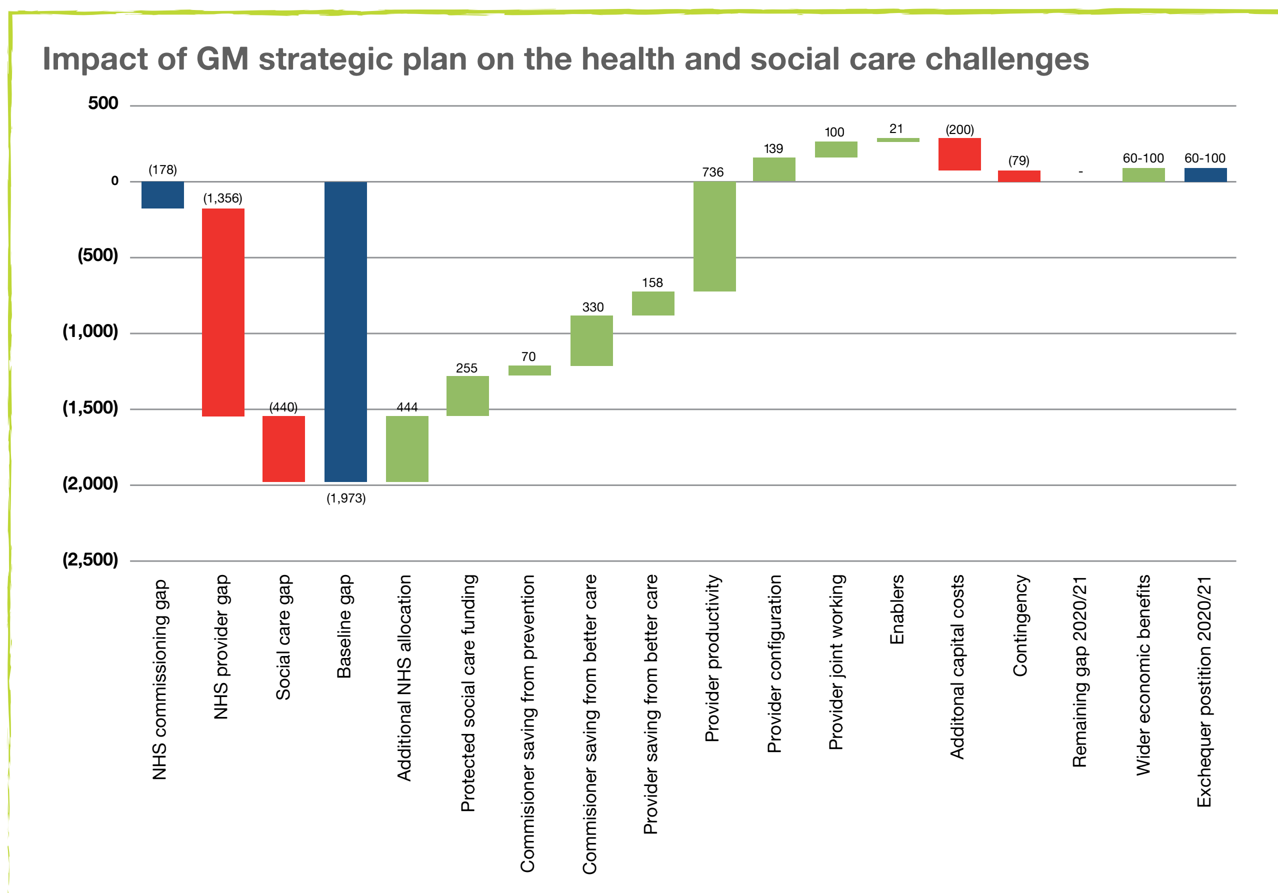
In addition to the above, benefits to the wider economy are expected through increased employment and productivity in the workplace, estimated at £160 million to £315 million.

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 pre-vention
- Transforming community based care and sup-port
- 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



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 Design	Apr – Sep Mobilise	Oct > 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

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