



# Commissioning for reform

## The Greater Manchester Commissioning Strategy



# Greater Manchester Health and Social Care Partnership

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# Commissioning for reform

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**On 1 April 2016 a new era in Greater Manchester'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 health and care services for Greater Manchester (GM).**

But GM is not just taking charge of health and social care provision.

Fundamental to the success of the groundbreaking devolution 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% 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, focused 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.

Our approach to commissioning must support this new era of GM public services. We must commission services at the right spatial level, in collaboration with one another, and with a focus on the outcomes we are seeking to achieve for GM.

This commissioning strategy shows that we have seized the opportunity to shape our future, looking beyond organisational boundaries and moving away from single-service planning to consider the cumulative impact we can achieve by working together in new ways. We are working together to help GM thrive.

# Greater Manchester's ambitions

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**Greater Manchester (GM) requires a single commissioning strategy that encompasses all public services to deliver its ambitions for reform. This strategy describes how we will transform our commissioning approach to meet GM's needs.**

## Public service reform

In GM we want to enable a truly place-based approach to public service reform, transforming the way all public services work together in one particular place. This approach will enable GM organisations to make real changes to the lives of residents, in ways relevant to them, free from the restriction and fragmentation created by organisational boundaries.

**Stronger Together: Greater Manchester Strategy 2013** put public service reform at the heart of our strategic ambition. **A Plan for Growth and Reform in Greater Manchester (2014)**, subsequent devolution agreements and **Taking Charge of our Health and Social Care in Greater Manchester: The Plan**, published at the end of 2015, have all restated that commitment to reshaping our services, and supporting as many people as possible to contribute to, and benefit from, the opportunities it brings.

Delivering transformational change in GM will require public services to work together in different ways. A key component in supporting this will be the creation of mechanisms that support these new conversations, recognising the interdependencies between a range of service areas in achieving improved outcomes for GM residents.

## Meeting the financial challenge

Delivering on our ambitions for reform will also contribute to meeting the financial challenges facing our public services. Health and social care alone faces a deficit in excess of £2 billion by 2021. We can tackle this by reducing demand on expensive, reactive public services through greater integration, prevention and early intervention.

It will require a new approach to commissioning services that focuses on delivering outcomes for residents, putting artificial boundaries to one side. This new approach will help us to deliver our strategic objectives of supporting GM residents to 'start well, live well, age well', while commissioning a financially and clinically sustainable health and social care economy.

## Making the most of devolution opportunities

GM is in a unique position to maximise a number of 'once in a generation' opportunities. The devolution agreements that GM has made with government and national bodies will provide the influence, powers and scale to commission for reform.

Devolution to the Greater Manchester Combined Authority for a range of public service reform priorities now includes the Life Chances Investment Fund, which from April 2017 aligns funding from several budgets such as the Troubled Families programme and Working Well pilot, and potentially a range of innovative funding streams. The five-year GM Transformation Fund created as part of the Comprehensive Spending Review settlement to support health and social care transformation, and potential four-year settlements for local authorities, also provide relative certainty of funding that will enable development of longer-term strategies and more effective commissioning for truly transformational change.

These are real opportunities to ensure both the £6 billion health and social care budget and the broader £22 billion GM budget for public spending are used as efficiently as possible to improve outcomes for GM residents.

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Increased certainty about funding and control over budgets offers the ability to move away from short-term financial planning. This will allow us to invest in early prevention and intervention, particularly as we know that the return on investments that reduce demand falls beyond normal budgeting rounds.

Devolution has provided significant incentives to invest in transformational reform, removing those barriers that precluded investment in preventive approaches, particularly those where investments provided benefit to other agencies, for example in the form of reduced demand.

More than ever, we are committed to integration. We want to reduce the incidence of silo working and putting organisational priorities ahead of people and places.

Devolution and the governance we have already developed mean we are now in a position to overcome the barriers of fragmented decision making, overlapping or duplicated investment, and to address the long-standing challenge of co-investment.

A new approach to commissioning will underpin and support our capacity to bring together the breadth of reform activity being implemented across GM. A radical approach to commissioning will be needed to deliver on the GM transformation programmes associated with our Health and Social Care reforms, our wider GM Reform Programme and the local implementation of reform.

As well as developing a radical approach to commissioning, GM will need to develop innovative ways of decommissioning. The commissioning cycle that we will adopt embeds decommissioning and disinvestment within it. Our commissioning aspirations must be complemented by the strength of our decommissioning intentions.

## Commissioning to deliver core reform objectives

Delivering transformational change in GM will require public services to work together in different ways. A key component in supporting this will be the creation of mechanisms that support these new conversations, recognising the interdependencies between a range of service areas in achieving improved outcomes for GM residents. We know that delivering the objectives of the Health and Social Care Strategic Plan will rely on services that have traditionally sat beyond the remit of Health and Social Care providers and commissioners. Transforming our commissioning is not about reassigning responsibility but enabling the breadth of integration we need to bring together decision making across areas that have historically been fragmented.

Our commissioning strategy will be a key enabler to deliver the core objectives that sit across both **Taking Charge of our Health and Social Care in Greater Manchester: The Plan, 2015** and **Stronger Together: Greater Manchester Strategy 2013**. These are to:

- improve the health and wellbeing and life chances of GM residents
- improve the quality of public services and outcomes for GM residents
- reduce inequalities that exist both within GM and between GM and the rest of the country
- ensure services are clinically and financially sustainable and create a sustainable public service economy
- unlock devolution dividends to support public service reform.

# Our vision:

## A radical approach to commissioning

**We need a radical new approach to commissioning that will underpin and support our capacity to bring together the breadth of reform activity being implemented across GM. This approach will be necessary to deliver transformation associated with our health and social care reforms, our wider GM reform programme and the local implementation of reform.**

We know that delivering the objectives of **Taking Charge of our Health and Social Care in Greater Manchester: The Plan, 2015 and Stronger Together: Greater Manchester Strategy 2013** will rely on services that have traditionally sat beyond the remit of health and social care providers and commissioners. Transforming our commissioning is not about reassigning responsibility but enabling the breadth of integration we need to bring together decision making across areas that have historically been fragmented.

GM will also need to develop innovative ways of decommissioning to ensure our commissioning aspirations are matched by strong decommissioning intentions, and adopt a commissioning cycle in which decommissioning and disinvestment are firmly embedded.

### A new era of opportunities

GM is in a unique position to maximise a number of once in a generation opportunities:

- The agreements that GM has made with Government and national bodies will provide influence/powers and scale to commission for reform.
- The five year Health and Social Care settlement, and potential four year settlements for local authorities provide relative certainty of funding, enabling the development of longer term strategies and more effective commissioning for truly transformational change. Our ability to move away from short-term financial

planning will allow us to invest in early prevention and intervention, particularly as we know that the return on investments that reduce demand fall beyond normal budgeting rounds.

- Devolution to the Combined Authority for a range of public service reform priorities, and Health and Social Care devolution now includes the Health and Social Care Transformation Fund and Life Chances Investment Fund (and potentially a range of innovative funding streams). These are real opportunities to transform both the £6bn Health and Social Care budget, and the broader £22bn GM public spending, improving outcomes for GM residents and ensuring public money spent in GM is used as efficiently as possible.
- The governance that we have developed and our increased commitment to integration significantly reduces the incidence of silo working, and placement of organisational priority before that of place and person. With this, devolution has provide significant incentives to invest in transformational reform, removing those barriers that precluded investment in preventive approaches, particularly those where investments provided benefit to other agencies in the form of reduced demand etc.

We are now in a position to overcome the barriers of fragmented decision making, overlapping or duplicated investment, and reconciling the longstanding challenge of co-investment.

## Opportunities to commission differently

Devolution and reform enable us to change our current approach to commissioning. The table at the bottom of the page shows some ways we can move to a different approach.

Effective integrated commissioning can act as a catalyst for the implementation of new delivery models, such as moving to outcome-based, multi-year capitation models that support implementation of new models of provider collaboration and innovation.

We are able to take an overall approach that facilitates more effective and rapid change to new ways of working. In doing so, it will be important to assess and prioritise areas with the ability to make the most significant steps towards the delivery of local implementation plans and GM strategies.

## Developing our approach

Devolution offers the freedom to work together in new ways. We have already developed an infrastructure and process to support joint commissioning across GM services that will enable us to take on key decisions from 1 April 2016.

This strategy outlines steps we have already taken to support our commitment to joint commissioning across GM services.

We have agreed a set of principles that will underpin our new approach to reform and commissioning.

We have developed an investment-led approach to commissioning that will support a shift from reactive to preventive services.

We have identified a set of initial joint commissioning and supporting workstreams

From	To
● Focus on organisations and separate areas of spend	● Focus on place and population health needs
● Fragmented view of health, social care and other public services	● Holistic view of health, care and wider public sector reform
● Bound by annual planning horizons	● Multi-year investment programmes
● Excess of relatively small initiatives	● Comprehensive view across GM
● Lack of flexibility of GM commissioning or lack of efficiency of local commissioning	● Economies of scale combined with integrated delivery around individuals and families at neighbourhood level
● Change initiatives that sit on top of, but do not fundamentally change, the mainstream	● Creating robust evidence for decommissioning existing models of care shown to be of lesser value compared to new models
● Single-service planning	● Integrated strategic planning focused on cumulative impact and outcomes

Our immediate focus for jointly commissioned services during 2016/17 is specialised health services and primary care. But at the same time we aim to make significant progress on jointly commissioning other areas of activity.

that can be mapped against transformation and reform priorities.

We have identified implementation priorities for our strategy, including learning from and building on the initial workstreams and strengthening governance and leadership to support the new commissioning approach.

Throughout 2016/17 we will refine our planned approach. We want to be sure we are operating flexibly and able to respond to emerging reform implementation plans, and that we consider the breadth of potential joint commissioning decisions. In taking any decision we will focus on innovation, financial and clinical sustainability, and improved outcomes for GM residents.

### A phased approach to change

We need to adopt a phased approach to our commissioning transition. This will ensure

that we can maintain a clear focus on current system performance.

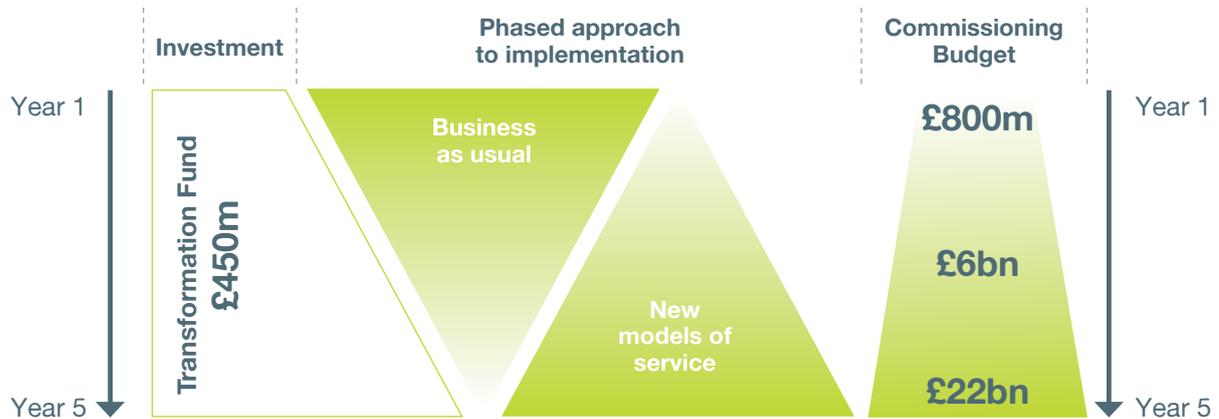
Our immediate focus for jointly commissioned services during 2016/17 is specialised health services and primary care. The total value of these services is approximately £800 million. But at the same time we aim to make significant progress on jointly commissioning other areas of activity.

As we move through 2016/17 and into future years, the scope, scale, ambition and, ultimately, the budget for our joint commissioning activity will broaden significantly.

It is neither practical nor sensible to make the significant transition required in a short period of time. Supporting a phased approach to reform, we will be scaling up the level of investments in our new delivery models, while decommissioning and disinvesting in existing models that are shown not to deliver required outcomes or that fail to meet minimum GM and national standards. By adopting this approach we will be able deliver a managed transition from current 'business as usual' to new models of delivery.

Figure 1 outlines our phased approach to implementing new commissioning models.

Figure 1: Phased approach to implementation



# Our principles

## Underpinning reform principles

To enable place-based, whole-system reform across Greater Manchester (GM), we need to ensure that wider reform principles drive our commissioning activity, and that we firmly embed this new approach in the way we work.

These are the principles that underpin GM reform.

- There is a new relationship between public services and residents, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services.
- There is a place-based approach that redefines services and puts individuals, families and communities at their heart.
- We are asset conscious, recognising and building on the strengths of individuals, families and our communities rather than focusing on the deficits.
- Collaboration is at the heart of reform, with providers and commissioners working together to develop solutions that bring benefits to both.
- We focus on driving behaviour change in our communities that builds independence and supports residents to be in control.
- Wellbeing, prevention and early intervention are stronger priorities.
- We develop an evidence-led understanding of risk and impact to ensure the right intervention at the right time.
- We adopt an approach that supports the development of new investment and resourcing models and the decommissioning of failing approaches.

## Our commissioning principles

We will draw on these overall principles for reform to embed five core principles specific to commissioning for GM residents, outlined below.



### 1. People and place

For all the bureaucracy and complexity of commissioning, and whatever the scale of commissioning in the end, what matters is that our decisions help the people and places of GM achieve their own vision of the future.

Our commissioning ambition has to drive significant behaviour change across our residents, organisations and workforce. Our residents need to be less reliant on public services and more proactive in their lifestyle choices. Our organisations need to think beyond their organisational boundaries towards people and place. Our workforce needs to think differently and outside their own organisation to commission for outcomes.

## 2. Co-design

Commissioners, providers and residents working together will create better proposals and a quicker route to successful change.

## 3. Decommissioning

Our success will be defined as much by our decommissioning decisions as by our commissioning activity. We have a £2 billion financial challenge to address across GM health and social care and will not achieve it by commissioning more of the same; we need to commission new models of care. This will mean reviewing existing models and decommissioning those that do not meet minimum standard requirements or deliver appropriate outcomes.

## 4. Commissioning at the right level

To be successful we need to commission services at the most appropriate spatial level. We also need to be able to connect our commissioning, whether services are commissioned at a macro level (GM and locality) or at micro level (individuals or teams) For instance, we need to make best use of voluntary and community organisations to deliver an asset-based approach. So we must ensure that commissioning activity across different levels takes into account and, wherever possible, complements what is happening at other levels.

Our new commissioning approach cannot be confined to macro commissioners, whether they operate at locality or GM level. To deliver new models of care we need to drive demand reduction through a programme of behaviour change – the role and behaviour of the micro commissioner will be integral to delivering integrated care closer to home. We need to support micro commissioners to embrace new models of care, and to challenge existing activity.

## 5. Be bold

To deliver improved outcomes and achieve financial sustainability we must be bold and embrace new commissioning models, such as outcome-based commissioning. It is not enough to simply commission the same activity in the same way but at a different spatial level.

Being bold and commissioning differently means adopting best practice not just from within GM but from around the world.

Underpinning these five principles is a commitment to commissioning services that meet GM and national agreed standards and ensures research and innovation are embedded at the heart of our commissioning activity and decisions.

# An investment-led approach to commissioning

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**One of the most important changes we need to make is to move from a transactional and linear approach to an investment-led approach to commissioning. Shifting activity must lead to resources being freed up in one part of the GM public service economy to be reinvested in another.**

In developing an approach to joint commissioning we therefore need to think beyond organisational boundaries, and consider how we can invest collaboratively to achieve the outcomes we have committed to achieving. This is key to the way we will apply the GM Transformation Fund and Life Chances Investment Fund.

## Commissioning for improved outcomes

Through our broader approach to public service reform, we are supporting residents to become increasingly independent, resilient, and better connected to the opportunities of economic growth. These are outcomes that will also support our capacity to achieve improved health outcomes.

For example, we know that being out of work can have a significant impact on mental and physical health. Investing in employment support – particularly for those who have identified health-related barriers to employment – can deliver longer-term, sustainable savings for the health system. Ensuring access to the right support to get someone into work, or to stay in work, potentially saves significant health-related spending in the future.

Similarly, at the heart of our health and social care reform ambitions is the recognition that we need to see a significant shift in activity. We want to shift the balance from reactive, crisis services to preventive services that help reduce escalation of need, for example, moving from inappropriate use of in-hospital acute settings to out-of-hospital

and community care. Our approach will be underpinned by a need to make significant investments in prevention.

## Criteria for investment

GM cannot simply move from one model of commissioning to another overnight. Our transition has to be managed. In support of this our commissioning activity will need to satisfy clear criteria.

Our investment propositions must look beyond purely the delivery of value for money. Obviously they should do that, but they will also need to:

- clearly contribute to the delivery of GM priorities, including those set out in **Taking Charge of our Health and Social Care in Greater Manchester: The Plan and Stronger Together: Greater Manchester Strategy 2013**. We cannot commission services that do not deliver our strategic priorities.
- have synergy with the implementation plans of our reform and transformation strategies – our commissioning activity has to deliver our reform and transformation agenda.
- meet agreed GM and national standards – we cannot commission services that fail to meet minimum service requirements. By working collectively we can identify what best practice looks like and, more importantly, commission to ensure we provide services that deliver such good practice.
- be supported by robust evidence – our investments and interventions have

to be supported by an evidence base that demonstrates that they will deliver improved outcomes and efficiencies.

- meet the GM criteria for investment that have been developed and agreed by GM organisations.

## An outcome-based commissioning cycle

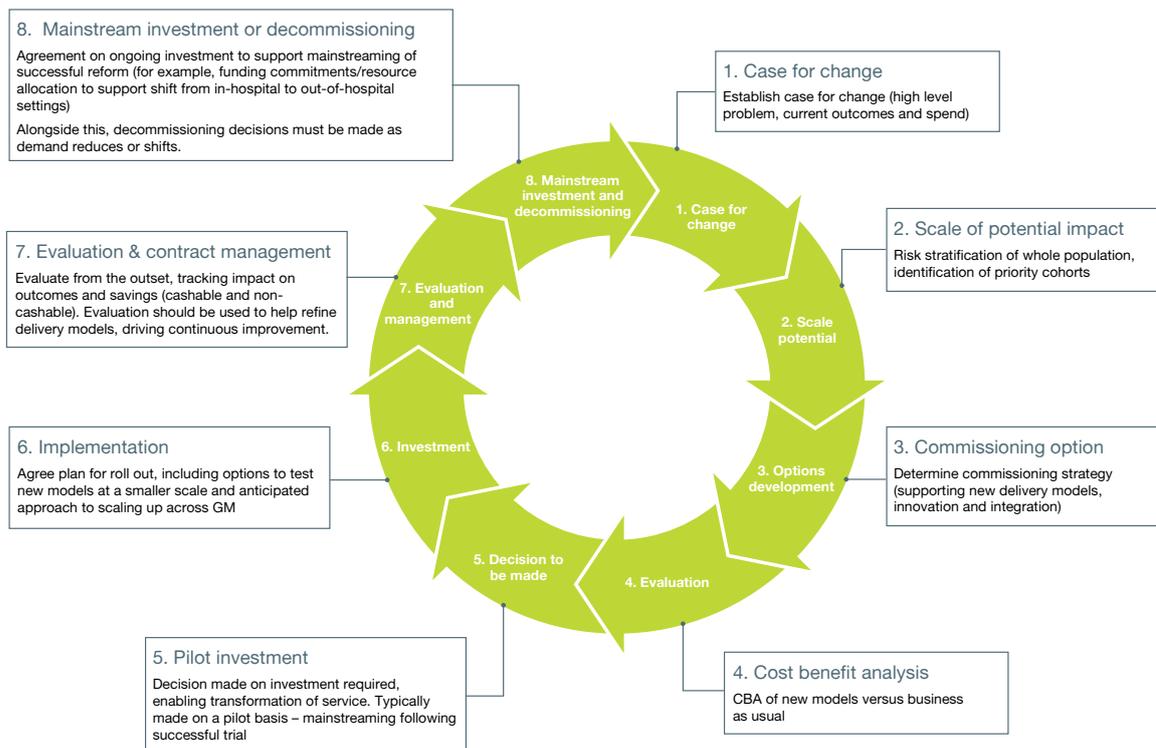
We need to take a longer- term view that examines the entirety of our expenditure on an individual and constantly evaluates how it can best be spent.

An approach to commissioning focused on improving outcomes has been established during development of the GM reform programme. This new model is set out in Figure 2. Through this process, financial efficiencies – generated through service improvement, efficiencies and demand reduction – should be identified to support decommissioning and reinvestment decisions.

In addition, it supports an approach to commissioning that enables:

- innovation and supports our capacity to test new public service models, based on a robust case for change and an understanding of costs and benefits and the potential scale of impact of reform
- scaling up of reform models, based on robust evidence and evaluation. This will enable GM to take commissioning decisions that, if shown to have impact, can be scaled to support broader groups of residents or wider geographies, ensuring flexible approaches that support and reinforce place-based models of delivery. At this point, commissioning decisions will increasingly move from a ‘reform’ focus to embedding new service models as ‘business as usual’.
- decommissioning decisions. Options and their implications can be considered during the process of mainstreaming and embedding reform programmes in mainstream investment planning.

Figure 2: A new approach to the commissioning cycle



# Initial joint commissioning and supporting workstreams

Our new commissioning strategy is a key enabler of GM health and social care devolution and complements areas of work under the Enabling Better Care transformation programme of Taking Charge of our Health and Social Care in Greater Manchester: The Plan, such as information management and technology, workforce, estates, and contracting and payment mechanisms. Our initial focus has been on ensuring plans are in place to support GM health and social care reforms from April 2016.

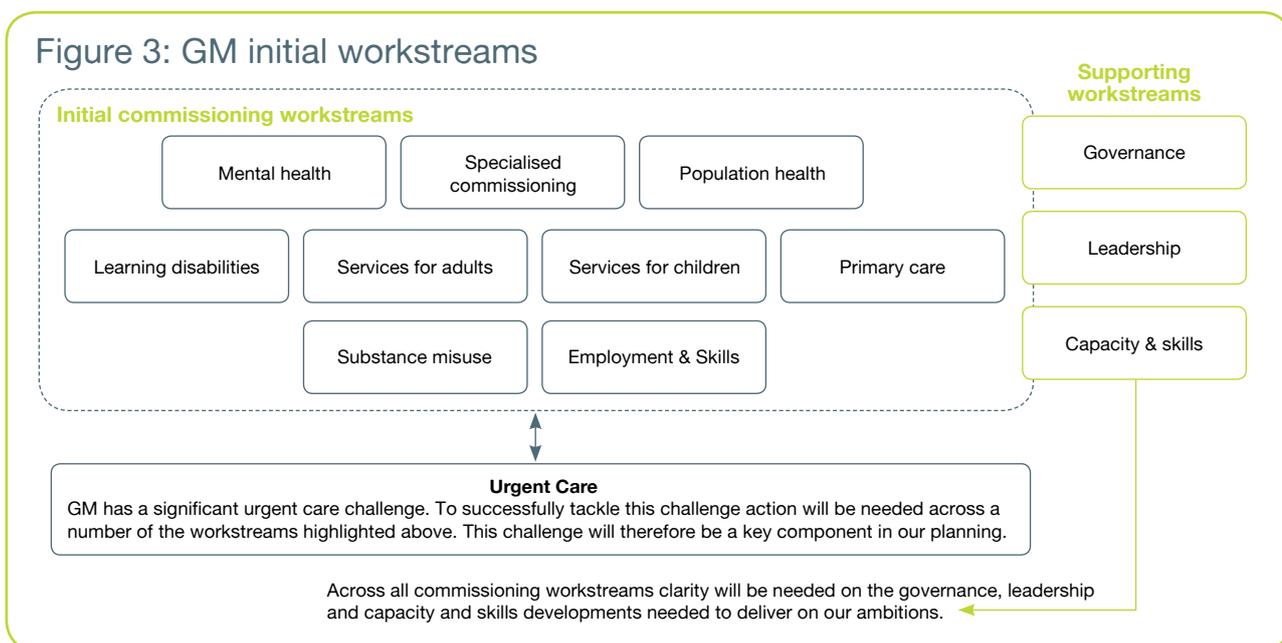
One of our key priorities is real improvement in intermediate and home care.

There are a total of seven joint commissioning workstreams initially, as shown in Figure 3, plus two broader workstreams – substance misuse and employment and skills –that we intend to adopt swiftly. These all focus on health and social care services, but such services form only a part of our commissioning intentions. The three supporting workstreams also shown already look beyond health and social care to the commissioning of wider public services.

There are a range of reasons for our focus on these initial workstreams. We need to invest in new models of care that reduce demand in the acute sector and support transition from hospitals into community-based settings.

One of our key priorities is commissioning for a rapid and real improvement in intermediate and home care. We know that across GM we need to undertake a review of the domiciliary/ homecare market, and that by working at a GM level we are able to address the fundamental challenges that exist within those markets.

As a result of the national Winterbourne View inquiry we know that our commissioning approach for services that support people with learning disabilities must deliver fundamentally different outcomes. We need



to deliver care and services closer to home and in the community, and ensure those with learning disabilities are supported to fulfil their potential.

## Workstream action plans

We have developed action plans for 2016/17 for each of the initial commissioning workstreams.

The initiatives that form part of these plans will be aligned to both emerging locality plans and implementation plans, demonstrating how they are delivering against the wider goals of Taking Charge of our Health and Social Care in Greater Manchester: The Plan and Stronger Together: Greater Manchester Strategy 2013.

Appendix 1 of this strategy shows the 2016/17 milestones for the initial workstreams.

Appendix 2 provides more detail on each one, including their outcome objectives and phases and potential contribution to financial and clinical sustainability.

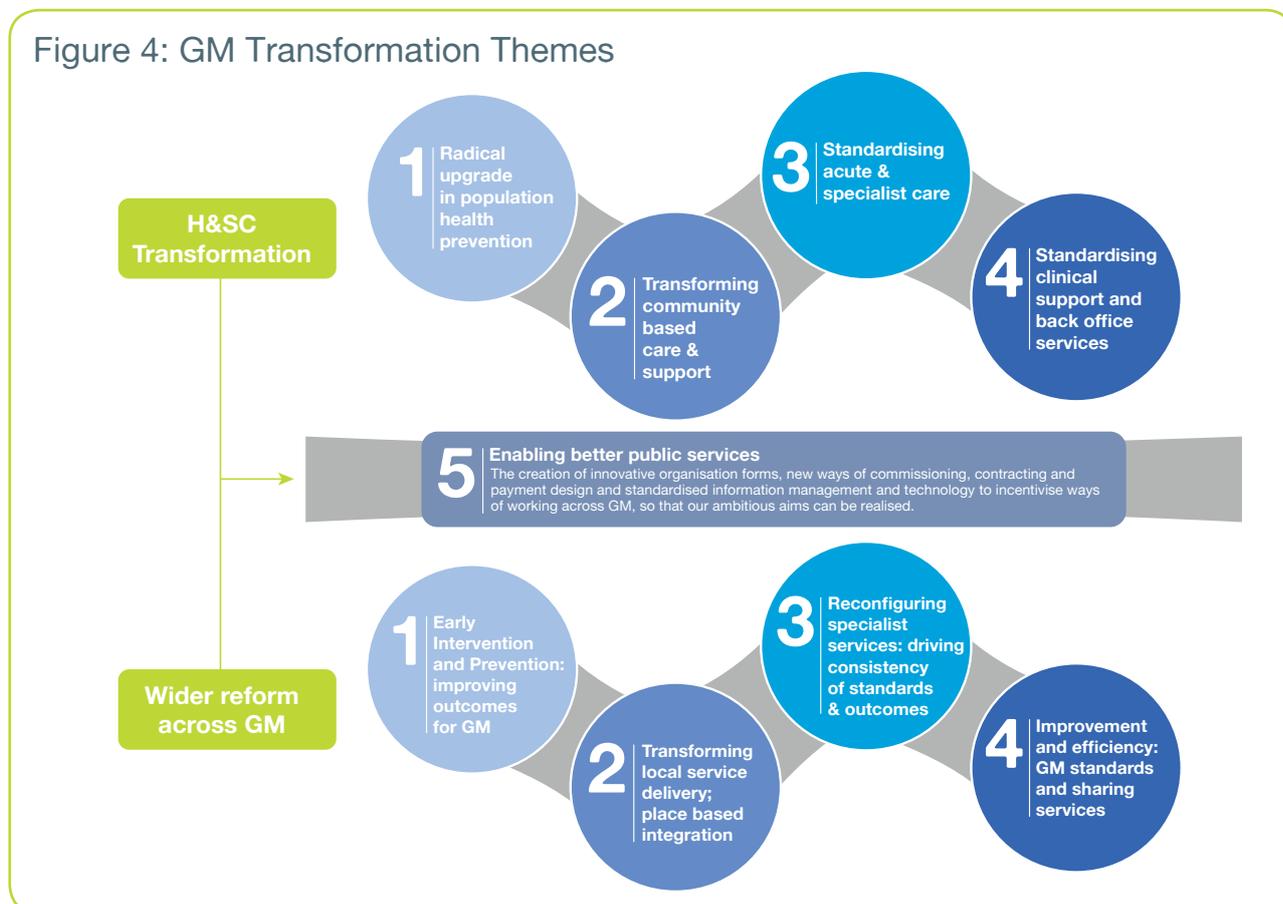
## Our future focus

As we move into 2016/17 and beyond, all of our commissioning activity must deliver against or across broader health and social care transformation themes and the GM reform agenda. As Figure 4 demonstrates, we must align activity to capitalise on the opportunities that devolution opens to GM.

During 2016/17 new joint commissioning workstreams will be identified, driving our ability to deliver on the priorities set out below.

As an early priority, employment and skills and substance misuse are two areas that can swiftly be added as joint commissioning workstreams. We have already developed initial draft action plans covering these areas, set out in Appendix 3. These plans highlight the interdependencies between health and social care commissioning decisions and those made across broader public services, and therefore the need to integrate our approach to commissioning to deliver reform.

Figure 4: GM Transformation Themes



# Our implementation priorities

**We have identified several priorities in implementing our new commissioning strategy. One is to engage our partners in its development and delivery. The others are outlined below.**

## Learning from and building on initial workstreams

We are in the process of identifying lead commissioners for each of our initial commissioning workstreams. All of them will be brought together through the new Joint Commissioning Board Working Group (part of our governance arrangements outlined below) to facilitate learning from the application of the principles set out in this strategy.

As we move through 2016/17 and beyond, other commissioning workstreams will be identified. New workstreams will only be formally adopted following approval by the Joint Commissioning Board (JCB).

- And as the joint commissioning strategy is refined, clear criteria will be developed to support identification of new workstreams. These may include the following.
- Services where there are a small number of high-cost placements and where provision could be more efficiently and effectively delivered through a single GM service.
- Services that are more specialist in nature and provided from a very small number of centres.
- Services that are more generic in nature and would have significant delivery commonalities and characteristics across each locality. This could include service areas where there is potential for common service specifications collectively commissioned as a conurbation.
- Services that have a very limited number of potential providers or have significant

ongoing workforce challenges that mean providers need to collaborate to ensure stability of the service.

- Services with significant performance and outcome concerns where major transformation is required at a macro level to bring them up to standard.
- Services where major transformation is needed to co-design and implement a radically different model.
- Services where evidence suggests it would be more economical and efficient to commission and deliver on a GM footprint.
- Services for which there is significant cross-border activity that could benefit from a pooled commissioning budget with disbursements based on activity.

In developing the future programme of JCB commissioning decisions, an early area of work should be to develop an overview of the key decisions anticipated for public service reform in the medium term. As the GM approach to place-based integration is refined (through existing pilot activity), it is anticipated that further joint commissioning recommendations will emerge.

Reform is needed within localities, including the development of integrated commissioning functions.

We know our commissioning reform must extend beyond those services commissioned at a GM level. Reform is needed within localities, including the development of integrated commissioning functions. GM is committed to standardisation and reducing variation and this will be achieved, in part, by GM adopting standards frameworks that are used to guide commissioning at a local level.

## Strengthening our governance arrangements

Our commissioning ambition is bold and complex, it brings organisations together in a way we have not seen before. To support the delivery of our strategy we will need to develop robust supporting architecture. We need to be able to bring the right people together, at the right time. As we develop new structures, we need to identify those that are no longer fit for purpose.

The signing of the Greater Manchester Health and Social Care Devolution: Memorandum of Understanding, and the subsequent devolution of health and social care budgets, provides a unique opportunity for organisations across GM to address a range of challenges.

These include poor population health, high levels of non-elective provider activity, capacity-constrained social care, wide variability in outcomes and patient experience, and significant health inequalities. We also face a forecast £2 billion financial challenge by 2021.

New governance is required to enable GM to effectively and efficiently address these challenges, including the creation of the Joint Commissioning Board (JCB).

A shadow Joint Commissioning Board (JCB) has already brought together the 23 GM commissioning organisations. From April 2016, the JCB will consider the wider range of commissioning activity and associated decisions that we may want to undertake as GM. For example, to deliver our employment and skills ambition decisions will need to be made that cut across commissioning of health and social care, employment support and skills provision. Over time, the remit of the JCB is expected to develop to align and integrate GM strategic commissioning.

To support our ambitions to broaden our joint commissioning activity beyond

health and social care, and to integrate our transformation initiatives with those required to deliver a comprehensive programme of public service reform, GM has amalgamated the governance structures that have supported our prevention and public service reform agendas, creating a GM Reform Board.

We believe that aligning our governance at a GM level will create stronger structures to commission system-wide reform. The production of locality plans has already paved the way for stronger integrated commissioning at local level.

To drive forward the delivery of our commissioning strategy at pace, we need to build on the foundations provided by the Joint Commissioning Board (JCB). We will adopt a multi-platform supporting structure that will include:

- a JCB to maintain strategic oversight, a high-level overview, and ownership and integrated leadership of our commissioning across GM
- a JCB Working Group to provide the engine and capacity to drive workstreams forward
- a JCB Executive to provide detailed oversight of the process and key workstreams. This group will act as the conduit between the JCB and JCB Working Group, and give the JCB the opportunity to look in-depth at key policy areas.

## Developing leadership, capacity and skills

Collectively across GM, local authorities and CCGs are intending to pool funding to support integrated delivery of the health and social care strategic plan.

Securing integrated delivery will require integrated commissioning at both locality and GM level, and having the leadership, capacity and skills to support it. Each of the 10 GM localities will be encouraged

to review their own arrangements for integrated commissioning across CCGs and local authorities and how these link to the wider reform of public services within their locality. At a district level, single integrated commissioning functions will provide a catalyst for commissioning reform.

GM will undertake a review of skills and capacity for integrated commissioning. This will include reviewing:

- capacity within the GM health and social care devolution team once NHS England staff have been assigned to it
- links with the GM public service reform team, New Economy (which is working with GM to support economic growth) and other combined authority bodies
- clinical engagement and integration across the core functions of finance, research and intelligence
- support to localities to develop their capability for integrated commissioning.

The task of bringing together the relevant skills to implement our new commissioning approach will have implications for the future shape and organisation of both local authorities and CCGs. We should therefore support and learn from the development of integrated commissioning across all districts.

The outcome of the skills and capacity review will feed into the GM Commissioning Academy to develop high-quality commissioning professionals and related core functions.

The academy will provide an opportunity for all commissioning professionals from health, social care and related fields to access a development programme and ongoing support and will model the skills, behaviours and values required by our new integrated commissioning system as described in this strategy. The academy's first two cohorts were due to commence in April 2016.

# Appendix 1: Milestones for each of the initial commissioning workstreams for 2016/17

Commis- sioning Area	Milestone	Quarter in which milestone is completed			
		Q1	Q2	Q3	Q4
		01/04/2016 - 30/06/2016	01/07/2016 - 30/09/2016	01/10/2016 - 31/12/2016	01/01/2016 - 31/03/2016
Adult social care	<b>Scoping and delivery planning</b>	■			
	1. Development of a common ethical commissioning framework for GM		■		
	2. Identification of exemplar care models for upscaling and implementation across GM		■		
	3. Integrated commissioning functions, working closely with CCGs and well connected with partners such as housing and VCS			■	
	4. GM Discharge Framework agreed and established			■	
	5. Telemedicine and assistive technology opportunities pursued				■
Children's services	<b>Scoping and delivery planning</b>	■			
	1. Positioning the Director of Children's Services for the Integrated Health Commissioning Children's Workstream on the Joint Commissioning Board.		■		
	2. Ensuring programme teams supporting the Children's Review and Health & Social Care are meeting regularly to align activity and that appropriate Health and Local Authority representatives are involved in the different			■	
	3. The Service Director for Children's Safeguarding & Prevention at Stockport Council spending two sessions per week working with the Health and Social Care Programme Team to help ensure that there is alignment across the Integrated Health Commissioning and Delivery workstream and related areas of work.				■
Learning Disability Services	<b>Scoping and delivery planning</b>	■			
	1. GM Extended Collaborative Commissioning		■		
	2. GM Extended Case Management and Pre-CTR AT Risk and Discharge Coordination Team - and support for extended Panels			■	
Mental Health	<b>Scoping and delivery planning</b>	■			
	1. Development of a stepped care multi agency pathway that describes the offer across the whole system based on presenting need		■		
	2. Development of a GM Transformation plan for CAMHS			■	
	3. Scope opportunities across GM for commissioning highly specialist elements of the pathway as a collective to improve consistency, equity and efficiency				■
	4. Establish GM wide information sharing				■
Specialised Commissioning	<b>Scoping and delivery planning</b>	■			
	1. Complete the process to ensure we address long standing non-compliant cancer pathways in upper GI and urology		■		
	2. Implement outcomes from prioritisation matrix, which has been developed with providers to support identification of the next services for transformation			■	
	3. Specialist cancer services are to be reviewed within the work of the GM cancer vanguard schemes The model of care is to consider whole pathway re-design which will incorporate all specialist cancer services into the re-design process				■

<b>Population Health Improvement</b>	<b>Scoping and delivery planning</b>			
	1. Develop specific proposals for GM level PH commissioning, including Sexual Health services, drugs and alcohol services and EY health services			
	2. Screening and Immunisation: whole pathway approach as part of the Cancer Vanguard arrangements; Local Care Organisations and their new contractual forms and wider PSR developments such as the expansion of Working Well and the Early Years NDM			
	3. Integration of information systems including Child Health Information Systems, (CHIS)			
	4. Integration of commissioning such as for sexual Assault Services, which could be linked more strongly to local safeguarding and complex dependency arrangements.			
	5. Health and Justice: Liaison and Diversion services and opportunities to develop a unique integrated commissioning and delivery model with police custody healthcare.			
	6. Find and Treat Programme: GM commissioning of NHS Health Checks programme to address variation in price and outcomes and drive up standards; Commissioning a bespoke integrated intervention for the 10% most deprived communities with the poorest health to provide an enhanced service with broader support packages including social support and access to work			
	7. Cancer Vanguard: Delivery of year one commissioning intentions: to include commissioning behavioural insights work to support key elements of programme e.g. improving screening attendance			
	8. Radical upgrade in lifestyle behaviour change support: Commissioning a GM lifestyle and wellness hub to provide a single access point/portal for behaviour change advice and support including triage into 10 placed based locality lifestyle and wellness service offers.			
	9. Early Years NDM: Commission at GM level bringing together the commissioning of HV, FNP related maternity services, perinatal MH services, children centre and early education offers and other targeted support.			
10. Digital Strategy: The development of a digital health commissioning strategy aligned across three specific areas: digital innovation, empowered citizens and communities and digital navigation to underpin a radical upgrade in prevention and population health.				
<b>Primary Care</b>	<b>Scoping and delivery planning</b>			
	1. Primary care at scale: Development, implementation and commissioning of 'early adopter sites' – delivering primary care at scale. Early adopter sites have been identified in at least 4 localities.			
	2. Population health and wellbeing: <ul style="list-style-type: none"> <li>GM wide roll out of Healthy Living Pharmacy Framework to all community pharmacies</li> <li>Delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities</li> <li>Healthy Living Dental Framework pilot in Wigan.</li> <li>Mainstreaming 'Healthy gums DO matter' across GM and periodontal care following recent pilot</li> <li>Eye Care pilot for people with learning disabilities</li> <li>Pilot asset based training for front line staff.</li> </ul>			
3. Improving access and responsiveness: <ul style="list-style-type: none"> <li>7 day services to primary care, hubs operational in all parts of GM</li> <li>GM wide roll out of Minor Ailments Scheme to all community pharmacies</li> <li>Implementation of emergency and urgent repeat medication provision to all CCG localities</li> <li>Implementation of single Minor Eye Conditions Service across GM</li> <li>Extend access to dental health services 'Baby Teeth DO matter' and 'Buddy Practice'</li> <li>Pride in practice pilot launched – improving access for LGBT population</li> <li>Asylum Seeker Pilot launched</li> </ul>				

# Appendix 2: Summary of initial workstream action plans

## 1. Services for adults

### Five-year vision, outcome objectives and phases

- Rapid improvement in intermediate care, discharge to assess facilities and home care capacity to improve resilience and reduce non-elective.
- The work from the Early Accelerator to support the transition from Winterbourne View and better planning for transition services for people with learning difficulties.
- Investment in scaling up the innovation and demand reduction work through a programme of behaviour change/ workforce reform that alters the mindset of individual practitioners. This changes 'micro-commissioning' behaviour and if wrapped around reformed primary care with community health partners, it will make a significant contribution to improved outcomes, reduced prescribing and acute spend.

### 2016/17 action plans with key milestones

- Quarter 1
- Embed asset-based working and micro-commissioning as key drivers for reform, building on existing exemplars (across all quarters). This will include 'rite of passage' training for workforce.
- Map providers across GM footprint.
- Undertake quality appraisal of shared providers.
- Deliver three market engagement events.
- Deliver a GM ethical service specification for reformed home care.
- Develop a GM job description for integrated care worker role.
- Launch of GM Commissioning Academy.

- Scope and develop appropriate infrastructure to deliver at scale and pace, including alignment with CCG Heads of Commissioning Group.
- Deliver cost benefit analysis for the key areas of asset-based model, home care, residential and nursing care and learning disabilities. This will clearly identify system-wide payback and return on investment.
- Deliver a series of market events with technology providers to articulate the contribution of technology to the reform programme.
- Development of a common ethical commissioning framework for GM – standardise process across GM under a core specification for procurement of individual placements.
- Identification of exemplar care models for upscaling and implementation across GM.
- Integrated commissioning functions, working closely with CCGs and well connected with partners such as housing and voluntary and community sector.
- GM Discharge Framework agreed and established.
- Telemedicine and assistive technology opportunities pursued.
- Workforce reform opportunities developed, e.g. in blending health and social care roles.
- Development of the Strategic Plan for Services for Adults.

### Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)

1. **Rapid improvement in intermediate care, discharge to assess facilities and home care capacity**

- Delivery of flexible support for home care (time banking visits). Use of personal digital assistant (PDA)/ smart phone technology to monitor compliance and facilitate time banking.
- Provision fits around the person. Move away from time/task-oriented provision to meeting the needs of individuals and recognising that they will differ.
- Promotes independence – not bound by assessment as per the current model and enshrines reablement principles.
- Bespoke solutions based on need – professionals to triage needs considering the wider offer, including community assets, to ensure value for money.
- Proactive provision – carers encouraged to be intuitive and do what is required not what is on their task sheet.
- Career of choice for care staff – pathway into health provision. Commissioners and providers to champion the profession. Caseloads rather than task/time sheets.
- Reducing social isolation and connecting people – carers actively encouraged to link people to community assets, not just leaving it to other professionals.
- Upskill staff to carry out lower level medical tasks. Reduced duplication and better use of telemedicine and district nurses to focus on priority patients.
- Revised regulatory framework through Care Quality Commission to facilitate a blending of health and social care roles.
- Standardised commissioning framework in place, based on common values, to improve the market offer in each locality

through collective market management once at GM level.

- Sufficiency and stability ensured in the market.
- All patients have clear and communicated discharge plan and point of contact.

## **2. The work from the Early Accelerator**

- Local authorities and CCGs to have commissioned joined-up clinical and social care responses to proactive, all-age care planning and, where unsuccessful, crisis interventions.
- Movement of activity and resource from acute-based services into the community, and improved transition between these.
- Integrated services throughout the life course, i.e. commissioning strategy outlines transitional arrangements for young people and links with education/ CCG/NHS continuing healthcare (CHC) arrangements.
- Closer integration of mental and physical health and care offer (in localities).
- Reduced incidence of fragmentation, variation and silo working.
- Increased community-based offer with principle of positive behaviour support.
- Expansion of community-based accommodation.
- Greater Manchester recognised as an Age-Friendly City.

## **3. Investment in scaling up innovation and demand reduction work**

- Behaviour change embedded across all health and care practitioners, with a common culture/ethos.

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## 2. Services for children

### Five-year vision, outcome objectives and phases

The ambition is to deliver improved outcomes for children across GM by:

- Improving outcomes for children and families; supporting parents and carers to be the best they can be.
- Reducing, appropriately, the number of looked-after children (LAC) and setting a high-level ambition, e.g. 20% reduction in spend on LAC.
- Reducing, appropriately, the number of children in need and children with child protection plans.
- Developing a safe system that is financially sustainable within five years through joint investment of resources to reduce future demand.
- Supporting more asset-based interventions to promote resilience, confidence and wellbeing in families and local communities.
- Applying a more effective organisational system in order to make best use of resources and expertise.
- Increasing social worker capability and capacity, as part of wider workforce reform and development.
- Reduction of caseload so more time can be spent with families. Less sickness time and fewer agency staff.
- Deepening commissioning arrangements and stimulating new models of early intervention, prevention and provision.
- Learning from best practice and building on existing innovation.

### 2016/17 action plans with key milestones

A number of steps are being undertaken that it is proposed will help ensure the alignment of proposals in the Services for Children

Review and health and social care strategic plan. These include:

- Agree consistent GM approach to Early Years (EY) baseline methodology (education).
- Plan for accelerated delivery of EY delivery model where gaps exist (integrated health).
- Agree GM Early Help (EH) model, standards and joint outcomes framework (EH/complex dependency).
- Establish EH leadership teams (EH/complex dependency).
- Agree EH core minimum offer that must be available across all boroughs (EH/complex dependency).
- Establish role for full-time safeguarding officer in Wetherby (youth offending).
- Establish GM youth offending commissioning framework and develop single GM courts team (youth offending).
- Increase understanding of child safeguarding through Research in Practice (RiP) (complex safeguarding).
- All GM local authorities will be active members of Fostering Front Door and Adopt North West (LAC).
- All LAC children will have an exit plan (LAC).
- No LAC (over two years old) will be cared for at home (LAC).
- Extensive engagement of national, regional and local stakeholders in the co-design of a new GM quality assurance (QA) vehicle (QA).
- Joint development work regarding GM's pathfinder status as part of the national local safeguarding children board (LSCB) review (QA).
- Innovation fund investment in a joint Department for Education, Cafcass and Ofsted analytical team to undertake robust

technical support during the design and negotiation of the new GM QA framework (QA).

- Commission a robust, independent, longitudinal evaluation of the newly launched GM QA framework in practice to inform national policy making (QA).
- Design a workforce, culture and leadership programme (QA).

### **Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)**

There is significant overlap and potential dependency between the proposals identified thus far through the Services for Children Review and the ambitions in the GM health and social care strategic plan:

- Commissioning of mental health provision – The ambition to develop simpler models for commissioning and service provision of child and adolescent mental health services (CAMHS), including Early Help, plus explore how perinatal mental health services could be improved through greater co-ordination. A focus on early intervention and prevention is also a key priority in the Services for Children workstream and is fundamentally intertwined with delivery of an all-age mental health strategy for GM that has strategic initiatives that focus on children and young people.
- Early Years – The GM Early Years new delivery model already has the full engagement of all authorities. There is, however, an ambition in the Services for Children workstream to build on this to develop a truly integrated, multi-agency approach to Early Years (0-5 years) and Early Help (0-18 years) to help secure positive health, wellbeing and educational outcomes, plus the potential to develop a model where primary schools take a lead role in progressing the learning and

educational development of children from the age of two linked to the Early Years pathway. This will require joint planning, commissioning and delivery linked to the health and social care strategy, including defining health visiting, midwifery, pre/post-natal and primary care alongside the role of schools. Ensuring that more children are reaching a good level of development cognitively, socially and emotionally (as cited in the devolution agreement) should act as a shared outcome for targeted improvement alongside the ambition for fewer babies with low birth weight.

- Quality assurance – This workstream includes an aspiration for a single GM outcomes and quality assurance framework in statutory children’s services that involves the impact of the work with children of all partners in this cohort. In addition, there exists the opportunity to develop a pilot model of a GM LSCB linked to modified local arrangements, and such an arrangement would need the commitment of all partners with regard to revised information-sharing and governance arrangements.
- Complex dependency and Early Help – The Services for Children Review advocates the development of systematic prevention system for children and families (Start Well) that needs to be a fully integrated part of the whole life course (with Live Well and Age Well), place-based prevention system in order to reduce demand on acute and specialist services. A ‘whole system’ approach that can articulate how health services can best integrate with services for children in a place is a key area of work linked to locality plan implementation. It is based firmly on the development of resilient and healthy communities, and in particular how the health and social care focus on seven-day GP access and community healthcare will support the complex dependency

and Early Help priorities of the children's services work.

- Targeted and specialist support – Being able to target particularly vulnerable groups of young people more effectively, including looked after children, those who are vulnerable to complex safeguarding issues, young people with special education needs or disabilities (including linking into the development of a learning disability fast track), and those transitioning from children's to adult care, requires a better understanding of the needs of these groups if we are to ensure that they receive the 'wraparound' support needed. This may include different commissioning and delivery models to support improved access rates for vulnerable children, looking at options for 24/7 crisis care support and the better integration of children's and adult care.
- Integrated commissioning – Aligning the proposals within the Services for Children Review with the health and social care strategic plan will offer the opportunity for integrated commissioning of specific services or interventions for children and parents at a GM level. The Joint

Commissioning Board will have a key role to play in understanding where maximum value and impact can be achieved through an integrated approach to commissioning.

- Workforce development – A common set of values and behaviours and a more flexible workforce will be vital for both programme areas' work. There is opportunity to develop these jointly and consider how workforce development activity can be jointly commissioned/delivered using pooled resources.
- Data sharing and analytics capability – The need to understand the needs of populations better and understand/predict demand is a vital element of the Services for Children Review. This will require new approaches to jointly tackling barriers around data sharing (GM Connect) but also to maximising the information we hold and the analytical resources we have at our disposal. There is an opportunity to explore how to develop better integrated needs assessments for GM that will support more effective commissioning, provision and monitoring.

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### 3. Learning disability services

#### Five-year vision, outcome objectives and phases

- Greater Manchester has developed the following seven principles within which service delivery models will be developed and delivered. These are based on recognised best practice.
- All people with learning disabilities and/or autism will be supported within the community wherever possible.
- People with severe disabilities and complex support needs will be integrated into typical neighbourhoods, work environments and community settings.
- Support will be provided for the placement

of individuals with severe disabilities and complex needs in homes and natural settings.

- Community living arrangements will be family-scale and/or in line with age-appropriate communal styles. They will all enable individuals to have their own space.
- We will encourage the development of social relationships between people with severe disabilities and complex needs and a range of other people.
- Individuals will be supported to participate in busy community life and develop functional, meaningful, interesting and community-living skills.

- Families and service users will be involved in the co-design, development, active delivery and monitoring of services.

## 2016/17 action plans with key milestones

### 1. Development of a common ethical commissioning framework

To develop a commissioning approach that enables the market to offer care solutions that represent best value, offer high-quality affordable services and can be purchased from within the personal budgets that people with a learning disability have to spend.

### 2. Identification of exemplar care models for upscaling and implementation across GM

To identify schemes and initiatives that demonstrate good practice across GM localities and highlight what works and what does not. Where one locality is able to evidence an approach or service that has resulted in good outcomes, then this will be automatically shared across all localities for consideration.

### 3. Integrated commissioning functions, working closely with CCGs and well connected with partners such as housing and the voluntary and community sector (VCS)

Development of a commissioning function across GM that is collaborative in nature between local CCGs and local authorities, reflects the importance of local connections and strategic priorities, and can be flexed to support wholesale commissioning across GM when required.

### 4. GM discharge framework agreed and established

A framework for ensuring that the work required to facilitate discharges from secure and non-secure environments is agreed to include implementation of community treatment reviews.

### 5. Telemedicine and assistive opportunities pursued

Take a positive risk-taking approach to managing risk in a range of environments using telecare and other technology to mitigate identified risks.

### 6. Workforce reform opportunities developed, blending health and social care roles

To ensure that where integrated teams are in existence, roles are developed to be deployed flexibly, recognising the points at which investment is required in specialist roles that can be used appropriately.

## Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)

Greater Manchester's ambition for learning disabilities services is predicated on four key objectives:

- 60% reduction in non-secure beds
- 34% reduction in the number of low-secure commissioned beds
- Improving in/out-reach intensive support
- Expansion of community-based accommodation

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## 4. Mental health

### Five-year vision, outcome objectives and phases

- Improving child and adult mental health, narrowing their gap in life expectancy and ensuring parity of esteem with physical health.
- Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in GM requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and wellbeing of GM residents.

### 2016/17 action plans with key milestones

#### Q1

- Links to children's services, specifically child and adolescent mental health service (CAMHS), to be strengthened.
- Mental health links to worklessness and physical ill health to be more clearly articulated and programmes already in existence to address these issues, such as Working Well, to be referenced.
- Optimise opportunities for all primary care providers to support the delivery of mental health services in line with the GM Mental Health and Wellbeing Strategy
- Need more focus on asset-based work and lower level community-based solutions.

#### 2016/17

- Development of a stepped-care, multi-agency pathway that describes the offer across the whole system based on presenting need.
- Development of a GM transformation plan for CAMHS.
- Scope opportunities across GM for commissioning highly specialist elements of the pathway as a collective to improve consistency, equity and efficiency.
- Establish GM-wide information sharing.

### Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)

- Simplify provider system and bring together commissioning across GM.
- Children and young people are a key part of the strategy.
- Greater integration across mental and physical health and social care in each of the 10 GM localities. Mental health integrated within local care organisations (LCOs).
- Support those people who are vulnerable to mental ill health.
- Promote employment for people with mental ill health.
- Address the wider financial impact of poor mental health on wider public services.

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## 5. Population health improvement

### Five-year vision, outcome objectives and phases

- Creating a health and care system capable of contributing to a transformational and sustainable shift in the health of the 2.8 million people who live in GM.
- Enable more people to manage health, looking after themselves and each other.
- Shift public and clinical behaviours towards early intervention and prevention.
- Children under the age of five reaching a good level of development to make the most of education and training opportunities and provide the best start in life.
- Improving the health and wellbeing of working-age adults and ensuring all residents are connected to the current and future economic growth in the GM conurbation, including quality work, improved housing and strengthened education and skills attainment.
- Close the health inequalities gap faster, both within GM and between GM and the rest of England.
- Increasing intervention at scale and finding the missing thousands who have diseases but do not know it yet.
- Support older people to stay well and independent and live at home for as long as possible.

### 2016/17 action plans with key milestones

- Develop specific proposals for **GM-level public health commissioning**, including sexual health services, drugs and alcohol services and Early Years health services.
- **Screening and immunisation:** Whole pathway approach as part of the Cancer Vanguard arrangements; local care organisations and their new contractual forms and wider public service reform (PSR) developments, such as the

expansion of Working Well and the Early Years new delivery model (NDM). Priority will be given to those areas that require significant performance improvement e.g. cancer screening and childhood flu.

- **Integration of information systems** including child health information systems, (CHIS).
- **Integration of commissioning** such as for sexual assault services, which could be linked more strongly to local safeguarding and complex dependency arrangements.
- **Health and justice:** Liaison and diversion services and opportunities to develop an integrated commissioning and delivery model with police custody healthcare.
- **Find and Treat programme:** GM commissioning of NHS health checks programme to address variation in price and outcomes and drive up standards; commissioning a bespoke integrated intervention for the 10% most deprived communities with the poorest health to provide an enhanced service with broader support packages, including social support and access to work.
- **Cancer Vanguard:** Delivery of year-one commissioning intentions, to include commissioning behavioural insights work to support key elements of programme e.g. improving screening attendance.
- **Radical upgrade in lifestyle behaviour change support:** Commissioning a GM lifestyle and wellness hub to provide a single access point/portal for behaviour change advice and support, including triage into 10 place-based locality lifestyle and wellness service offers.
- **Early Years NDM:** Commission at GM level, bringing together the commissioning of health visiting, family nurse practitioner related maternity services, perinatal mental health services, children's centre and early education offers, and other targeted support.

- **Digital strategy:** The development of a digital health commissioning strategy aligned across three specific areas – digital innovation, empowered citizens and communities, and digital navigation – to underpin a radical upgrade in prevention and population health.

### Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)

- Radical upgrade in lifestyle behaviour change support that delivers innovative approaches at scale to drive long-term behaviour changes and reduces current and future demand on health services from lifestyle-related long-term conditions.

## 6. Primary care

### Five-year vision, outcome objectives and phases

- **Delivery of primary care at scale:** The integrated provision of primary, community, social care, mental health and other services, serving defined neighbourhoods of circa 30-50,000 people. These integrated neighbourhood teams provide a foundation for the development of local care organisations (LCOs), operating at a borough/city-wide level. A number of ‘early adopter sites’ have been identified to implement this new way of working in shadow form in early 2016/17. By 2021, LCOs will be operating in all 10 GM localities.
- **A population approach to health and wellbeing:** The creation of a primary care system that more proactively supports people and communities to take charge of – and responsibility for – managing their own health and wellbeing, whether they are well or ill. Rolling out the Healthy Living Framework will increase the number of outlets where people are able to access health improvement advice and services. During 2017/18, the Healthy Living Framework will have been rolled out to all community pharmacies in GM, and to all community optical and dental practices by April 2018.
- **Improving access and responsiveness:** The development of seven-day access

plans was part of the commitment to the Healthier Together programme and was specifically designed make sure that primary care services are available seven days a week to mirror the move to seven-day working in hospitals. All parts of Greater Manchester are now delivering seven-day services. However, it is expected these will be redesigned in 2017/18 based on the findings of an independent evaluation and to align to wider commissioning intentions/service transformation. Increased access to dental, pharmacy and optometry services will provide a more responsive service, ensuring people access treatment and advice by the right person, at the right time and closer to home.

- **Consistently high quality care/reducing unwarranted variation:** The quality of most primary care provision is good, but there are wide and often unwarranted variations in performance. There is a need to reduce this inconsistency so patients, the public and professional colleagues across the health and social care system are assured that primary care in Greater Manchester is of the highest possible quality. By December 2017, the Greater Manchester Primary Care Medical Standards will be implemented across the 10 localities. Aligned and complementary standards for dental, optometry and

pharmacy are also being developed and implemented.

## 2016/17 action plans with key milestones

- **Primary care at scale:** Development, implementation and commissioning of 'early adopter sites' delivering primary care at scale. Early adopter sites have been identified in at least four localities.
- **Population health and wellbeing:**
  - GM-wide roll-out of Healthy Living Pharmacy Framework to all community pharmacies – delivery of a broad range of high-quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.
  - Healthy Living Dental Framework pilot in Wigan.
  - Mainstreaming 'Healthy gums DO matter' across GM and periodontal care following recent pilot.
  - Eye care pilot for people with learning disabilities.
  - Pilot asset-based training for frontline staff.
  - Sector-led oral health improvement programme.
- Improving access and responsiveness:
  - Seven- day services to primary care, hubs operational in all parts of GM.
  - GM wide roll-out of minor ailments scheme to all community pharmacies.
  - Implementation of emergency and urgent repeat medication provision to all CCG localities.
  - Implementation of single minor eye conditions service across GM.
  - Extend access to dental health services 'Baby Teeth DO matter' and 'Buddy Practice'.
  - 'Pride in practice' pilot improving access for LGBT population.
- Delivery of Asylum Health Project establishing co-ordinated good practice in delivery and access to services and development of community asset.
- **Specialist dental services:**
  - Developing pathways management for access and delivery of specialist dental care.
  - Establishment of managed clinical networks, delivering single service model and provider assurance of specialist care.
  - Integrate dental and oral health considerations in the care of children subject to general anaesthetics.
- The GM strategic plan notes primary care as the driving force behind a prevention-focused approach within localities across Greater Manchester. There is massive untapped potential for primary care to prevent health problems, take action quickly once they are detected and reduce complications that can arise from late diagnosis. Significant health gain will be made by implementing early intervention at scale and identifying the 'missing thousands' who have undiagnosed disease.
- In Greater Manchester we want to create a primary care system that more proactively supports people and communities to take charge of – and responsibility for – managing their own health and wellbeing, whether they are well or ill. This will draw on a range of approaches that have already been tested in Greater Manchester, including work to improve health literacy and to draw on the strengths and assets that exist in communities.
- We want to strengthen the focus on wellbeing. This means putting more emphasis on prevention, self-care, public health, resilience and recovery, and reducing lifestyle and behavioural risks. As noted in the GM strategic plan, 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.

- We particularly want to make the most of interaction between the public and dental, pharmacy and optometry services to support self-care and prevention, rather than thinking about contact with primary care purely in terms of illness.
- This fresh approach will mean people will better understand how they contribute to their own health and wellbeing and can make the most of available services. They will have the information they need to prevent ill health, manage any conditions and access the right support in their local neighbourhood when they need it.
- Managing and using information better – including patient records – is one of the principles supporting our overall vision for primary care and will support more consistent quality across services.
- Reducing silos, networks and systems that operate in isolation will enable greater connectivity and integrated electronic communication. This will help co-ordinate patient care when it is appropriate to share data. For example, optometrists could access patients' summary care

records and GP records and let individual patients' GPs know about the results of eye health checks, including any wider health issues these have identified.

- Sharing information in this way will mean action can be taken to support patients to manage their health at the earliest opportune moment, without unnecessarily duplicated assessments. It may be particularly useful in connecting various professionals so they can co-ordinate care for more vulnerable patients and help them to remain thriving members of the community.
- We want to improve the way different health and care professionals work together to get the most from what each profession brings to primary care services and individual patient care. Our aim is for all the various professions to contribute to both the preventative and healthcare delivery agendas, to maintain independent living for the maximum number of people – which will help 'spread the load' across both health and social care – and embed best practice in all services across Greater Manchester. We also want to foster closer working with the acute sector (including hospital pharmacists) to improve the way patients are discharged to the community.

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## 7. Specialised commissioning

### Five-year vision, outcome objectives and phases

Model to be implemented based on the following principles and outcomes, which will guide the development of future service delivery models. These are based on recognised best practice.

- Elimination of variation and improvement of patient outcomes and experience.
- Achievement of evidence-based clinical standardisation.

- Creation of one clinical workforce for key services.
- Achievement of consistent and effective clinical governance for all services.
- Optimise scale and achieve consolidation of services, where required.
- Improve efficiency.
- Achieve integration of care for the whole patient pathway for the GM population.

## 2016/17 action plans with key milestones

- Complete the process to ensure we address long-standing non-compliant cancer pathways in upper GI (gastrointestinal) and urology.
- Implement outcomes from prioritisation matrix, which has been developed with providers to support identification of the next services for transformation.
- Specialist cancer services are to be reviewed within the work of the GM Cancer Vanguard schemes. The model of care is to consider whole pathway re-design, which will incorporate all specialist cancer services into the re-design process.

## Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)

The implementation of the commissioning strategy will support the commissioning of specialised services to consider different models of delivery. Work is underway with providers to understand what the best approach to this is, with the focus being on delivery of high-quality care rather than organisations. This will lead to the following outcomes.

- Optimise patient outcomes, access and experience through the integration of care along the whole patient pathway, elimination of variation in referrals, access and outcomes, and introduction of integrated and standardised pathways that take account of the needs of the whole patient pathway, including prevention.
- Improve efficiency by moving away from fragmented organisation-based delivery to clusters of single services that optimise the scale of service delivery and consolidate service delivery where required. This will ensure services meet the minimum volumes required to optimise patient outcomes and run a 24/7 service.

- Support world-class clinical practice, education and training, research and development, and innovation by achievement of evidence-based clinical standardisation, optimising recruitment to local and national clinical trials, increasing research opportunities and resources for GM and optimising training and education of the clinical workforce. The single service model will also support the spread and adoption of evidence-based pathways and threshold management from primary care to specialist care.
- Create clinical and system leadership for integrated patient pathway transformation by creating a lead organisation responsible for developing a single service cluster with a single clinical workforce, to achieve world-class standards and clinical outcomes, and consistent and effective clinical governance for key services. Most importantly, such an approach would move from the existing formal procurement processes for specialised services to the collaborative re-design of service clusters.

## Appendix 3: Initial action plans for broader workstreams to be swiftly adopted

### Employment skills

#### Three-year vision, outcome objectives and phases

The 10 GM employment and skills priorities for 2016/19 are:

- 1. Careers education, information and guidance (CEIAG):** Based on up-to-date labour market information, enhance high quality CEIAG across school, further education (FE) and work provision to ensure young people, their parents and teachers, and adults understand the range of education, skills and employment opportunities and progression pathways available in GM and, as a result, make informed choices.
- 2. Outcome frameworks:** Develop outcome frameworks to ensure all work and skills provision supports positive progression pathways and, ultimately, sustainable employment outcomes for Greater Manchester's young people and adults. Embedded in the provision should be good English and maths outcomes, digital skills, meaningful work experience and those behaviours/core competencies (enterprise skills) needed in the world of work. The outcome frameworks will underpin future GM commissioning.
- 3. Infrastructure:** Develop a GM work and skills infrastructure via the area-based review, Jobcentre Plus estate review and One Public Estate programme to ensure accessible local provision for education and skills to Level 2/3, with specialist/technical provision at Level 3/4 and above, linked to GM's economic and growth needs and delivered through a discrete number of high-quality centres.
- 4. Attainment:** Focused activity to support the attainment of Level 2 English and scient, technology, engineering and mathematics (STEM) subjects at age 16 across GM, thereby improving Level 3 attainment at 19.
- 5. Employer engagement:** Develop a comprehensive approach to employer engagement and investment in the work and skills system, working with the local enterprise partnership (LEP), employer bodies and local authorities to ensure that: (a) employers are at the heart of the system; (b) employers recognise the value of workforce development and plan and invest in their workforce development needs; (c) the higher level skills needed for economic growth are developed and commissioned by business, recognising that most of this will be funded via FE loans and employer investment; (d) employers develop good employment practices to support people to retain employment and help people, including via work experience, to enter or re-enter the labour market
- 6. Apprenticeships:** Increase the number, quality and level of apprenticeships in core and growth sectors in GM via better CEIAG, employer workforce development and co-ordination of public sector activity in response to the Apprenticeship Levy. Apprenticeships also offer opportunities for re-skilling and upskilling the existing workforce as they move into new roles, to support them in work progression.
- 7. Higher level skills:** Develop the education and skills system in GM, including via FE and higher education (HE) loans, to support young people and adults to develop the higher level (minimum Level 3) and STEM skills needed by them to compete and progress in the labour market and by employers to drive productivity. Graduate retention in Greater

Manchester is good but there is more to do to enable access to HE and move graduates into small and medium sized enterprises (SMEs).

- 8. Universal support:** Redesign services to support workless residents, ensuring early assessment and rapid response for low-need 18-65 year olds back into work. Create a universal support offer for all jobseekers and benefit claimants, providing a personalised offer based on their needs and delivered in an integrated, co-located way with local support services, improving the customer experience, and increasing sustainable job outcomes. This will improve the functioning of the GM labour market and ensure that as residents move into and progress in work, there is a reduction in the number of GM residents dependent on in-work benefits.
- 9. Specialist support:** Expand the Working Well programme and design a new offer for complex 18-65 year olds who have experienced long periods outside of the labour market via work and health programme commissioning that fully utilises complementary public services and supports more GM long-term benefit claimants to secure work.
- 10. Commissioned activity:** Commission activity that integrates work and skills, supporting the priorities above, including European Social Fund (ESF) programmes and employment outcomes in GM health (particularly mental health) commissioned programmes.

### 2016/17 action plans with key milestones

An action plan has been developed for each of the priorities that detail short, medium and long-term actions. Many of these priorities can be progressed in the short term via a range of deliverables that GM is already committed

to pursuing to implement the November 2014 and November 2015 devolution agreements. Key priorities among these are:

- To undertake the area-based review and ensure conclusions are implemented.
- To restructure post-19 provision, analysing current curriculum, future skills demands of the economy, population trends and the financial position of providers.
- The development of an outcomes framework, influencing commissioning of the 2016/17 adult skills budget and leading to potential budget responsibility in 2017/18. This framework can also be used to shape the new Work and Health programme.
- The expansion of Working Well up to 2017.
- The recommissioning of the Work and Health programme from 2017 to include the ongoing expansion of Working Well.
- The development of a GM approach to the Apprenticeship Levy – including a public sector ‘ring-fencing’ to ensure GM develops the skills it needs to drive growth and reform.
- Work with Jobcentre Plus to review and rationalise its estate, linked to the One Public Estate programme and the development of integrated local Early Help hubs.
- The work to commission £130m+ of ESF funding to ensure GM achieves the work and skills outcomes that it requires.

### Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)

There are a number of key areas where skills and work priorities and the ambitions in the health and social care strategic plan align:

- Integrated commissioning, in particular the Working Well expansion and Work and Health programme. The Joint Commissioning Board could be a vehicle

to deliver an integrated approach to commissioning. There is a particular opportunity around the development of an outcomes framework.

- Prevention and community-based care – There are clear links in terms of employer engagement and helping residents remain healthy and in work, creating pathways into job opportunities in the health system

and in creating more integrated service delivery in communities.

- Data sharing and analytics capability – More effective customer segmentation and data sharing across systems and practitioners will help to target our commissioning strategies and enable greater joint working on the ground.

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## Substance misuse

### Five-year vision, outcome objectives and phases

The aim of the review of substance misuse commissioning and delivery is to ensure that substance misuse commissioning is better co-ordinated and achieving the best possible outcomes and value for money across GM.

The nature of substance misuse is complex and changing.

- Increasing numbers of people are damaging their health through excessive drinking, and there has been an associated rise in the prevalence of alcohol related conditions.
- There remain a large number of opiate and crack users for whom a recovery-orientated clinical service is crucial.
- New types of drug users are emerging; they are younger, likely to be poly-drug users, more diverse, more likely to buy drugs online and more willing to try unknown substances.
- There are specific behaviours and issues. For example the increase in prescription/over the counter drug misuse, and a surge in the use of new psychoactive substances in particular are common and recognised as challenges and that our system response is still evolving.

Extensive work has been undertaken to construct a single narrative and vision that:

- Traces through some of the key changes

in patterns of substance misuse, reflecting on the latest developments and how the service offer in GM has evolved and responded

- Draws together our clearest GM evidence base on how substance misuse interconnects with other issues – from mental health and domestic abuse to worklessness/productivity and child safeguarding challenges
- Sets a level of ambition for collaboration across GM.

There is a wide recognition that all districts are some way towards successfully recommissioning their treatment system to reflect the changing nature of substance misuse, a recovery-oriented approach and the links to complex dependency. Some areas are recognised as having good recovery and mutual aid, while others provide well developed brief interventions for alcohol, and others have good shared care and strong digital services.

And yet there remains a continued sense that there is a mixed picture of drug and alcohol provision across GM, with significant variation in how these services are commissioned, structured and configured, an inconsistent pathway for complex individuals and families seeking to access these services, as well as limited options for new and emerging drug users. There is also a sense that within GM there are still genuine opportunities to reduce

duplication and to identify more efficient commissioning options.

GM has a clear legacy of traditional opiate and crack users in treatment for whom support is absolutely necessary. However, the landscape has shifted and there is therefore a strong appetite for GM commissioners to work collaboratively, to establish a clear and meaningful spine of GM commissioning principles, and to give fuller consideration to those interventions that might be co-commissioned against agreed specifications.

There needs to be an equitable offer across GM in relation to the criminal justice system and we will ensure that our 'common standards' reflect this. We are working closely with Public Health England (PHE) to ensure that our proposals are in line with the new national drug strategy.

This substance misuse work has been commissioned by the Association of Greater Manchester Authorities wider leadership team. To ensure that the work is situated in all the appropriate strategic discussions on public service reform and health and social care devolution, the work is regularly reported to the PSR Leadership Group, Complex Dependency Executive, GM Directors of Public Health, GM Health and Social Care Early Intervention and Prevention Board and other groups as required.

There is however currently a gap in governance and decision making in relation to GM-wide commissioning.

### **2016/17 action plans with key milestones**

The body of works being taken forward during 2016 will deliver the following.

- A set of shared principles for substance misuse commissioning, reflecting the broader vision and aligned to PSR principles.
- A benchmarking exercise that reviews

the current specifications in the 10 GM localities and helps to develop a common framework across the domains of early help, targeted interventions, recovery and community, and treatment.

- An options report with recommendations on what services/interventions might be commissioned collaboratively at different spatial levels.
- Early market engagement that supports both incumbent and potential new providers to better understand GM's broader reform ambition.

### **Clarity of outcomes required and contribution to financial and clinical sustainability and public service reform (PSR)**

The substance misuse case for change narrative that has been constructed and agreed draws together our evidence base on the nature and scale of the GM challenge, how this is evolving, the status of our collective response, and the opportunities now presented through the twin prioritisation of complex dependency and health and social care devolution.

- The shared vision statement and principles for substance misuse commissioning across GM, which have been prepared and agreed in consultation with all 10 local authority substance misuse commissioning leads, need to be equally embedded within the health and social care strategic plan and public service reform.
- The benchmarking exercise will review the current configuration of services available in the 10 districts against a common framework (e.g. intervention at the levels of prevention, harm reduction and specialist treatment). This should establish who commissions what and where, match this against evidence-based best practice, and reflect on current performance/outcomes and value for money.
- An options report will be drafted

with recommendations on what services/interventions could viably be commissioned differently through a collective approach. This should consider what specific opportunities exist for greater GM collaboration (across spatial levels, either at GM, cluster or neighbourhood level), and can build on the existing ways in which we have already collaborated for mutual benefit e.g. in respect of in-patient detoxification and residential rehabilitation. This should also review opportunities to commission together in response to common emerging challenges (e.g. digital engagement and prevention work with young people), or in relation to workforce training and skills development.

- An appraisal of the current provider landscape in GM will result in practical recommendations for future market stimulation/development. This may require a dedicated market event, the purpose of which would be to convene existing and potential new providers and undertake a development exercise.

A key requirement throughout this next phase of work is to pinpoint what particular opportunities exist for future collaboration with CCGs. This dialogue will take a different form in each area, but it would be particularly helpful if (for example) the provision of alcohol liaison services and identification and brief advice (IBA) within acute trusts was considered, as part of a wider reconsideration of commissioning options to support a sustainable approach to funding of preventive alcohol services that meet local need.

The wider GM Association of CCGs Association Governing Group leadership support for Rapid Access to Alcohol Detoxification Acute Referral (RADAR) and Rapid Assessment Interface and Discharge (RAID) services remains of fundamental importance in line with the confirmed independent cost-benefit evaluation report.

There may be further essential contributions from CCGs in defining common GM standards, and in defining short/medium/long-term opportunities for practical collaboration.

### **GM Vision Statement and Substance Misuse Principles**

The GM commissioners have worked together to draft a proposed shared vision for GM substance misuse commissioning, as follows.

GM partners will work collaboratively to ensure that local systems of substance misuse intervention and treatment are commissioned and provided in accordance with common principles and standards, so that individuals and families affected by all forms of substance misuse, including alcohol, are supported to achieve recovery and live independently.

We will achieve more for less by:

- Recognising that substance use is diverse and complex, and collectively responding to changing patterns of substance use and behaviour to provide the most effective route to recovery from all types of substance misuse.
- Rooting our approach in prevention and early intervention, anticipating future cost and escalating demand on services, and ensuring responses are appropriate to levels of need and health risk.
- Basing our approach to treatment and harm reduction on a growing evidence base, and a shared understanding of challenges, opportunities and changing circumstances - ensuring that we share learning, expertise and resources.
- Using asset-based approaches to enable long-term and sustained recovery from all types of substance misuse.
- Adopting a whole-person approach to working with complex families and individuals, and integrating provision with wider delivery models tackling complex dependency.







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

Website: [www.gmhsc.org.uk](http://www.gmhsc.org.uk)

Email: [gm.hsc@nhs.net](mailto:gm.hsc@nhs.net)

Twitter: [@GMHSC\\_devo](https://twitter.com/GMHSC_devo)