# APPENDIX A

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

# GREATER MANCHESTER HEALTH AND SOCIAL CARE TRANSFORMATION
# TAMESIDE AND GLOSSOP INVESTMENT AGREEMENT

**CONTENTS**

## PARTIES

This is an agreement between:

(1) NHS England, 3 Piccadilly Place, London Road, Manchester, M1 3BN

(2) NHS Tameside and Glossop Clinical Commissioning Group (CCG)
New Century House
Progress Way, Off Windmill Lane
Denton, Manchester
M34 2GP

(3) Tameside Metropolitan Borough Council
PO Box 304
Ashton-under-Lyne
Tameside
OL6 0GA

(4) Tameside and Glossop Integrated Care NHS Foundation Trust
Fountain Street,
Ashton-under-Lyne,
OL6 9RW

each a **Party** and together, the **Parties.**

## BACKGROUND

(A) Pursuant to the GM devolution agreement between Government and GM local authorities and the MoU developed between GM local authorities, GM CCGs and NHS England (which created a framework for the delegation and ultimate devolution of health and social care responsibilities to GM), from April 2016, the NHS bodies and local authorities in GM have taken control of £6bn of public money to run health and social care throughout the region.

(B) The Greater Manchester Health and Social Care Devolution Memorandum of Understanding ('MOU') sets out the ambition for full devolution of funding and decision making for health and social care in GM. It describes the principles for how partners will work together, including a commitment to collaborate and make decisions in the best interests of patients and the people of GM.

(C) The NHS bodies and local authorities in GM have developed a comprehensive GM Strategic Plan ('Taking Charge') to address the key challenges facing health and social care. The GM Strategic Plan sets out how, in pursuing five transformation themes, the NHS bodies and local authorities in GM will achieve clinical and financial sustainability.

(D) NHS England agreed in December 2015 that £450m would be made available over a five year period for the establishment of a 'Transformation Fund' on the basis that the GM HSCPB would oversee the deployment of this fund within GM to deliver the major change programme set out in the GM Strategic Plan, whilst securing locally the outcomes to which NHS England is committed as a consequence of the November 2015 Comprehensive Spending Review.

(E) The objectives of the Transformation Fund are to support solutions which deliver clinical and financial sustainability across GM and at locality level and improve the health and social outcomes included in the GM Strategic Plan.

(F) The specific purpose of the Transformation Fund is: investment in new systems, processes and infrastructure; and/or additional costs involved in developing and implementing new services while existing services are decommissioned.

(G) In order to access the Transformation Fund a Locality must have in place a robust Locality Plan agreed by all key parties in the Locality Area, which is wholly aligned to the broader vision for health and social care transformation in GM and the specific schemes identified in the GM Strategic Plan.

(H) Access Criteria for the Transformation Fund have been developed and agreed by the GM HSCPB.

(I) These criteria have been adopted by the GM Chief Officer on behalf of NHS England.

(J) The overall governance and accountability of the Transformation Fund is the responsibility of the GM Chief Officer and Head of Paid Service, GMCA, both supported by the GM HSCPBE.

(K) The Transformation Fund will be subject to the GM Accountability Framework, which will specify a full range of outcomes across health and social care to be delivered by the Transformation Fund.

(L) NHS England has delegated responsibility internally to the GM Chief Officer for allocating the awards from the Transformation Fund. The GM HSCPBE has considered the Transformation Fund proposal from the Locality and made a recommendation to the GM Chief Officer for action. The GM Chief Officer having considered the application accepted this recommendation on 23rd September 2016.

(M) This Agreement sets out the terms and conditions upon which funding from the Transformation Fund has been awarded to the CCG for distribution within the Locality Area.

(N) This Agreement should be read in association with other key documents:

(i) SCHEDULE 1 - Locality Plan
(ii) SCHEDULE 2
A – Metrics
B – Milestones (Word)
B(i) – Milestones (Gantt)
C – Finance Roll Up
C (i) – Expenditure and benefit plan
C (ii) – Activity reduction schedule
(iii) SCHEDULE 3 - Dispute Resolution
(iv) SCHEDULE 4 - Terms of Reference GM Health and Social Care Partnership Board
(v) SCHEDULE 5 - National Requirements
(vi) SCHEDULE 6 - Locality management and governance arrangements

## 1. Definition and Interpretation of terms

1.1 The definitions and rules of interpretation in this clause apply in this Agreement

**Access Criteria**: criteria agreed on in March 2016 by the GM HSCPB[1] and adopted by NHS England that must be satisfied in order for a Locality to be granted Transformation Funding:

- Deliver the GM vision
- Enable transformational change
- Consolidate resources
- Secure value for money
- Facilitate learning for others

**Agreement:** this agreement between the Parties comprising these terms and conditions together with all schedules attached to it

**CCG**: the Clinical Commissioning Group specified as a Party to this Agreement and which is receiving Transformation Funding in accordance with this Agreement

**Commencement Date**: 1st December 2016

**Expiry Date**: At the end of financial year 2019/2020

**Five Year Forward View**: the document published in October 2015 by NHS Improvement, the Care Quality Commission, Public Health England and

[1] https://www.greatermanchester-ca.gov.uk/download/meetings/id/753/04a_transformation_fund_criteria

Health Education England setting out a new shared vision for the future of the NHS based around new models of care[2]

**GM**: the Greater Manchester region comprising 10 local authority areas: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan

**GM Accountability Framework**: A GM Accountability Framework to set the approach to be undertaken internal to GM describing thresholds and levels of intervention and how the GM system can have oversight of its own performance to inform any national requirements." Timescale for completion of the Framework is August 2016[3]

**GM Chief Officer**: means the NHS England officer appointed to lead the GM health and social care devolution programme

**GMCA**: Greater Manchester Combined Authority

**GM HSCPB**: the Greater Manchester Health and Social Care Partnership Board governed by the terms of reference set out in Schedule 5, which is responsible for setting the overarching strategic vision for the GM health and social care economy

**GM HSCPBE**: the Greater Manchester Health and Social Care Partnership Board Executive a group comprised of members of the GM HSCPB which was established to provide support to the GM HSCPB

**GM Strategic Plan**: the GM Strategic Sustainability Plan – Taking Charge[4] and the implementation plan set out within, aligned to the Five Year Forward View, which sets out how GM will achieve clinical and financial sustainability during a five year period underpinned by a number of principles agreed in the MoU signed in February 2015[5]

**Health and Wellbeing Board**: the forum established by the Health and Social Care Act 2012 where key leaders from the health and care system work together to improve the health and wellbeing of their local population and

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[3] https://www.greatermanchester-ca.gov.uk/download/meetings/id/1166/07_taking_charge_-_implementation_plan

[4] https://www.greatermanchester-ca.gov.uk/homepage/73/taking_charge_of_our_health_and_social_care_in_greater_manchester

[5] https://www.greatermanchester-ca.gov.uk/downloads/download/40/greater_manchester_health_and_social_care_devolution_memorandum_of_understanding

reduce health inequalities and, in the context of this Agreement, refers to the relevant Health and Wellbeing Board for the Locality Area.

**Inter Authority Transfer:** An Inter Authority Transfer (IAT), is the mechanism used by CCGs, NHS England and NHS England local area teams to transfer resource known as allocations. It cannot be used with other organisations such as NHS providers or LAs

A sending and receiving organisation is required (like a budget transfer between budget holders in a standard organisation)

**Key Milestones:** has the meaning set out in Clause 7.2

**Local Authority**: the local authority specified as a Party to this Agreement

**Local Authority Transformation Funding**: the proportion of the Transformation Funding payable to a Local Authority to enable it to deliver the Locality Plan

**Locality**: the GM Local Authority, the CCG and the Providers who are Parties to this Agreement

**Locality Area**: The geographical area covered by the Local Authority

**Locality Cost Benefit Analysis**: the detailed financial analysis and evaluation of the costs and benefits associated with the Locality Plan

**Locality Plan**: a 5 year plan for health and social care and wider public service reform, which has been developed and agreed between the commissioners and providers within the Locality Area [and which is attached at Schedule 1[A] to this Agreement] (now added to front page)
**Locality Plan Implementation Plan**: the plan describing the implementation of the Locality Plan, which was endorsed by the GM HSCPB [and which is attached at Schedule 1B to this Agreement]

**MoU**: the Greater Manchester Health and Social Care Devolution Memorandum of Understanding, an agreement between the GM local authorities, the GM CCGs and NHS England which was signed in February 2015 and which creates a framework for the delegation and ultimate devolution of health and social care responsibilities to GM

**NHS Act:** National Health Service Act 2006

**NHS England**: the National Health Service Commissioning Board established by section 1H of the NHS Act and known as NHS England

**NHS Improvement:** the operational name for the organisation bringing together Monitor, the NHS Trust Development Authority and certain patient safety and service change teams

**NHS Improvement Agreement**: any agreement entered into between NHS Improvement (or one of its constituent legal entities) and a provider in the Locality Area relating to an allocation from the Sustainability and Transformation Fund

**Programme**: The Care Together programme of reform (set out in Schedule 2) created in accordance with the Locality Plan or transformation theme, for which Transformation Funding has been awarded

**Provider:** the NHS Trust(s) or NHS Foundation Trust(s) specified as Parties to this Agreement

**Provider Transformation Funding:** the proportion of the Transformation Funding payable to a NHS Trust/Foundation Trust to enable it to deliver the Locality Plan

**Recipients:** those Parties who have been identified in the Locality Plan Implementation Plan as proposed recipients of the Transformation Funding

**Senior Leader**: the person appointed by the Locality responsible for delivering the Programme and for delivering value for money from the funds awarded to the Locality.

**Stronger Together**: the GM strategy published in 2013 by GMCA and the Local Enterprise Partnership (LEP) around the twin themes of Growth and Reform that sets out a series of priorities that will drive sustainable economic growth and reform the way that public services are delivered

**Sustainability and Transformation Fund**: the national transformation fund established to support delivery of the Five Year Forward View

**Taking Charge**: the GM Strategic Plan

**Transformation Fund**: the £450m fund that NHS England has agreed to allocate to GM to deliver the major change programme set out in the GM Strategic Plan, whilst securing locally the outcomes to which NHS England is committed as a consequence of the November 2015 Comprehensive Spending Review, and which represents GM's share of the available transformation budget over the period 2016 to 2021

**Transformation Funding**: the sum of funding allocated by NHS England from the Transformation Fund to the CCG to distribute to the Recipients

**Transformation Fund Proposal:** the proposal documentation that was submitted by the Locality to secure access to Transformation Funding [and which is attached at Schedule 8 to this Agreement]

1.2 Clause, Schedule and paragraph headings shall not affect the interpretation of this Agreement.

1.3 The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement. Any reference to this Agreement includes the Schedules.

1.4 A reference to a statute or statutory provision is a reference to it as it is in force for the time being, taking account of any amendment, extension or re-enactment and includes any subordinate legislation for the time being in force made under it.

1.5 A reference to a document is a reference to that document as varied (other than in breach of the provisions of this Agreement) at any time.

1.6 References to clauses and Schedules are to the clauses and Schedules of this Agreement. References to paragraphs are to paragraphs of the relevant Schedule.

## 2. Term

2.1 This Agreement shall take effect on the Commencement Date and shall continue until the Expiry Date, unless extended in accordance with clause 2.2 or terminated sooner in accordance with the provisions of this Agreement.

2.2 The Parties may extend this Agreement by such period as they agree.

## 3. Objectives of the Agreement

3.1 By entering into this Agreement the Parties re-affirm their commitment to:

(i) deliver the transformation of health and social care services in GM and the wider reform of public services in GM as set out in the GM Strategic Plan.

(ii) collaborate and cooperate with each other, in line with the principles set out in the MOU, and work within the agreed GM Health and Social Care partnership governance arrangements.

3.2 Each Party confirms that implementation of its obligations under this Agreement is consistent with its statutory obligations, and that it has complied

with any relevant requirements imposed upon it by legislation or regulatory authority, and will continue to do so.

## 4. Commitment to the Locality Plan

4.1 The Locality affirms their commitment to the delivery of the Locality Plan set out in Schedule 1 noting that this Agreement:

- covers the metrics as set out in Schedule 2
- supports the delivery of the broader locality objectives set out in Schedule 1, *although will not cover delivery of* the entirety of the Locality Plan.

4.2 The Locality is satisfied that the Locality Plan has a strong foundation and a good trajectory for improvement and delivery of health and social care services across the system.

4.3 The Locality commits to meeting the requirements of the Programme in support of the delivery of the Locality Plan and, as appropriate, the NHS Improvement Agreements.

4.4 The Locality affirms its commitment to the delivery of national outcome, quality and operational standards. Schedule 5 sets out the national NHS requirements and identifies those outcomes and standards that will be directly or indirectly supported by this Agreement.

## 5. Purpose of the Programme

5.1 As part of closing the financial and quality gaps set out in the Locality Plan and delivering both "Taking Charge" and "Stronger Together[6]", the Locality has established the Care Together Programme.

5.2 By 2020/21 the purpose of the Programme is to:

- Improve Healthy Life Expectancy to average GM levels
- Improve population outcomes and population experience
- Create a financially sustainable health and social care economy

5.3 The Programme is set out in detail in Schedule 2 together with the metrics against which the Programme will be measured.

## 6. Confirmation of support for the Programme by the Health and Wellbeing Board

[6] https://www.greatermanchester-ca.gov.uk/downloads/file/8/stronger_together_-_greater_manchester_strategy

6.1 The Locality confirms that details of the Programme have been discussed at the Health and Wellbeing Board; and the Health and Wellbeing Board is supportive of the objectives and approach of the Programme as reflected in the Locality Plan. This plan was approved by the Health and Wellbeing Board in November 2015.

## 7. Agreed milestones

7.1 The Parties have agreed key milestones addressing:

(i) expected reductions in demand;
(ii) improvements in outputs, outcomes, prevalence and impacts (measured against specific metrics);
(iii) expected decommissioning of existing resources and how resources will transfer between different organisations;
(iv) ways the impact will be tracked and evaluated over time; and
(v) expected changes in productivity

7.2 The key milestones for the period of the Term are set out in detail in Schedule 2 ("Key Milestones").

## 8. Transformation funding

8.1 To support the delivery of the Programme the GM Chief Officer has agreed to allocate £23.2m of Transformation Funding to the Locality. (See Clause 9.1 for funding flow).

8.2 The profile of this funding is:

| Quarter | Funding |
|---|---|
| Q4 2016/17 | £5.226m |
| Q1 2017/18 | £1.956m |
| Q2 2017/18 | £2.002m |
| Q3 2017/18 | £2.078m |
| Q4 2017/18 | £1.937m |
| 2018/19 | £6.341m |
| 2019/20 | £3.659m |
| 2020/21 | 0 |

*Note: The duration of the period of fixed funding and the profile of fixed funding will be determined by the GM Chief Officer (with the support and advice of the GM HSCPBE), in the light of the specific Locality Plan under consideration, and the proposed Key Milestones to meet under that Locality Plan. The Agreement may also include an illustrative guide to the anticipated level and profile of funding beyond the fixed period, but this will be subject to review and confirmation by the GM Chief Officer (with the support and advice*

*of the GM HSCPBE) no later than six months before the end of the fixed funding period*.

8.3 The Transformation Funding awarded may only be used for the purpose for which it is intended, as set in the Transformation Fund Proposal and Locality Cost Benefit Analysis as contained within Schedule 8 of this Agreement.

8.4 Recipients of Transformation Funding are required to adhere to their own Standing Financial Instructions. However, with the exception of reports prepared by advisors for regulatory purposes, expenditure incurred on external consultancy contracts in excess of £50,000 (advisory or management capacity) will be subject to the approval of the GM Chief Officer.

## 9. Flow of funding

9.1 The Transformation Funding will be transferred to the CCG by means of an Inter Authority Transfer.

9.2 The CCG shall distribute the Transformation Funding to the Recipients as required to deliver the Programme as defined in Schedules 1 and 2.

9.3 The CCG shall effect the distribution of the Local Authority Transformation Funding to the Local Authority by exercising its powers under Section 256 (payments towards community services) of the NHS Act.

9.4 The CCG shall effect the distribution of the Provider Transformation Funding to the Provider by exercising its powers under Section 3A of the NHS Act and Section 2 of the NHS Act (as appropriate).

## 10. Senior leader responsible for delivery

10.1 The Locality has appointed Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council and Chief Accountable Officer, NHS Tameside and Glossop CCG as the Senior Leader responsible for delivering the Programme and for delivering value for money from the funds awarded to the Locality as set out in in Clause 8 of this Agreement.

## 11. Reporting and evaluation

11.1 The Senior Leader will provide regular updates to the GM HSCPB and GM HSCPBE (in a form and at a frequency to be determined by the GM HSCPB and GM HSCPBE) and to the Health and Wellbeing Board on the Locality's progress towards achieving the Key Milestones.

11.2 The Senior Leader will provide all such information, documents, records and other items and assistance as the GM Chief Officer may reasonably require in connection with the performance of any Party's obligations under this Agreement.

11.3 The CCG, Local Authority and the Provider agree that they will provide all such information and assistance as the Senior Leader may reasonably require to enable it to:

(i) report to the GM HSCPB in accordance with Clause 11.1; and
(ii) provide such information and assistance as may be required by the GM Chief Officer pursuant to Clause 11.2.

11.4 The Locality will undertake a formal annual review of the delivery of the Locality Plan with the support of, and in accordance with a process and format prescribed by, the GM HSCPBE. The annual review will, amongst other things to be prescribed by the GM HSCPBE, check that Transformation Funding has been used for the purposes for which it was allocated. The Locality will deliver the first formal annual review to the GM HSCPBE within 6 months of the Commencement Date.

11.5 The Locality will undertake a comprehensive evaluation of the Programme in a form to be agreed with the GM HSCPB as part of the ongoing operation of the GM Accountability Framework.

11.6 The Locality will ensure the Locality Plan and the Programme associated with this Agreement is monitored through its governance and programme management arrangements, as set out in Schedule 6. The GM Chief Officer and / or their representatives will have the right to attend Locality meetings that relate to the distribution or use of the Transformation Funding and/or the delivery of the Programme.

## 12. Performance

12.1 The GM HSCPB and the Locality agree to work together for the successful implementation of the Programme and to work collaboratively to address any issues that arise or are foreseen.

12.2 If the Locality:

(i) fails to deliver any Key Milestone;
(ii) delivers the Key Milestones outwith the timescales for delivery specified in Schedule 2; or
(iii) commits a material breach of this Agreement and either such breach is in the reasonable opinion of the GM Chief Officer not capable of remedy or such breach is in the reasonable opinion of the GM Chief

Officer capable of remedy and is not remedied to his reasonable satisfaction within such time period as he shall stipulate, acting reasonably,

then the GM Chief Officer (with advice and support from the GM HSCPB and/or the GM HSCPBE) may:

(a) specify additional or amended requirements on the Locality and make the allocation of further Transformation Funding contingent on performance of those additional requirements;
(b) re-profile, pause, reduce or cease payment of some or all of further Transformation Funding;
(c) seek the recovery of some or all of the Transformation Funding; and/or
(d) terminate this Agreement by giving written notice to the Parties.

Before exercising any right under clause 12.2(a)-(d) inclusive, the GM Chief Officer shall have, at the least:

(iv) considered whether any alternative options are available that would address the outstanding performance issue(s);
(v) taken reasonable steps to meet with the Locality to discuss the performance issue(s) and seek alternative options to address them; and
(vi) discussed the matter with the GM HSCPB.

12.3 The GM Chief Officer and the GM HSCPBE may agree a package of non-financial support for the Locality to support it in delivering the Key Milestones. This support will be tailored to reflect the particular challenges and problems faced by the Locality.

12.4 For the avoidance of doubt, the GM Chief Officer, with the support of the GM HSCPBE shall have the final decision in relation to:

(i) any package of non-financial support that is to be offered to the Locality pursuant to Clause 12.3; and
(ii) any action that is to be taken pursuant to Clause 12.2.

12.5 The Locality recognises that any decision made by the GM Chief Officer pursuant to this Clause 12 shall be final.

12.6 If the GM Chief Officer and the GM HSCPBE require the repayment of some or all of the Transformation Funding then, subject to Clause 12.7 below, the CCG shall repay to NHS England the relevant amount of the Transformation Funding as soon as reasonably practicable.

12.7 The CCG would only be required to repay to NHS England:

(i) any uncommitted Transformation Funding that it has not yet distributed to the Recipient; any Transformation Funding that the CCG has in turn been repaid by the Recipients.

12.8 If the CCG requests:

(i) the Local Authority; and/or
(ii) the Provider

to repay to it a proportion of the uncommitted Transformation Funding so that it can, in turn, repay some or all of the Transformation Funding to NHS England then the Local Authority and/ or the Provider (as applicable) agree to repay the relevant proportion of the Transformation Funding to the CCG as soon as reasonably practicable and in any event within [thirty (30)] days of the request.

**12.9** The GM Chief Officer will not be held liable for any misappropriation of funds, and/or any Third Party costs that would be incurred in relation to the same.

## 13. Variations

13.1 This Agreement may be varied by the Parties at any time by agreement in writing in accordance with the Parties' internal decision-making processes.

## 14. Confidentiality

14.1 The Parties agree to keep confidential all documents relating to or received from another Party under this Agreement that are labelled as confidential.

14.2 Clause 14.1 shall not apply to disclosure of information:

(i) required by any applicable law;
(ii) where a Party can demonstrate that such information is already generally available and in the public domain otherwise than as a result of a breach of Clause 14.1
(iii) which is already lawfully in the possession of the receiving party, prior to its disclosure by the disclosing party.

14.3 Where a Party receives a request to disclose information that another Party has designated as confidential, the receiving Party shall consult with the other Parties before deciding whether the information is subject to disclosure.

## 15. Dispute Resolution

15.1 Subject to Clause 15.2, if any dispute arises out of or in connection with this Agreement, the Parties must first attempt to settle the dispute in accordance with the procedures set out in Schedule 4.

15.2 A Party may seek an injunction in connection with any breach by another Party of its obligations under Clause 14.

## 16. Publicity

16.1 The Parties shall use reasonable endeavours to consult one another before making any press announcements concerning the services or the discharge of any Party's responsibilities under this Agreement.

## 17. Payment of legal costs

17.1 The Parties agree that each shall bear their respective legal costs incurred in connection with this Agreement.

## 18. Third Party Rights

18.1 No person other than a Party to this Agreement shall have any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this Agreement.

## 19. General

19.1 Subject to clause 19.2, this Agreement is personal to the Parties and no Party shall, without the prior written consent of the other Parties, assign, transfer or vest, except by the operation of any statutory provision, the benefit of the Agreement to any other person.

19.2 The benefit and/or burden of this Agreement may be assigned or transferred by any Party to any successor of all or part of its functions, property, rights and liabilities.

19.3 The Parties agree that this Agreement shall not be interpreted as constituting a partnership between the Parties nor as constituting any agency between the Parties and the Parties agree that they shall not do cause or permit anything to be done which might lead any person to believe otherwise.

19.4 Any termination of this Agreement shall be without prejudice to any rights or remedies of the Parties in respect of any antecedent breach of this Agreement.

19.5 The termination of this Agreement shall not affect the coming into force or the continuation in force of any provision of this Agreement which is expressly or by implication intended to come into or continue in force on or after such termination or expiry.

19.6 Unless otherwise stated all sums stated in this Agreement are inclusive of all applicable tax, including any VAT.

19.7 The construction, validity and performance of this Agreement shall be governed by the laws of England.

19.8 This Agreement may be entered into in any number of counterparts and by the parties to it on separate counterparts, each of which, when so executed and delivered shall be an original.

**Signatures**

**NHS England**

Signed on behalf of NHS England

Name: Jon Rouse

Role: GM Chief Officer

Signature:

_____

Date:

**The Greater Manchester Health and Social Care Partnership Board**

Signed on behalf of the Greater Manchester Health and Social Care Partnership Board

Name: Lord Peter Smith

Role: Chair

Signature:

_____

Date:

**The Locality**

Signed on behalf of the Locality (signatories must include the Leader of the Local Authority, Chief Executive of the Local Authority, Chair of the Clinical Commissioning

Group, Chief Executive of the Clinical Commissioning Group, Chair of the acute provider, Chief Executive of the acute provider).

**Signed on behalf of the Commissioners**

Name: Steven Pleasant OBE

Role: Chief Executive, Metropolitan Borough Council and Chief Accountable Officer, NHS Tameside and Glossop CCG

Signature: _____

Date:

Name: Dr. Alan Dow

Role: Chair, NHS Tameside and Glossop CCG

Signature: _____

Date:

**Signed on behalf of the Provider**

Name: Karen James

Role: Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust

Signature: _____

Date:

Name: Paul Connellan

Role: Chair, Tameside and Glossop Integrated Care NHS Foundation Trust

Signature: _____

Date:

**SCHEDULE 1 – LOCALITY PLAN**

Locality Plan - 2nd Iteration FINAL.pdf

## SCHEDULE 2A – PROGRAMME METRICS

Schedule 2A Programme Metrics for Tameside and Glossop need to read in conjunction with the (draft) Planning 2017/18 - 2018/19 CCG Monthly Activity and Other Requirements which was submitted to NHSE on 24th November. This is an extensive Excel spreadsheet and attached as Schedule 2A(i) which identifies trajectories on a range of performance metrics.

This will be finalised by 23rd December in line with the date requested by NHSE for contracts between CCGs and providers to be agreed. At this stage, Tameside and Glossop will also highlight the key trajectories in the table below. This will include prevalence, provider productivity, configuration/decommissioning and any additional in the category of activity not already highlighted below.

STP Core Metrics 17/18 - 18/19 (once these are released by NHSE – estimated February 2017) will be incorporated in the trajectories and metrics before Q1 of 2017/18.

**Investment Agreement – Metrics and approach to monitoring**

Below is a summary of the metrics proposed for the Tameside and Glossop Investment agreement along with the proposed approach to be taken by in conjunction with GM H&SC Partnership to monitor performance over the duration of the Agreement. These focus on financial and activity metrics as being the most likely to show progress of the transformational fund schemes and which can be reported quarterly.

As stated above, additional metrics will be added in once contract negotiations within Tameside and Glossop have concluded and a financial position for 2017/18 agreed.

| Category | Measure | Threshold/target by 2020/21 (incl. baseline) | Lead & Organisation | Data Source | Monitoring mechanism | Frequency |
|---|---|---|---|---|---|---|
| Financial | Economy Gap as defined by and agreed by GM | <table><tr><th>Year</th><th>Total Locality Gap: Do Nothing £'000s</th><th>Do Something £'000s</th></tr><tr><td>2016/17</td><td>56,212</td><td>38,950</td></tr><tr><td>2017/18</td><td>82,489</td><td>55,568</td></tr><tr><td>2018/19</td><td>88,867</td><td>40,150</td></tr><tr><td>2019/20</td><td>94,478</td><td>26,449</td></tr><tr><td>2020/21</td><td>101,507</td><td>9,461</td></tr></table> | Directors of Finance<br><br>(Commissioner & T&GICFT) | Reporting via internal governance of CCG and FT as well as GM submissions | FEW / GM Assurance<br><br>Meetings | Monthly internally.<br><br>Quarterly to NHS/GM through IAF |

<table>
<tr><th>Category</th><th>Measure</th><th>Threshold/target by 2020/21 (incl. baseline)</th><th>Lead & Organisation</th><th>Data Source</th><th>Monitoring mechanism</th><th>Frequency</th></tr>
<tr><td>Financial</td><td>£’s spent on prescribing per 1000 population</td><td>Reduction in spend pa of:<br><table><tr><th>Year</th><th>16/17 £m</th><th>17/18 £m</th><th>18/19 £m</th><th>19/20 £m</th><th>20/21 £m</th></tr><tr><td>Baseline (budget)</td><td>40.288</td><td>42.234</td><td>43.436</td><td>44.670</td><td>45.938</td></tr><tr><td>Reduction in spend</td><td>0</td><td>-1.000</td><td>-1.500</td><td>-2.000</td><td>-2.500</td></tr><tr><td>Plan</td><td>40.288</td><td>41.234</td><td>41.936</td><td>42.670</td><td>43.438</td></tr><tr><td>£’000s per 1000 pop</td><td>164</td><td>168</td><td>171</td><td>174</td><td>177</td></tr></table></td><td>Chair of Single Commissioning Board (Alan Dow)</td><td>CCG Financial System</td><td>Care Together Financial Monitoring Statement</td><td>Monthly internally, quarterly to GM</td></tr>
</table>

<table>
<tr><th>Category</th><th>Measure</th><th>Threshold/target by 2020/21 (incl. baseline)</th><th>Lead & Organisation</th><th>Data Source</th><th>Monitoring mechanism</th><th>Frequency</th></tr>
<tr><td>Activity</td><td>Number of emergency admissions to Hospital (per 1000 population)</td><td>
<ul>
<li>Neighbourhoods would stem 25% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 50% of forecast growth from 2018/19 onwards</li>
<li>Digital Health would reduce NEL admissions by 455 admissions</li>
</ul>
Reduction on 16/17 baseline growth assumptions of:
<table>
<tr><th>Year</th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th><th>20/21</th></tr>
<tr><td>Baseline (admissions)</td><td>33,165</td><td>33,826</td><td>34,399</td><td>34,983</td><td>35,866</td></tr>
<tr><td>INs</td><td>0</td><td>-331</td><td>-1,235</td><td>-1,818</td><td>-2,701</td></tr>
<tr><td>Digital Health</td><td>0</td><td>-228</td><td>-455</td><td>-455</td><td>-455</td></tr>
<tr><td>Plan</td><td>33,165</td><td>33,267</td><td>32,710</td><td>32,710</td><td>32,710</td></tr>
<tr><td>per 1000 pop</td><td>135</td><td>136</td><td>133</td><td>133</td><td>133</td></tr>
</table>
</td><td>Director of Integrated Neighbourhoods<br><br>(Director of Operations until appointed), ICFT</td><td>No of emergency admissions routinely collected through SLAM data</td><td>CCG and provider contract performance governance</td><td>Monthly internally.<br><br>Quarterly to GM</td></tr>
</table>

<table>
<tr><th>Category</th><th>Measure</th><th>Threshold/target by 2020/21 (incl. baseline)</th><th>Lead & Organisation</th><th>Data Source</th><th>Monitoring mechanism</th><th>Frequency</th></tr>
<tr><td>Activity</td><td>Number of ED attendances</td><td>
<ul>
<li>Neighbourhoods would stem 50% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 100% of forecast growth from 2018/19 onwards</li>
<li>Digital Health would reduce ED attendances by 1733 attendances.</li>
</ul>
Reduction on 16/17 baseline growth assumption of:
<table>
<tr><th>Year</th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th><th>20/21</th></tr>
<tr><td>Baseline (attendances)</td><td>88,291</td><td>90,052</td><td>91,579</td><td>93,131</td><td>95,482</td></tr>
<tr><td>INs</td><td>0</td><td>-880</td><td>-3,287</td><td>-4,840</td><td>-7,191</td></tr>
<tr><td>Digital Health</td><td>0</td><td>-867</td><td>-1,733</td><td>-1,733</td><td>-1,733</td></tr>
<tr><td>Plan</td><td>88,291</td><td>88,305</td><td>86,558</td><td>86,558</td><td>86,558</td></tr>
<tr><td>per 1000 pop</td><td>360</td><td>360</td><td>353</td><td>353</td><td>353</td></tr>
</table>
</td><td>Director of Integrated Neighbourhoods<br><br>(Director of Operations until appointed), ICFT</td><td>No of emergency attendances routinely collected through SLAM data</td><td>CCG and Provider contract Performance governance</td><td>Monthly internally.<br><br>Quarterly to GM</td></tr>
</table>

<table>
<tr><th>Category</th><th>Measure</th><th>Threshold/target by 2020/21 (incl. baseline)</th><th>Lead & Organisation</th><th>Data Source</th><th>Monitoring mechanism</th><th>Frequency</th></tr>
<tr><td>Activity</td><td>Hospital Bed days per 1000 population</td><td>
<ul><li>Digital Health would reduce 4380 bed days. (12 beds) by end of 31st March 2018</li><li>Home First would reduce 9903 bed days (24 beds)</li></ul>
1st April 8 beds 2017<br><br>30th Sept 16 beds 2017
<table>
<tr><th>Year</th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th><th>20/21</th></tr>
<tr><td>Baseline (bed days)</td><td>175,089</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Digital Health / Home First</td><td>0</td><td>-14283</td><td>-14283</td><td>-14283</td><td>-14283</td></tr>
<tr><td>Plan</td><td>175,089</td><td>160,806</td><td>160,806</td><td>160,806</td><td>160,806</td></tr>
<tr><td>Per 1000 pop</td><td>713.5</td><td>655.3</td><td>655.3</td><td>655.3</td><td>655.3</td></tr>
</table>
</td><td>Director of Operations, ICFT</td><td>No of bed days routinely collected through SLAM data</td><td>CCG and Provider contract Performance governance</td><td>Monthly internally.<br><br>Quarterly to GM</td></tr>
<tr><td>Activity</td><td>Intermediate Care Beds</td><td>
Community bed base restructuring would release 8395 bed days (23 beds) (by 18/19)
<table>
<tr><th>Year</th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th><th>20/21</th></tr>
<tr><td>Baseline (beds)</td><td>119</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Flexible Community Bed base</td><td>0</td><td>-11</td><td>-23</td><td>-23</td><td>-23</td></tr>
<tr><td>Plan</td><td>119</td><td>108</td><td>96</td><td>96</td><td>96</td></tr>
</table>
</td><td>Director of Operations, ICFT<br><br>Director of Commissioning, SCF<br><br>Director of Estates, ICFT</td><td>ICFT records of bed capacity</td><td>CCG and Provider contract performance governance</td><td>Monthly internally.<br><br>Quarterly to GM</td></tr>
</table>

<table>
<tr><th>Category</th><th>Measure</th><th>Threshold/target by 2020/21 (incl. baseline)</th><th>Lead & Organisation</th><th>Data Source</th><th>Monitoring mechanism</th><th>Frequency</th></tr>
<tr><td>Activity</td><td>% delayed transfers of care</td><td>4.5% by end of March 2017<br><br>(subject to locality approval, and prior to GM submission on 2nd of Dec)</td><td>Director of Operations, ICFT<br><br>Director of Integrated Neighbourhoods, ICFT</td><td>DTOCs are reported on a daily basis per UCIST data set</td><td>CCG and Provider contract Performance governance</td><td>Daily internally and quarterly to GM</td></tr>
<tr><td>Activity</td><td>Number of Planned Admissions</td><td>• Neighbourhoods would stem 25% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 50% of forecast growth from 2018/19 onwards<br>• Linked to SCF recovery plan<br><br>Reduction on 16/17 baseline growth assumption of:<br><br>
<table>
<tr><th>Year</th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th><th>20/21</th></tr>
<tr><td>Baseline (admissions)</td><td>31,903</td><td>32,539</td><td>33,091</td><td>33,652</td><td>34,501</td></tr>
<tr><td>INs</td><td>0</td><td>-159</td><td>-594</td><td>-875</td><td>-1,299</td></tr>
<tr><td>Plan</td><td>31,903</td><td>32,380</td><td>32,497</td><td>32,777</td><td>33,202</td></tr>
<tr><td>per 1000 pop</td><td>130</td><td>132</td><td>132</td><td>134</td><td>135</td></tr>
</table>
</td><td>Director of Integrated Neighbourhoods<br><br>(Director of Operations until appointed), ICFT</td><td>Admissions routinely collected through SLAM</td><td>CCG and Provider contract Performance governance</td><td>Monthly internally.<br><br>Quarterly to GM</td></tr>
</table>

<table>
<tr><th>Category</th><th>Measure</th><th>Threshold/target by 2020/21 (incl. baseline)</th><th>Lead & Organisation</th><th>Data Source</th><th>Monitoring mechanism</th><th>Frequency</th></tr>
<tr><td>Activity</td><td>Number of Outpatient Appointments</td><td>• Neighbourhoods would stem 50% of forecast growth in planned admissions (based on 2016/17 growth baseline) in 2017/18 increasing to 100% of forecast growth from 2018/19 onwards<br>• Neighbourhoods would stem 100% of growth in outpatients (based on 2015/16 growth baseline).<br>• Linked to SC Recovery plan<br><br>Reduction on 16/17 baseline growth assumption of<br><br>
<table>
<tr><th>Year</th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th><th>20/21</th></tr>
<tr><td>Baseline (appointments)</td><td>308,704</td><td>314,860</td><td>320,198</td><td>325,626</td><td>333,876</td></tr>
<tr><td>INs</td><td>0</td><td>-3,078</td><td>-11,493</td><td>-16,921</td><td>-25,141</td></tr>
<tr><td>Plan</td><td>308,704</td><td>311,782</td><td>308,704</td><td>308,704</td><td>308,704</td></tr>
<tr><td>per 1000 pop</td><td>1258</td><td>1271</td><td>1258</td><td>1258</td><td>1258</td></tr>
</table>
</td><td>Director of Integrated Neighbourhoods<br><br>(Director of Operations until appointed), ICFT</td><td>Admissions routinely collected through SLAM</td><td>CCG and Provider contract Performance governance</td><td>Monthly internally.<br><br>Quarterly to GM</td></tr>
</table>

The ‘Reduction in ambulance attendances from T&G Care Homes to the Emergency Department’ is a subset of ‘Number of Emergency Department Attendances’ and the specific reduction trajectories for Digital Health are contained within it. Therefore, to avoid duplication, it has been removed from the schedule.

## SCHEDULE 2B – PROGRAMME MILESTONES

The programme milestones should be SMART with clear timelines and named responsible leads for each action over the term of the Investment Agreement. These milestones should align to your Locality Implementation Plan and linked to your outcomes outlined in Schedule 2A as appropriate. Please insert additional rows as required. A worked example has been provided to illustrate the level of detail required.

| Activities / Deliverables | By When | Lead / Responsible Organisation |
|---|---|---|
| **Year 1: 2016/17 - Pre-mobilisation / set up** | | |
| • Integrated Neighbourhoods Core Offer identified – including staff skill mix | Oct 2016 | Joint Locality |
| • New Homecare contract commences - 'as is' state | Nov 2016 | SCF |
| • Flexible Community Beds : Open 1st Floor of Stamford Unit | Nov 2016 | ICFT |
| • Digi Health: Agree Urgent Care/Medicine cost reductions to deliver financial benefits detailed in CBA | Nov 2016 | ICFT |
| • Digi Health Technology proof of concept | Dec 2016 | ICFT |
| • New Outcomes based Contract issued for ICFT for 2017/18 | Dec 2016 | SCF |
| • Flexible Community Beds: Notice given on Grange View | Dec 2016 | ICFT |
| • Overarching Neighbourhood dash board in place to demonstrate CBA activity | Dec 2016 | ICFT |
| • Home First: complete staff recruitment & training | Dec 2016 | ICFT |

| Activities / Deliverables | By When | Lead / Responsible Organisation |
|---|---|---|
| • Home First: Continue to engage with care homes providers to develop Home First community bed pathways | -> Dec 2016 | ICFT |
| • Delivery of Digital Health operational learning test | Dec 2016 – Feb 2017 | ICFT |
| • Delivery of PAM Pilot | Dec 2016 – Q1 2017/18 | ICFT |
| • IN Workforce Plan approved by the ICO | Jan 2017 | ICFT |
| • Quality Indicators Identified for extensivists | Jan 2017 | ICFT |
| • Outcome Framework agreed | Jan 2017 | Joint Locality |
| • Launch of PAM Recurrent Quarterly Training Programme | Jan 2017 | ICFT |
| • Volunteering Scheme Commences | Jan 2107 | ICFT |
| • Commence paediatric community upskilling process (planned care) (annually Q4) | Jan 2017 | ICFT |
| • Go live! for SPA | Feb 2017 | ICFT |
| • Co-location of teams for IN #1 Ashton | Feb 2017 | ICFT |
| • Co-location of team for IN #2 Denton / Audenshaw | Feb 2017 | ICFT |
| • Digital Health: Review impact of Home first phase 1 roll out on ED attendances and admissions from care homes | Feb 2017 | ICFT |

| Activities / Deliverables | By When | Lead / Responsible Organisation |
|---|---|---|
| • Home first: full implementation | -> March 2017 | ICFT |
| • Over 75's funding schemes identified to continue post March 2017 | Mar 2017 | Joint Locality |
| • IN Managers in post | Mar 2017 | ICFT |
| • Home Care Supervisory Staff in place | Mar 2017 | ICFT |
| • Social Prescribing Procurement process complete | Mar 2017 | ICFT |
| • ABCD Procurement process complete | Mar 2017 | ICFT |
| • Commence Digital health phase 2 roll out | March 2017 -> Q2 2017/18 | ICFT |
| **Year 2: 2017/18** | | |
| • Extensivist Clinicians in post | Q1 | ICFT |
| • Community Pharmacists in post | Q1 | SCF |
| • Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #1 Ashton | Q1 | ICFT |
| • Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #2 Denton / Audenshaw | Q1 | ICFT |
| • Co-Location and Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #4 Mossley/Stalybrige and Dukinfield | Q1 | ICFT |

| Activities / Deliverables | By When | Lead / Responsible Organisation |
|---|---|---|
| • Personalised Care Plans Rollout (duration: one full year) | Q1 – Q1 2018/19 | ICFT |
| • Extensivists proactive management of high risk stratification | Q1 | ICFT |
| • Flexible Community Beds: Closure of Grange View Beds | Q1 | ICFT |
| • Flexible Community Beds: Commence Consultation on the closure of Shirehill | Q1 | ICFT |
| • Flexible Community Beds: Open ground floor of Stamford Unit | Q1 | ICFT |
| • SPA: Expected to see reduction in community referrals, across health and social care | Q1 -> onwards | ICFT |
| • SPA: Expected to see reduced contact points for service users | Q1 -> onwards | ICFT |
| • Homecare new offer: locality #1 goes live with complete rollout to whole "zone" | Q1 | ICFT |
| • Social Prescribing: Posts recruited to (Neighbourhoods / Hospital) | Q1 | ICFT |
| • ABCD: Grant scheme/investment agreements into the VCFS commenced | Q1 | ICFT |
| • IT Support for Social Prescribing procurement completed | Q1 | ICFT |
| • Social Marketing: commence delivery of Programme | Q1 | ICFT |
| • Expected to see neighbourhood teams referring to social prescribing with a % increase month on month | Q1 -> onwards | ICFT |
| • Hospital social prescribing established in admissions avoidance and Darnton unit | Q1 | ICFT |

| Activities / Deliverables | By When | Lead / Responsible Organisation |
|---|---|---|
| • Home First: Close Beds in line with CBA (8 April 17) - 8 beds | Q1 | ICFT |
| • Digital Health: Review delivery of benefits (decrease in ED attendances and admissions from baseline) | Q1-Q4 | ICFT |
| • Co-Location and Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #3 Hyde | Q2 | ICFT |
| • Co-Location and Go Live! Team re-design and appointments complete to new posts, structure fully implemented for IN #5 Glossop | Q2 | ICFT |
| • Homecare new offer: locality #2 goes live with complete rollout to whole "zone" | Q2 | ICFT |
| • Social Prescribing Referrals processes in place and referrals commenced | Q2 | ICFT |
| • Social Prescribing Research and evaluation processes commenced | Q2 | ICFT |
| • Home First: Close Beds in line with CBA (16 Sept 17) - further 8 beds | Q2 | ICFT |
| • Commence PAM rollout post pilot and lessons learnt | Q2 -> onwards | ICFT |
| • Volunteers recruited in each of the neighbourhoods | Q2 - Q3 | ICFT |
| • Homecare new offer: locality #3 goes live with complete rollout to whole "zone" | Q3 | ICFT |
| • ABCD Website Go Live! | Q3 | ICFT |
| • Flexible Community Beds: Close Shirehill | Q3 | ICFT |

| Activities / Deliverables | By When | Lead / Responsible Organisation |
|---|---|---|
| • Flexible Community Beds: Stamford Unit fully operational across 96 beds | Q3 | ICFT |
| • Homecare new offer: locality #4 goes live with complete rollout to whole "zone" | Q4 | ICFT |
| • Homecare new offer: locality #5 goes live with complete rollout to whole "zone" | Q4 | ICFT |
| • Social Prescribing: Expansion of the hospital model to all wards commences | Q4 -> | ICFT |
| • ABCD take referrals through portal Go Live! | Q4 | ICFT |
| • Formal transfer of Adult Social care complete | Q4 | ICFT |
| **Year 3: 2018/2019** | | |
| • Homecare new offer: locality #5 goes live with complete rollout to whole "zone" | Q1 | ICFT |
| • IN: Release of Estate | Q3-Q4 | Joint locality |
| **Year 4: 2019/2020** | | |
| • INs: self-funding | Q4 | ICFT |

## SCHEDULE 2C – FINANCIAL INFORMATION

schedule 2c
OVERVIEW

Schedule 2C(i)
PROGRAMME EXPENI

## SCHEDULE 3 – DISPUTE RESOLUTION

This Investment Agreement will be subject to a dispute resolution agreed by Greater Manchester.

This dispute resolution process is still in development, will be inserted at such time the agreed version is available.

## SCHEDULE 4 – TERMS OF REFERENCE FOR GM HSC PARTNERSHIP BOARD

### AUTHORITY

In February 2015 the Association of Greater Manchester Authorities (AGMA) and the Association of Greater Manchester Clinical Commissioning Groups (CCGs) signed a Memorandum of Understanding (MoU) with NHS England to create a framework for achieving the delegation and ultimate devolution of health and social care responsibilities to accountable and statutory bodies in Greater Manchester (GM).

The MoU outlined a process for collaborative working across health and social care making provision for arrangements to be in place (in shadow form) from November 2015 It also made provision for a programme of work to be undertaken during 2015/16 to move to fully devolved system from April 2016.This includes work to develop and agree the supporting governance

Following the creation of the Standing Conference in April 2015, it was agreed subsequently that from the beginning of the Shadow Period this would be superseded by the formal establishment of a Strategic Partnership Board.

### PURPOSE AND OBJECTIVES

The Strategic Partnership Board will be responsible for setting the overarching strategic vision for the Greater Manchester Health and Social Care economy. As it is not a legal body, its decisions are not binding, but recommendations for its members to formally adopt following their own governance procedures which may include delegation to a group of its members where possible.

### RESPONSIBILITIES

The key responsibilities of the Partnership Board are:

- To set the framework within which the Strategic Partnership Executive will operate.
- To agree the GM Health and Social Care Strategic priorities in accordance with the NHS five year forward view. The priorities and vision as defined by the Strategic Partnership Board will be delivered by the GM Joint Commissioning Board and the localities.
- To approve the content of the GM Strategic Plan (for financial and clinical sustainability), and note the content of the 10 locality plans to deliver the Strategic Plan locally and the matters remaining for the GM Joint Commissioning Board's remit.
- To agree the criteria that determines access to the transformation funding and ask the fund allocators (NHS England and GMCA) and fund recipients (Local Authorities and CCGs) to adopt them.
- To ensure that there remains ongoing and significant organisational commitment across the GM health economy to both the devolution agenda and a devolved health system.
- To be responsible to the people of Greater Manchester and to each other for the financial and clinical sustainability of the Greater Manchester health economy, through the agreement and the delivery of the Strategic Plan. The Board will receive regular update reports from the Executive on the ongoing progress of the delivery of the Strategic Plan.

- To provide a mutual assurance function over the outcomes linked to the commissioning decisions taken by members to deliver the Strategic Plan. The Board will receive regular reports from the Executive about the commissioning decisions of the GM Commissioning Board, and the performance (via agreed outcomes) linked to those decisions.
- To agree an assurance framework, developed jointly with regulators where required, that reflects the outcomes required by Greater Manchester, because the formal assurance that each individual party is delivering on their commitments to the Strategic Plan will be provided in the usual way by the SPB relevant statutory body. The Board will receive regular reporting of GM's performance against agreed assurance metrics.
- To provide leadership across the GM health economy to ensure that the key strategic priorities for a GM health system are achieved.

**MEMBERSHIP**
The membership of the Strategic Partnership Board is not a closed membership at this point but will include:

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

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

From October 2015 Primary care partners will be represented at the Board through the GMLMC. Further work will be undertaken from October to April 2016 the outcome of which will inform and determine the representation of primary care in the governance framework. This work will ensure that primary care is appropriately represented by accountable and representative bodies on an ongoing basis.

GMCVO will attend to represent the voluntary sector pending further discussion on third sector representation as set out below.

Any amendments to the membership of the Strategic Partnership Board will be agreed (by majority vote where necessary) by the Board.

**CHAIR**
The Strategic Partnership Board will have an independent chair. However, Lord Peter Smith (AGMA/GMCA) will act as chair until such time that a process to appoint an independent chair is completed.

**QUORUM**
*The quoracy of the meeting has yet to be defined.*

**SUPPORT**
Officers from the Greater Manchester Integrated Support Team (GMIST) will provide policy and administrative support to the Partnership Board.

**MEETING FREQUENCY**
The Partnership Board will meet monthly or more frequently if required.

**ACCOUNTABILITY**
The Strategic Partnership Board is accountable to Greater Manchester. Its members are accountable to their own organisations and stakeholder grouping.

**REVIEW OF TERMS OF REFERENCE**
These terms of reference will be formally reviewed by the Partnership Board by mutual agreement of the membership. Such review will take place at any time to reflect changes in circumstances which may arise.

## SCHEDULE 5 – NATIONAL REQUIREMENTS

**Option A** = Aim to deliver and fund from the IA completely
**Option B** = IA will make a part contribution
**Option C** = Outside the scope of the IA – seeking separate funding source (e.g. through a cross-programme or Theme investment)
**Option D** = Outside the scope of the IA – separate funding source identified (please state what this is)
**Option E** = Already being achieved and/or within core funding so no additional resource required

| Ref | National Requirements | Options (A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
|---|---|---|---|---|
| 1 | Get back on track with access standards for A&E in line with STF trajectories and ensuring that more than 95 percent of patients wait no more than four hours in A&E, | B | Transformation fund supports Admission Avoidance and Discharge priority.<br><br>Capital funding is required to enhance "front door" and support streaming of patients at A&E. May need additional funding to support flow. | Current performance is below trajectory for Quarter 3 however the expectation is the changes implemented in November along with the transformation plans will deliver the necessary improvements and bring the system back on track for 95%. Addressing bed capacity is essential through reduced Length of Stay and reduced DTOC.<br><br>**November Changes**<br><br>New Home Care providers have absorbed previously unmet need and are ensuring packages can be recommenced in 24 hours and new ones delivered within 48hrs.<br><br>**Increased nursing assessment capacity**<br><br>32 additional community beds to support out of |

| Ref | National Requirements | Options<br><br>(A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
|---|---|---|---|---|
| | | | | hospital assessment of people who are unsafe to be assessed at home. 16 in place with remainder due mid December.<br><br>Other transformation projects include Discharge to Assess, Flexible Community Bed Base development and increased capacity in the Integrated Urgent Care Team (IUCT) which alongside the use of SAFER and Red Green analysis will improve flow through the acute beds, reduce the risk of A&E breaches due to bed availability and reduce Delayed Transfers of Care. Implementation has started with a focus for DtA on patients who can be safely assessed at home and all wards will be operating this by end of November. Additional IUCT capacity is supporting people in their own homes. The additional community beds will support more complex assessments out of the acute bed base. SAFER will be fully implemented by end of November and will support earlier discharge including the focus on simple discharges.<br><br>IUCT and Digital Health for Care Homes will support increased admissions avoidance managing demand within the patient's home rather than attending A&E.<br><br>Existing schemes such as Alternative to Transfer (an AVS) and Glossop Community Specialist Paramedic |

| Ref | National Requirements | Options<br><br>(A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
|---|---|---|---|---|
| | | | | supports effective use of ambulances and increases See and Treat so reducing A&E demand. NWAS (April to Sep) Hear and Treat 11.4%, See and Treat 17.5% and See and Convey 68.9%<br><br>Integrated neighbourhoods will support demand reduction by reducing exacerbations of conditions.<br><br>The Emergency Care Village development (once capital has been gained) will enable effective management of patients via NWAS and self-presenters. It will enable full streaming and direct admissions to assessment facilities and ambulatory emergency care. |
| | including making progress in implementing the urgent and emergency care review. | B | Transformation for community bed base and INs.<br><br>Additional capital funding is required for Emergency Care Village and planned care | 1. Streaming patients on arrival at A&E is a key element of plans for an Integrated Urgent Care service. A proposed estate solution through redesign of the current A&E department will require capital funding and estate works. Alternative ways of delivering streaming at the front door continue to be developed. Current arrangement includes streaming to Ambulatory Emergency Care (AEC) with 19% increase in use of AEC.<br><br>2. NHS 111 - Working with GM to support our 111 provider to deliver the Integrated virtual clinical hub. |

| Ref | National Requirements | Options<br><br>(A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
|---|---|---|---|---|
| | | | | Current OoH undertakes enhanced triage on calls transferred. DoS in maintained to encourage use of A&E alternatives<br><br>3. Ambulances – DoD and code review pilots; NWAS is modelling expected impact of the Dispatch on Disposition and Coding changes on Red performance to identify impacts at a County, CCG and Regional level and the effect on performance variation. T&G are working with NWAS as described below.<br><br>4. Improved flow – T&G ICFT are implementing SAFER across wards by end of November alongside RED and GREEN day monitoring<br><br>5. Discharge – Discharge to Assess is operating across four wards with full roll out planned by end of November. Development of a more flexible community bed base will support discharge of patients who require respite and recuperation before they are safe to go home as well as step up provision to avoid emergency admissions. |
| | 75 percent of Category A **ambulance calls** responded to within 8 minutes. | B | Transformational funding.<br><br>May need additional funding for Acute | NWAS is doing work internally to increase Hear and Treat and See and Treat and will be encouraging consistent use of the local AVS when appropriate. Locally the Alternative to Transfer (AVS) has been in |

| Ref | National Requirements | Options<br><br>(A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
|---|---|---|---|---|
| | | | Visiting Service (AVS). | place since 2014 and will continue as discussions take place as to the best model for commissioning across GM continue. Deflection remains 80-90% with approx. 200 referrals a month.<br><br>The Community Specialist Paramedic in Glossop supports response times as well as working to reduce demand.<br><br>Transformation projects include the integrated neighbourhoods adopting the learning from the Glossop CSP to develop appropriate services that increase the number of people maintained in their own home. Through Home First the Integrated Urgent Care Team will support people in their own homes where appropriate to reduce conveyances when a crisis occurs.<br><br>The Hospital Ambulance Liaison Officer supports prompt ambulance turnaround to ensure release of ambulances to respond. HAS screen compliance has significantly improved and the interface between NWAS and the acute has enabled improved pathways and processes to be developed and is critical to the Emergency Care Village planning.<br><br>The Digital Health in Care Homes work will enable a |

| Ref | National Requirements | Options<br><br>(A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
|---|---|---|---|---|
| | | | | virtual consultation to take place to help identify the need for transport to hospital and avoid unnecessary 999 calls. |
| 2 | Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, | B | IN transformation and possibly some transition funding for planned care development. | The CCG has failed the target in several occasions in the past due to provider data validation or computer issues. However 2016/17 has seen sustained improvement and whilst not all specialities are meeting the national standard, overall the standard has been maintained.<br><br>T&G ICFT achieve the RTT standard in almost all specialties and have an improvement programme underway to offer choice for all first OPD appts. Also, increasing the uptake of e-referrals is a key workstream within the planned care programme<br><br>Pathway development through the planned care workstream has focussed on specialities where capacity issues exist with a focus on advice and guidance and effective use of the wider professional base to ensure that individuals receive the prompt appropriate care and are able to return to independence and self-care.<br><br>Integrated Neighbourhoods will provide holistic care to individuals with long term conditions to enable them to |

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| | | | | self-care effectively and reduce demand for acute care. The preventative focus in neighbourhoods will also reduce demand in the longer-term as people maintain positive health and wellbeing. |
| | ..including offering patient choice | E | Being achieved currently. | Patient Choice will continue to be offered where appropriate and the holistic nature of care planning will encourage shared decision making with individuals.<br><br>Use of E-referrals has fallen as Primary Care and Provider expectations and capability has not been aligned. The level of use across Primary Care is variable and work is taking place to ensure that all parties are in a position to fully utilise E-referral in 2017/18.<br><br>The Tameside and Glossop ICFT have an improvement plan in operation which aims to deliver choice to 100% of all first outpatient appointments.<br><br>All patients eligible for Continuing Health Care (CHC) are offered a Personal Health Budget (PHB).<br><br>Our PHB Coordinator is working with frontline staff to promote the offer of Personal Health Budgets to |

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| | | | | patients with MH, LD and LTC. We are also considering how PHBs can support those patients who have been agreed as either amber or red within the locality risk stratification model. Growth in this area is expected to reduce demand on high use pathways, resulting in a reduction of cost and demand to the system. Modelling against cost savings is currently taking place. |
| 3 | Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and | E | No direct investment but referral pathway development project in place as part of the Planned Care workstream, including early diagnostics. | Cancer performance has been maintained.<br><br>Single Commission and T&GICO working together via GM infrastructure (GM Cancer) and T&G Cancer Board to ensure local implementation of national and GM models of care / pathways, including implementation and promotion of NICE guidelines.<br><br>Achieving national standard for 62 day waits, and monitor performance via the T&G Cancer Board. |
| | make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. | B | No direct investment in diagnosis and treatment elements of cancer pathways, but integrated neighbourhood element of our model | Work is ongoing to review current performance and sourcing data to support this as part of the Quality Premium. 2013 survival data is 67.6% with 2014 diagnosis at 44.2% against 50.7% nationally.<br><br>Ensuring the Single Commission officers and clinical leads for cancer are working with colleagues in GM and TGICOFT on cancer service transformation (as |

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| | | | will enable improvements in delivery of messages around early presentation and therefore early diagnosis. Work ongoing as part of the planned care workstream to ensure adequate and robust early diagnostics pathways and capacity in place. | set out in latest planning guidance), engagement at all levels in GM Cancer, and local performance management and service improvement initiatives. T&G Cancer Board meet monthly to ensure local implementation of national and GM priorities.<br><br>This a long term issue that T&G have been making progress with through key focuses:<br>- Community cancer awareness programme: initially funded by Macmillan and now embedded in work of local health improvement team 'Be Well Tameside'<br>- Bowel cancer screening programme: close collaboration by GM Bowel Cancer Screening Promotion Team with local cancer awareness and health improvement activities; focus on primary care role by CCG Quality Local Implementation Group Quality Initiative on cancer.<br>Healthy lives and integrated neighbourhood elements of our integration model will enable improvements in delivery of messages and behaviour change around early presentation and therefore early diagnosis, by incorporation of 'Be Well Tameside' team members, social prescribing, asset based approaches and social marketing.<br>CCG have appointed a Macmillan GP who is promoting best practice in primary care including follow up of bowel screening non-responders.<br>T&G collaborates with GM Screening and |

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| | | | | Immunisation Team on initiatives to promote uptake of cancer screening programmes. |
| 4 | Deliver the **diagnostic standard** by ensuring that less than 1 percent of patients wait no more than six weeks, where this is not being met then recovery in line with the STF trajectory is to be achieved. | E | | Performance has significantly improved from quarter 1 but is below standard at 1.24% for September.<br><br>Endoscopy remains a key challenge. Central Manchester generally accounts for the majority of endoscopy breaches with Tameside generally delivering against the standard.<br><br>Audiology is another key issue and work is being undertaken to understand the level of demand in the reporting trusts compared to other AQP providers.<br><br>MRI activity has increased and whilst performance is improving work is ongoing with GPs to understand they increase in Direct Access MRI demand.<br><br>Improved guidance and increased E-Referral usage is expected to support improved performance through more accurate referring and improved timeliness of booking. |

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| 5 | Achieve and maintain the **mental health access standards**:<br><br>○ more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; | E | No direct relationship, although has a direct impact on spending on acute and primary care services | The access standard for early intervention psychosis, currently 50%, rising to 53% by 2018, is being consistently met. July 16 65.4% is on an upward trend.<br><br>Based on the current referral rate the access standard for EIP will be met within existing resources and does not require additional investment. |
| | ○ 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. | C | No direct relationship, although has a direct impact on spending on acute and primary care services | The current IAPT targets are being met<br><br>**6 and 18 week wait for first appointment Completed Treatment RTT**<br><br>The service has achieved 77.9% against a 75% target for 6 weeks and 99.8% against a 95% target for 18 weeks on cases completing treatment in October.<br><br>**IAPT rollout**<br>The service has in the early part of this year over achieved the 15% prevalence target and the CCG will work with the Provider to ensure this is sustained through 17/18 and 16.8% is achieved.<br><br>To support this, the service will build on the program of community engagement and work with third sector providers to ensure effective access to IAPT provision is maintained. |

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| | | | | In accordance with the MH 5YFV, additional investment will be required to train more specialised practitioners and to increase service capacity to meet the growth targets from 2018/19 onwards.<br><br>The CCG will develop a strategy to increase access further to address the new target of 25% by the end of 2020/21.<br><br>We will continue to work with GM HSCP to support MH priorities. |
| | ○ IAPT for children & young people - to be on track for delivery 2018 | D | Part funded by GM agreed approaches, LTP funds and the announced non recurrent investment | The CYP Wellbeing and Mental Health Local Transformation Plan (LTP) is been implemented. The LTPs are 'living' documents and our plan has been in place for a year and is being updated to stretch our ambition and align with GM commitment to develop the current provision of Mental Health |
| | ○ Improvement in Mental Health Crisis Care for all ages | E | No direct relation | Providing core 24 hour crisis services within acute hospital. T & G currently meet this standard |
| | ○ Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia, increase the numbers of people receiving a dementia diagnosis within six weeks of a GP | B | Dementia was outlined in the investment proposition to support post-diagnostic | Aug 16 71.3% against 67.3% national and work is ongoing to continue to exceed rather than to just meet the standard.<br><br>Dementia post-diagnostic support is integral to our |

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| | referral; and improve quality of post-diagnosis treatment and support for people with dementia and their carers. | | dementia support, and while not directly related to this outcome is key in our planning. | integrated neighbourhoods offer and will be delivered as part of our transformation projects. |
| 6 | Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy. | D | None.<br><br>No key components identified at this time - part of GM ongoing work. | In relation to the transforming care agenda, the locality is on track with expectations and no additional funding is required at present. We monitor and track our out of borough patients effectively, so if additional funding is required in future for a different cohort, we can assess and plan for that accordingly.<br><br>We are working with the GM Fast Track team to deliver the milestone plan. Funding is currently allocated through work being led by Sandy Bering, for the commissioning of an acute LD crisis pathway to cover the GM footprint. This is identified as a GM group, and not just a locality led area of work. |
| 7 | To help create the **safest, highest quality health and care** service<br><br>o Roll out of **seven-day services** in hospital to the population (four priority clinical standards in all relevant specialities, with progress also made on the other six | C | Transformation Fund will support access to seven-day services but not deliver them in hospital. | The urgent care models of care included in the transformational bid will improve 24/7 access to out of hospital urgent care, and develop a community based preventative approach.<br><br>These actions will directly contribute to access to seven day services however they will not deliver |

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| | standards), so that patients receive the same standards of care, seven days a week. | | | seven-day services in hospital alone.<br><br>T&G ICFT continues to progress against its action plan and has submitted a business case detailing plans to deliver seven day services. Additional funding will be required to fully deliver this standard.<br><br>We have plans to develop our 7 day services offer each year. This is cost neutral in 17/18. For future years, we will work with GM to identify additional resource and ensure we deliver the national trajectories within the required timeframes. |
| | ○ Achieve a significant reduction in **avoidable deaths**, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. | D | | There is a system wide group under the leadership of the ICO's Palliative Care Consultant who ensures the necessary pathways and protocols are in place to support the management of patients requiring palliative / end of life care in the place of their choice. This includes rapid discharge pathways from a hospital setting to home / community where an individual's choice is to die at home.<br><br>The recruitment to the Palliative Care Consultant vacancy in 2015 has been a significant benefit to the whole economy. |

| Ref | National Requirements | Options<br><br>(A, B, C or D) | Locality Response/ Comment on funding | Current progress and plans (November 2016) |
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| | ○ Measurable progress towards reducing the rate of **stillbirths, neonatal and maternal deaths and brain injuries** that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. | E | Local funded | A significant proportion of preventable stillbirths in the North are linked to unrecognised fatal growth restriction (FGR) as such the hospital is improving the detection and management of these babies. Tameside has been active with the North region 'Saving Babies Lives' initiatives.<br><br>The data does not reflect the improvements by Tameside provider in improving Neonatal mortality and reducing Stillbirths. The Regional (North West) Stillbirth Audit (November 2015) shows that Tameside Hospital is amongst the best performing hospital in North West in relation to low stillbirth number and positive downward trend reduction. |
| | ○ Measurable improvement in antimicrobial prescribing and resistance rates. | D | Not reliant on Transformation funding | On target to achieve both indicators relating to appropriate prescribing of antibiotics in Primary Care Each month we receive an updated practice level report on Impact based on e-pact data. Any practices showing signs of increase or showing poor performance are audited by the CCG/Acute Trust antibiotic pharmacists and areas for improvement identified and an action plan produced. |
| 8 | Measurable reduction in **child obesity** as part of the Government's childhood obesity strategy. Contribute to the agreed child | B | Part of the social prescribing/improved public health within | In 2015/16 obesity at age 10-11 was 20.2% compared to 19.8% nationally.<br>Current local approaches focus on nutrition and |

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| | obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. | | the INs | physical activity:<br>- Breastfeeding support<br>- Appropriate weaning<br>- Early Years/Children Centres programme including The Under 5s Food and Nutrition Award, delivered by the Children's Nutrition Team.<br>- The food4life school food award supports schools in meeting the School Food Standards and to develop a healthier food culture.<br><br>- Currently about 1/5 of Tameside schools have achieved an award and about 1/4 are working towards an award.<br><br>- On-line School Health Check and Healthy Weight: roll out in progress.<br>- Family Health Mentor service. |
| 9 | Achieve full local implementation of the national **Diabetes Prevention Programme**, 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme and a measurable reduction in variation in management and care for people with diabetes. | B | Support for people with Long Term Conditions is a priority area for IN within the proposal to the GM Transformation Fund. | Currently working with NHS England Health & Social Care Partnership on GM Wide roll out of phase 2 of the National Diabetes Prevention Programme. Work ongoing during November to develop locality level prospectus<br><br>Completion of National Diabetes Audit increased from 4.9% in 2015 to 80% in 2016. Results are due to be released in January 2017 but the CCG are using the recently released 2015-16 QOF data to produce a |

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| | | | | local version to give indication of locality delivery of the NICE guidance. Have identified significant variation across the 41 practices and will deliver training and education to reduce this. |
| 10 | Implement agreed recommendations of the National **Maternity** Review in relation to safety, support progress on delivering | Not known | | This Investment Agreement does not include maternity services and so will not contribute to delivery of this requirement. |
| | and significantly improve patient choice. | | Any changes to choice in Maternity as a result of the GM Maternity review may require additional funding however, this is unlikely as patients already choose between providers. | In response to national review 'Better Birth's' (2016) Tameside provider has lead on developing an action plan. Information is provided to enable women to make informed choices based on evidence.<br><br>We are not in a position to offer full choice of place of birth, but working towards establishing a midwifery-led unit at Tameside. We are seeking to explore a partnership with another maternity service to enable an affordable model providing all choices of place of birth to be established. |

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| 11 | To improve **out-of-hospital care** with new models of care and general practice<br><br>○ 100 percent of population has access to weekend/evening **routine GP appointments**. | B | | Existing CCG resource already funds access to evening and weekend routine GP appointments through the Extended Access DES and Extended Access pilot provided by Orbit Healthcare (Federation) and both remain in 17/18, however Transformation Funding through neighbourhood workstreams also provides provision. |
| | ○ Measurable reduction in **age standardised emergency admission rates and emergency inpatient bed-day rates;** more significant reductions through the New Care Model programme covering at least 50 percent of population. | B | | Integrated neighbourhoods will support demand reduction by reducing exacerbations of conditions.<br><br>IUCT and Digital Health for Care Homes will support admissions avoidance. Individuals that cannot be managed safely in their own home but do not require acute care will be supported in the flexible community bed base. Individuals will be stepped up or stepped down into the bed base as appropriate.<br><br>Proposal to the GM Transformation Fund included targets for measurable reductions in emergency admission rates for both the general population and specifically for patients over the age of 55. |

## SCHEDULE 6 – LOCALITY MANAGEMENT AND GOVERNANCE ARRANGEMENTS

To reflect the transition from the design to the implementation phase of the Care Together programme, the Programme Board reviewed its governance arrangements in October 2016. The revised governance structure ensures focus on delivery of national and local quality and performance metrics, the drive for financial sustainability and ensures appropriate, timely mechanisms to provide the necessary assurance to GM Health and Social Partnership that progress against milestones is being made.

The attached slide shows the revised Care Together management and governance arrangement. Key management and governance meetings are highlighted and split by whether these are commissioner, provider or as is the case with most, an economy wide approach. Leads for each of these meetings are also identified (Chairs may be different) to provide clarity on responsibilities. Key relationships and accountabilities are shown by arrows.

All meetings are a minimum of monthly apart from where indicated.

TAMESIDE AND GLOSSOP
Caretogether

# Proposed Care Together Programme Delivery Structure