SUMMARY OF REPORT:

The enclosed document is the Partnership’s Annual Report for 2017-18

KEY MESSAGES:

The document describes the Partnership’s work in 2017-18 – the second year of our operation as a devolved system.

Accompanying the Annual Report is a summary document covering both this report and our Business Plan for 2018-19.

PURPOSE OF REPORT:

The report provides the Health & Care Board with an overview of the Partnership’s work in 2017-18.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Endorse the 2017-18 Annual Report.

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1.0 FOREWORD

In April 2016 Greater Manchester took charge of its health and care system as one Partnership. In doing so, we embarked upon the most radical health and care transformation programme in the country.

Our goal is to deliver the fastest and greatest improvement of the health and wellbeing of the people who live here. This, our second Annual Report, captures the steps that we have taken to achieve that vision in 2017/18.

In our second year we have achieved a great deal, including exceeding many national performance targets, delivering strong financial results, broadening our partnership working, investing in new care models, closing the gap between mental and physical health, reforming commissioning and improving the quality of services.

Of course, this year also saw the first ever mayoral elections in Greater Manchester. We have forged a strong partnership with the Mayor as we seek to bring together all the resources in the public service and civic society to contribute to the health, well-being and prosperity of our city region.

As we move into our third year, we are now firmly into the implementation of our plans. The health and social care landscape in Greater Manchester is changing fundamentally. We are now seeing a system emerge with: a population health system that keeps people well; an at-scale community offer that builds from the assets in our neighbourhoods; a step change in commissioning – with new-place based models and a pooling of health and care budgets unmatched anywhere in the country; and hospitals working even more closely together – providing specialist expertise to consistent quality standards.

We know that some difficult challenges are ahead of us. We need to ensure our hospital services are organised to provide the highest possible standards of treatment and care. We will also fall short in achieving our vision if we do not make sure that social care services across Greater Manchester meet the changing and growing needs of our population. Equally, our performance on Urgent and Emergency Care must improve - particularly on the A&E four-hour waiting standard. We also still face significant workforce shortages in key areas.

However, these challenges will not dent our ambition for the people of Greater Manchester – nor will they diminish our commitment to radical change. At difficult times, we are always sustained by the strength of the partnerships across Greater Manchester – and this was shown more clearly than ever following the events at Manchester Arena in May 2017.

We approach 2018/19 with a sense of optimism as we increase the pace of the changes we are making and build on the momentum from this year. Our detailed plans for the year ahead can be found in our Business Plan that accompanies this document.

We must also turn our focus this year to the longer term. Whilst we are in the third year of our five year strategy, and there remains much to do to deliver our plans, the Comprehensive Spending Review in 2019 offers the opportunity to set out our plans for the
next five years and make the case for further freedoms for Greater Manchester to serve its people.

Lord Peter Smith - Chair GMHSC Partnership
2.0 INTRODUCTION

2.1. This is the second Annual Report and set of Annual Accounts produced by the Greater Manchester Health & Social Care Partnership.

2.2. It provides an overview of our work in 2017/18 and sets the scene for our delivery in 2018/19 – and further ahead. Our detailed plans for 2018/19 can be found in our Business Plan that accompanies this document.

2.3. We are now moving into the third phase of our operation as a devolved system. The first phase – lasting until April 2016 – was focused on establishing the devolved settlement for health and care in Greater Manchester; the second – broadly until autumn 2017 – saw us embedding our governance, strategies and programme structures as well as supporting the allocation of the majority of the Transformation Fund; the third has an absolute focus on implementation of our plans.

2.4. Through our programme of reform and investment we now see our way to the system architecture in GM that will be in place as a legacy of Taking Charge. This will comprise these recognisable and consistent features:

- The establishment of 10 Local Care Organisations (LCOs) integrating provision;
- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten localities;
- New models of hospital provision seeing hospitals working together in Greater Manchester at a much greater scale than ever before to a set of consistent quality standards;
- A Greater Manchester-wide architecture where it makes sense to do things at greater scale – including the GM Commissioning Hub, Health Innovation Manchester, a Digital Collaborative, a Workforce Collaborative and a ‘one public service estate’ strategy.

2.5. In 2017/18 we have continued to build on the achievements in our first full year. We have again demonstrated strong financial management and performance. We have ramped up our investments in new care models and on initiatives to support people to stay well. Whilst Urgent and Emergency Care remains a significant challenge, we now have a firmly embedded improvement programme to tackle this.

2.6. 2017/18 also saw the agreement of the new Greater Manchester Strategy Our People Our Place covering 10 policy areas, including health and social care. We will play our full part in implementing this strategy, including how health and social care can contribute to, and benefit from, the other areas including transport, housing and the development of skills and good quality work.
This report sets out our work and how we have performed in 2017/18 in four areas:

- Improving the Health of GM Residents;
- Transforming Care and Support;
- Enabling Better Care;
- Financial Performance and Annual Accounts

3.0 IMPROVING THE HEALTH OF GM RESIDENTS

3.1. Population Health

3.1.1. Greater Manchester may be a great place to live and work for many, but people here die younger than in other parts of England. We want to change this. We are now firmly into the implementation of our Population Health Plan and are making major targeted investments to improve health and well-being across the city region.

3.1.2. In delivering the plan, we are taking a life course approach: starting well; living well; and ageing well.

**Start Well**

3.1.3. Our ambition is for all children to be given the best start in life. We share the Greater Manchester Mayor’s commitment to improve school readiness radically across our city region. By 2020, our aim is to meet or exceed the national average for the proportion of children in Greater Manchester reaching a good level of development by the end of reception.

3.1.4. Reaching this goal will often require a multi-agency approach in order to address the complexity of some families’ problems. The case study from Wigan at the end of this section illustrates the difference this type of help can make.

3.1.5. To help achieve this aim we have this year:

- Commenced investment of over £2m to support school readiness in Greater Manchester through a Greater Manchester Early Years Delivery Model (EYDM). This includes the development of a tailored pathway to support some of the most vulnerable families in Greater Manchester; enhancing the role of schools in Early Years provision; and creation of an antenatal parenting programme;

- Agreed to invest over £1.7m to reduce the number of women and their partners who smoke in pregnancy. This is being rolled out in all parts of Greater Manchester in 2018 and 36,500 pregnant woman and their families will receive consistent support and advice across our city region;
• This year, we have become the world’s first city region committed to the Daily Mile. 43% of schools in Greater Manchester are already on board with the initiative, contributing to our 2020 ambition of 75% of primary schools across GM regularly taking part in the Daily Mile - over 180,000 children a year by 2020;

• Invested £1.5m in the priority areas of Oldham, Rochdale, Salford and Bolton to improve the oral health of children between ages 0 and 5. Free toothbrush and paste is now being provided to all young families in these areas totalling over 13,000 children per year;

• Developed a new plan for maternity services in response to the Government’s Better Births Initiative. The aim is for services in the region to be comparable to the best in the world, increasing safety of maternity services by reducing still births, neonatal deaths, brain injuries and separation of babies from mothers;

• Established a Children’s Health and Well Being Board to provide co-ordination and oversight of the children’s health agenda. The Board has identified a set of objectives for the development of a Greater Manchester Children’s Health and Well Being Framework.
Live Well

3.1.6. The primary aim of the Live Well theme is to support people at key stages of their lives when physical and mental health can be most strongly influenced, ensuring that we give all of our residents the opportunity to connect to economic growth in Greater Manchester.

3.1.7. We currently have a range of programmes to support people back into employment. During 2017/18 we secured funding for a new three year programme due to go live in early 2019, aiming to support up to 14,000 Greater Manchester residents in danger of dropping out of work due to ill health.

3.1.8. This year, Made to Move was launched by the Greater Manchester Cycling and Walking Commissioner, which will see £160m infrastructure investment leading to more active travel.

Wigan Locality Case Study - Start Well

Background
Ryan is dad to 9 month old baby girl Emma, he lives with his partner Joanne (mum) and they are teenage parents. They had recently been found housing, where a new family to the local area and this was their first home. Since moving in they were having problems with the neighbours (noisy and drinking) on the estate, making them feel isolated not wanting to cause any problems by raising a concern with authorities.

Early in baby Emma’s life the Health Visitor had seen the family and recognised the family would need some support.

A New Approach
A Start Well worker led on the Early Help for the family and felt that by having a ‘different conversation’ she could identify and build on their strengths and aspirations. The worker recognised that although the family had challenges they were coping with big changes.

Recognising both Ryan and Joanne’s aspirations helped the Start Well worker coordinate a ‘support offer’ around the whole family, involving a number of multi-agency professionals.

Both parents have been supported to access sessions with Emma in their local community coordinated by the Start Well Family Centre. The impact of these sessions have helped with baby Emma’s development.

Joanne and Ryan were also suffering with poor mental health, so the Start Well worker connected them to counselling services.

During this period Ryan was trying to get back into work and has attended a number of training courses. He has also received guidance on updating his CV from the ‘supported employment’ team working in the community. One course Ryan attended resulted in him gaining his CSCS card which enabled him to gain some valuable work experience on a local building project leading to a job. He also become a pivotal member of a Dads/male carers group which is run by the Start Well Family Centre and attends regularly.

Ryan really values the dad’s group and wants to do more for other Dads/families in the community through peer support.

Benefits to the family
Joanne is looking to undertake an open university course and has signed up as a Start Well Volunteer as well as looking at using ‘Care to Learn’ which is childcare support for Emma while mum does her university course. Both Joanne and Ryan are more confident parents – which benefits Emma hugely. This journey has enabled them to build friendships, share experiences and therefore avoiding further reliance on services in future and enjoy living in their local community.
3.1.9. Rates of smoking are also falling in our city region – but we know that we need to move faster in this area. Our ambition to reduce smoking at a pace and scale faster than any other major global city will see 115,000 fewer smokers by 2021. Work in 2017 has focussed on major TV and multimedia campaigns, specific intensive programmes supporting our sickest smokers in hospitals and our History Makers consultation with over 7,500 Greater Manchester residents to learn about and engage with the tobacco strategy.

3.1.10. Another area where we have recently secured investment is around our ambition to eliminate new cases of HIV within a generation. This multi-year programme will look at enhancing prevention; scaling up testing and optimizing programmes of treatment for those who are HIV positive.

3.1.11. The case study below shows the benefits that can flow from a joined up approach on health and work: Salford is using the Real Living Wage as one of the ways to reduce inequalities and improve health and wellbeing in the city.

**Salford Locality Case Study - Real Living Wage System**

**Background**

The UK Real Living Wage is set annually by the Living Wage Foundation and is currently £8.75 per hour. Salford’s Health and Wellbeing Board has found strong evidence that adopting the real Living Wage reduces inequalities and improves health and wellbeing at all stages of the life course. For employers, the real Living Wage has a significant beneficial impact on productivity, ease of recruitment and staff retention. Salford is working towards becoming the country’s first fully Real Living Wage health and wellbeing system by 2021.

**A New Approach**

Over several years, Salford’s Health and Wellbeing Board has promoted the real Living Wage, with each member committing in mid-2015 to consider working towards: introducing the real Living Wage; becoming an accredited Living Wage Employer; and incorporating the real Living Wage within its procurement. A multi-sector Living Wage task group has taken the work forward, chaired by Unlimited Potential, a local social enterprise. This includes colleagues from the Chamber of Commerce, CCG, CVS, local authority and mental health trust, plus liaison with the Living Wage Foundation.

**Adoption of the Real Living Wage**

Due to this work, 10 of the 13 members of Salford’s Health and Wellbeing Board are accredited Living Wage Employers and a further two members pay all staff the Real Living Wage (though they do not currently hold accreditation). Beyond the Health and Wellbeing Board, at least 11 other health and social care providers from all sectors operating in Salford are now accredited Living Wage Employers.

This work has been recognised nationally, winning the national 2018 Living Wage Champion Award for Industry Leadership.

**Age Well**

3.1.12. In March 2018, Greater Manchester became the UK’s first age-friendly city region. We are committed to a positive vision of ageing in Greater Manchester and building a health and social care system that works for older people.
3.1.13. We have played a full role in the establishment of the Greater Manchester Ageing Hub to coordinate a strategic response to the opportunities and challenges of an ageing population.

3.1.14. Social isolation and loneliness is an important issue that often faces older people and we are supporting all 10 areas in developing plans to tackle this.

3.1.15. Managing frailty well is essential in our health and social care system. This year we have put in place a task force to draw on best practice from around the world to develop a single plan to improve care pathways to manage frailty. The work on this has been led by the new Greater Manchester Frailty Collaborative.

3.1.16. Another important part of our programme is tackling dehydration and nutrition in old age. We are working with Salford Age UK to invest over £500,000 in the testing at scale of the Salford Nutrition and Hydration approach across Bolton, Bury, Oldham, Rochdale and Stockport, across a range of settings, aiming to reach over 7,000 older adults at risk.

4.0 TRANSFORMING CARE & SUPPORT

4.1. Local Care Organisations

4.1.1. We are developing Local Care Organisations (LCOs), which see the NHS, councils and other organisations, including the voluntary sector, working together much more closely to address an individual’s mental, social and physical health needs.

4.1.2. In 2017/18 each of our 10 localities has made considerable progress in their LCO development – all supported by investment from the Greater Manchester Transformation Fund.

4.1.3. We carried out a peer review of the 10 LCOs against an agreed framework. This produced vital learning which the 10 areas are using to progress their plans and is driving the work programme of our LCO Network.

4.1.4. The review showed that neighbourhood models are now established in all 10 localities proactively managing populations of 30-50,000 structured around the GP registered lists.

4.1.5. These teams are delivering locally led transformation programmes which enable people to be managed at home and in the community. A number of core delivery features are being demonstrated, These include:

- Urgent Primary Care
- High Impact Care
- Enhanced Care in Care Homes
- Supported Discharge
4.1.6. A summary of the progress made in each of 10 Local Care Organisations is illustrated below. Given the importance of the LCOs to our transformation, we have also included two case studies on different facets of the LCOs’ work from Stockport and Trafford.

**BOLTON**
- 18/19 as a transition year including refining the model and implementing phase 1 arrangements in shadow form.
- Initial phase of LCO to include adults social care, acute, community and primary care with mental health in phase two.
- Strong emphasis on neighbourhood working and integration.

**BURY**
- LCO Board in place.
- LCO-5 providers facilitating joint planning and transformation of services.
- Mutually beneficial contract in development and to be in place in April 18.
- Integrated Neighbourhood teams by April 19.

**ROCHDALE**
- LCO established — CORE Rochdale.
- Single integrated commissioning function in place.
- LCO Board established.
- Lead provider contract in place, which reflects demand management and ambitions as outlined in our Transformation Plan.
- LCO Chief Officer appointed and leadership/management arrangements in place.

**SALFORD**
- Commissioning pooled budget, ICO and Salford Primary Care Together in place since 2016.
- Joint ICO and SPCt Provider Board together with VCS in place.
- Transformation programme implementing neighbourhood teams, improving community access, supporting people at home and pathways redesign for adults during 2018/19.
- Integrated programme of work for children well established.

**TAMESIDE & GLOSSOP**
- Creation of single place-based budget for integrated strategic commissioning.
- Clinical and managerial leadership aligned to wider public sector and life course model.
- GP leaders driving neighbourhood development from within ICFT.
- 5 x neighbourhood teams co-located, operational and driving quality improvement/service transformation.
- Full roll out of social prescribing complete.

**TRAFORD**
- Mar: Local Care Alliance 7 originating providers to sign MoU, shadow form from Apr.
- GTF 18/19:
  - Completion of Outcomes consultancy work leading to KPI baselining.
  - Operating model & Governance developed through live testing 4 LCA transformation pathways.
  - Define 4 neighbourhoods delivery model(s).
- Plan for safe transition of year 1 services in place.
- Staff and partner engagement programme underway.

**WIGAN**
- Healthier Wigan Partnership Alliance Agreement in place, including care health providers & commissioners, Wigan Council and GPs.
- Healthier Wigan Partnership Programme defined.
- GH and wider services alignment at 30-50,000 populations.
- Place based health and care and public service model operating on a service delivery footprint.
- Integrated Community Services in place.
- Start Well Phase 2 design under consultation.
- Wigan GP Collaborative formed.

**BURY**
- LCO Board in place.
- LCO-5 providers facilitating joint planning and transformation of services.
- Mutually beneficial contract in development and to be in place in April 18.
- Integrated Neighbourhood teams by April 19.

**GM LCO SUMMARY**
- LCO established — CORE Rochdale.
- Single integrated commissioning function in place.
- LCO Board established.
- Lead provider contract in place, which reflects demand management and ambitions as outlined in our Transformation Plan.
- LCO Chief Officer appointed and leadership/management arrangements in place.

**ROCHDALE**
- LCO established — ONE Rochdale.
- Single integrated commissioning function in place.
- LCO Board established.
- Lead provider contract in place, which reflects demand management and ambitions as outlined in our Transformation Plan.
- LCO Chief Officer appointed and leadership/management arrangements in place.

**OLDHAM**
- Shadow LCO and services in place – April 2018.
- Establishment of an Alliance Agreement.
- CCG align with LA (SCF).

**SALFORD**
- Commissioning pooled budget, ICO and Salford Primary Care Together in place since 2016.
- Joint ICO and SPCt Provider Board together with VCS in place.
- Transformation programme implementing neighbourhood teams, improving community access, supporting people at home and pathways redesign for adults during 2018/19.
- Integrated programme of work for children well established.
Stockport Locality Case Study – Practice Health Champions

Background

A GP practice that piloted a Practice Health Champions scheme as part of the Healthy Communities work stream is beginning to see the success such a scheme can have in improving the health and wellbeing of patients as well as freeing up GPs time in dealing with social rather than medical issues.

The Alvanley Family Practice in Woodley was the first of three practices in Stockport along with Bracondale Medical Centre in Heaviley and Heaton Moor Medical Centre, to pilot this approach known as ‘social prescribing’ and benefit from input from the organisation ‘Altogether Better’ to recruit, train and support the health champions.

A New Approach

Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community. They organise activities and groups and work with other voluntary sector organisations, to help patients overcome loneliness and improve their general wellbeing.

Activities on offer that have been set up and run by champions include walking groups, singing, drama, IT sessions, allotments and cookery sessions. This goes beyond traditional volunteering and instead encourages co-production between surgeries and their patients.

The difference made by the Practice Health Champions

Following roll out, Alvanley has seen attendance drop among the 30% of highest use patients and a real improvement in patients’ health and wellbeing. Further unintended benefits include improved GP morale, reduction in staff sickness and improved links with local communities and businesses.
4.2. Transforming Primary Care

4.2.1. Our new local care models are being built around a transformed primary care system. To increase the pace and scale of that reform we have invested an additional £41m in primary care in Greater Manchester linked to a set of clear delivery milestones for each locality.

4.2.2. All areas in Greater Manchester now offer seven day access to General Practice, providing additional GP and practice nurse appointments in the evenings until 8pm and at weekends. This is an additional 1,500 hours of clinical time per week and is delivered from primary care hubs in each of the localities in Greater Manchester. Patients can book appointments via their usual GP practice.
4.2.3. We have delivered on our commitment to establish a single world-class hub to support General Practice in quality improvement and take a proactive response to vulnerabilities in the sector. The GP Excellence Programme is now in place through a strategic partnership with the Royal College of General Practice. An investment of £2m has been identified to fund the programme.

4.2.4. We support the delivery of Pride in Practice through the LGBT Foundation. Pride in Practice is a quality assurance and social prescribing programme for primary care services and lesbian, gay, bisexual and trans (LGBT) communities. The initiative has supported 264 primary care services to be able to meet the needs of LGBT people in Greater Manchester. Over 1,500,000 patients across our conurbation are now registered at Pride in Practice GP practices.

4.2.5. We are implementing our Focused Care model, aimed at supporting patients and staff working in over 31 GP practices in areas of severe deprivation. Over the last 12 months over 600 cases from across these GP practices have been referred to the programme.

4.2.6. Our local high street opticians are encouraging children to have regular eyesight tests, through the ‘See More, Learn More, Go Further’ project. The project highlighted the importance of good eye health and having regular sight tests for children. The next step is to build on the success of the work and prepare to expand it across Greater Manchester schools.

4.2.7. We are supporting our local GP practices by funding a programme to support pharmacists working in general practice across Greater Manchester. Pharmacists are working with GPs and nurses to support patients to get the best from their prescribed medicines and manage medical conditions.

4.2.8. The Asylum Health primary care programme has supported GP practices through training events and surgery visits to improve the knowledge and understanding of staff about asylum seekers and refugees. A video was put together, in conjunction with Hope Citadel Healthcare, named ‘How to register at a NHS GP’. This was subtitled in English, French, Kurdish, Urdu, Arabic and Farsi, and was sent as targeted Facebook advertising to specific language groups within the Greater Manchester area over a three month period. It has reached 84,588 people to date.

4.2.9. Improvements in general practice in Greater Manchester are shown by data on Patient Experience of GP Services. In the most recent survey 85.7% of those asked in Greater Manchester described their GP surgery as ‘very good’ or ‘fairly good’. This was up from the previous score of 85.4% in March 2016 and above the England average of 84.8%.

4.2.10. The case study from Oldham below gives a local example of the implementation of primary care transformation.
As noted earlier in this report, our performance on Urgent and Emergency Care has been challenging for some time. This year, we established a comprehensive Greater Manchester Urgent and Emergency Care Improvement Programme.

We have agreed four main areas of work for this programme:

- Stay Well
- Home First (attendance and admission avoidance)
- Patient Flow
- Discharge and Recovery

Underpinning all of these areas of work is the development of locality-level fully integrated urgent care services. The case study from Rochdale at the end of this section shows one example of local, innovative solutions to tackle the challenges of the urgent care system.
4.3.4. We have developed a model that provides a combination of virtually and physically co-located 24/7 urgent care services that will act as a true single point of access for care and treatment in each locality. These will have strong links into neighbourhood teams.

4.3.5. We have introduced primary care streaming at all Emergency Departments across Greater Manchester. Implementation was completed in preparation for the winter period and has proven to be highly successful in helping identifying patients with primary care needs much earlier. Around 200 patients across Greater Manchester each day are now streamed to primary care. This has helped reduce crowding in Emergency Departments and improve the experience for patients.

4.3.6. We established a Greater Manchester Urgent and Emergency Care Operational Hub in November to help provide support to organisations and systems to manage demand and patient flow in and out of hospital. The hub operates 24/7 and has established real time data feeds from all hospital emergency departments to help them monitor and respond to issues.

4.3.7. The Hub has proven invaluable during a challenging winter period in supporting organisations and systems. Despite a significant amount of winter planning and preparation, we saw increased demand on the system which negatively impacted on emergency departments’ ability to discharge or admit patients within four hours.

4.3.8. Improving our performance against the four-hour waiting standard for A&E is one of our highest priorities. 2017/18 was a particularly challenging year for us with an overall performance of 87% against the four-hour standard compared to national performance of 88.4%. This will be a major focus in 2018/19.

4.3.9. However, we did see significant improvements following our review of patients in acute hospitals whose transfer of care is delayed (known as a DTOC). In March 2018, there were 1,821 fewer beds occupied by patients whose care was delayed in acute trusts when compared to March 2017. In 2017/2018 there were 14,035 fewer bed days lost due to delayed transfers of care when compared to 2016/2017.
4.4. Transforming Hospital Care

4.4.1. The Standardising Acute and Specialised Care Programme aims to bring the region’s hospitals together to work more closely across a range of hospital services; to make sure expertise, experience and efficiencies can be shared widely in order that residents in Greater Manchester can benefit equally from the same high standards of specialised care.

4.4.2. The Programme is building on previous hospital transformation work and is responding to the changing needs of our population, making best use of our resources and compliments the shift in how care is and will be delivered in the community and at a local level.

4.4.3. It has been clear for some time that simply working our current hospital based models of care harder to meet rising demand is not the answer. Rather, the NHS needs to work differently by providing more care in people’s homes and the community and breaking down barriers between services.

4.4.4. In 2016, hospital Trusts and CCGs worked together to develop a list of acute and specialist hospital services, which could potentially be improved and made more sustainable in the future. As a Partnership we established links with other Greater
Manchester workstreams to ensure that we were not working in isolation and that a wide circle of partners were involved in developing joined up health and care services.

4.4.5. We have been engaging with key stakeholders to support and inform the work of the Programme. These discussions were mainly led by and involved doctors, nurses and wider healthcare professionals coming together as experts by forming design and oversight forums. These forums consider how each specific service could be improved upon for the benefit of patients, and importantly, how patient experience could inform the work being undertaken.

4.4.6. We created decision making processes, governance and assurance structures for the Programme, which are there to ensure that any changes that take place are done equitably, in the right way and complies with NHS rules and regulations.

4.4.7. We have enabled patient and Healthwatch representatives to actively and equally participate in informing our models of care and this activity will continue to grow. We have developed a Communications and Engagement Strategy and Operational Plan to support this work as it progresses so we keep listening and learning from all of our stakeholders as services are being reviewed.

4.4.8. Three services which are now part of the Programme were publicly consulted on in 2014/15 as ‘Healthier Together’. This involved the redesign of General Surgery, Acute and Emergency Medicine across the region.

4.4.9. The range of hospital services in the scope of this Programme are as follows:

4.4.10. Implementation Stage:
- General Surgery
- Acute and Emergency Medicine
- Gynaecology Cancer
- Urology Cancer
- Oesophageal Cancer

4.4.11. Design Phase:
- Cardiology
- Respiratory
- Musculoskeletal/Orthopaedics
- Benign Urology
- Paediatrics
- Breast Services
- Vascular
- Neuro-Rehabilitation
- Critical Care & Anaesthetics (as a co-dependency)
- Aspects of Clinical Radiology (as a co-dependency)
- Aspects of Clinical Pathology (as a co-dependency)
- Ophthalmology (in scoping phase)

4.4.12. During 2017/18 the Partnership has supported Salford Royal NHS Foundation Trust (SRFT) in driving forward improvements at Pennine Acute Hospital Trust (PAHT). In a CQC report published in March 2018, the overall rating of PAHT has since improved, from ‘Inadequate’ to ‘Requires Improvement’ following its inspection of services carried out in October/November 2017. The CQC has found significant improvements have been made across every hospital with 70% of the aspects of the services inspected now rated as either ‘Good’ or ‘Outstanding’. There are now no longer any services across the PAHT which are rated as ‘Inadequate’. The most significant improvements have been made in key areas including Maternity Services and Urgent and Emergency Care.

4.4.13. In 2017, Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester Foundation Trust (UHSM) joined together to create a new city wide Foundation Trust, Manchester University NHS Foundation Trust (MFT). The proposed transfer of North Manchester General Hospital (NMGH) to become part of MFT is also part of the plan to create one single hospital service providing consistent high quality care to patients across Manchester, Trafford and surrounding areas.

4.4.14. In 2017/18 NHS Improvement outlined its proposal for SRFT to explore the acquisition of the Oldham, Bury and Rochdale hospital sites and associated community services, currently part of PAHT, to become part of a new Northern Care Alliance (NCA) hospital group. The proposed future management and ownership of Pennine Acute’s hospitals is essential to support the future clinical and financial sustainability of acute hospital services including those currently run by PAHT across GM.

4.4.15. A Pennine Acute Transaction Board was established in 2017 to oversee the process and proposed acquisition of all sites, independently chaired by the Chief Officer of the Partnership. All partners are committed to the future of NMGH, they agree it has a positive and vibrant future, continuing to provide much needed health and care services to the local population of North Manchester, as well as, those who will travel from other parts of Greater Manchester to use its services.
4.4.16. This year we established a new programme for elective care in Greater Manchester. At the centre of this is our Elective Hub – allowing us to also improve data quality across the elective pathway, including live flows and patient tracking.

4.4.17. Our work in this area builds on a strong foundation. Our Referral to Treatment within 18 weeks’ performance in Greater Manchester stood at 90.4% for 2017/18 - ahead of the England average of 87.2%.

4.5. Adult Social Care

4.5.1. While we have more joined up working between health and social care than anywhere else in the country, we know that there are a range of problems we need to tackle in adult social care to ensure a sustainable, high quality model for the future.

4.5.2. This year we developed a `Care at Home' framework to be rolled out with localities which is about working with partners to support people to maintain their independence and ensuring interventions and prevention models are in place so that people can avoid going into long term support services.

4.5.3. This new framework is at the centre of our plans. We also have a number of other work programmes that seek to address the challenges the sector faces. In 2017/18 we:

- Established the Greater Manchester Independent Care Sector Network with 150 provider members so far. This network will support and facilitate both GM-level and locality engagement on a strategic level and will help to build strong partnerships and support collaborative working all to improve the system for people using services.

- Commenced the process of establishing the first cohort of Care Homes to develop the Teaching Care Homes model;

- Set up a programme dedicated to improving the quality of care homes with an established group of quality leads from across Greater Manchester. These leads are working together to improve the quality of care delivered, the quality of life experienced by people living in care homes and ensuring care homes are placed as equal partners in the social care sector.

- Developed a new Carer’s Charter and Commitment to Carers – carer representatives and the voluntary sector have worked with us to develop this. We will ensure that all carers in Greater Manchester are identified as early as possible and receive the right support. We have appointed an Independent Chair/Carers Champion who will play a key role in making sure carers’ issues are represented at the highest level across Greater Manchester.

4.5.4. We are beginning to see indications of improvement within the sector. For example, the proportion of Greater Manchester Care Homes inspected and rated Good or
Outstanding has gone up from 55% in April 2016 to 68% in June 2018 (latest figures).

4.6. **Learning Disability**

4.6.1. As with other parts of the country, we are supporting people with learning disabilities so that they can live in the community and move safely out of hospital settings. We are performing well against NHS England targets with many people resettled in new homes with the right support in place.

4.6.2. At the end of March 2018, there were 115 Greater Manchester inpatients within the Transforming Care Programme against a target of 119. 44 of those inpatients were in beds commissioned by Greater Manchester CCGs and 71, including 6 children and young people, were in beds commissioned by NHS England specialised commissioning. There has been an overall reduction in inpatient numbers of 25 since March 2017 when inpatient numbers stood at 141.

4.6.3. In addition, new assessment and treatment beds were commissioned in line with the national Building the Right Support service model which aims to provide inpatient treatment for a short periods of time for those that require it with a focus on supporting individuals to move safely back to the community. The service includes targets to discharge 75% of inpatients within three months and 90% within six months.

4.6.4. To support community Learning Disability teams to prevent admissions to hospital and facilitate discharges we established a new Specialist Support Team to provide intensive support to those at risk of admission and those recently discharged. The SST is a multi-disciplinary team which will work alongside local teams and provide specialist input in forensic cases and provide an out-of-hours 24/7 service.

4.6.5. Localities have also committed to increasing employment opportunities for people with a learning disability – all 10 have agreed targets and we have also developed some best practice standards around this for commissioners, providers and practitioners.

4.6.6. We also secured over £1m investment to support to develop new autism services and early intervention services for children and young people with complex support needs.

4.6.7. To bring all of this work together we are developing a Greater Manchester Learning Disability Strategy. Self-advocates, families and professionals are all working with us on this

4.7. **Housing and Health**

4.7.1. We know the importance of the link between safe, decent housing and health. Our Housing and Health programme will integrate housing into health and social care delivery.
4.7.2. To lead this work, this year we set up an innovative housing and health programme with a cross sector programme board – chaired by a GP.

4.7.3. Homelessness is a Mayoral and Greater Manchester priority. We have committed to supporting this agenda through improving access to health services for people experiencing homelessness and agreed the following priorities this year:

- Ensuring all people experiencing homelessness can register with a GP;
- Developing a GM Homeless Hospital Discharge Protocol to ensure that, where possible, there is no discharge to the streets;
- Supporting localities to develop outreach of health services into homelessness settings and onto the streets;
- Supporting localities to take a more flexible and joined up approach to commissioning services for people who are homeless or have complex needs;
- Pilot an approach to Mental Health outreach and support localities to develop services based on pilot outcomes;
- Support health and care providers to implement the Homelessness Reduction Act.

4.7.4. We have included a case study from Bury as part of this section to illustrate a local approach to tackling health and care need associated with homelessness.

4.7.5. Another major priority is the reform of the Supported Housing market in Greater Manchester. We want to work with housing partners in localities to develop models of supported housing and care that respond to the needs of our older population and those requiring support – enabling them to live healthy, safe, fulfilling lives. We took a significant first step this year by carrying out an audit of current provision to help us understand our future needs.
4.8. Mental Health

4.8.1. In July 2017, we committed to investing £134m in a coordinated approach to tackling mental health. The investment, which we believe is the biggest and most ambitious of its kind in the country, aims to put mental health on an equal footing with physical health.

4.8.2. It also seeks to ensure that no child who needs mental health support will be turned away. Nearly 60% or £80m (of the £134m agreed for mental health) is dedicated to children, young people and new mums.

4.8.3. Since the agreement of the investment in mental health, colleagues from across health and social care have been turning these plans into a reality.
4.8.4. One of the most significant achievements so far has been the launch of the Mentally Healthy Schools Pilot in March 2018. It is a six month pilot that is being delivered by four voluntary sector providers in a number of different schools across Greater Manchester. The pilot is working with staff and children and young people to encourage the development of mental and emotional wellbeing.

4.8.5. This year we have also made significant progress in implementing five different mental health programmes. These are:

- Perinatal and Parent-infant Mental Health - to establish a Greater Manchester wide approach to identifying and meeting the needs of parents and infants in pregnancy and the first two years of life by providing swift and easy access to mental health services;

- Children and Young Peoples (CYP) Mental Health Workforce Development - through roll out of the iTHRIVE model (a programme to accelerate improvement for mental health services for children and young people) for delivery of CYP Mental Health services;

- Liaison Mental Health services - by 2020/21 no acute hospital in Greater Manchester should be without all-age mental health liaison services in A&E departments and inpatient wards;

- Children and Young People’s Crisis Care Pathway - to develop a Greater Manchester wide crisis care pathway that provides a high quality and timely response to young people in crisis and their families and is accessible seven days a week

- Mental Wellbeing and Suicide Prevention – to develop a suicide bereavement liaison service across Greater Manchester to support people affected by deaths from suicide.

4.9. In February 2018 the specialist Perinatal Community Mental Health service was launched and referrals into the service are now taken in South Manchester, Central Manchester, Trafford and Stockport. Capacity to extend the service is being built and it will be rolled out to other areas of Greater Manchester in autumn 2018.

4.9.1. In April 2018, Salford Royal hospital became the first site to extend their Liaison Mental Health services and this will shortly be followed by the Royal Oldham hospital in early autumn 2018.

4.9.2. We are clear that our investment in mental health must lead to improvements in the national performance standards. For instance, in 2017/18, whilst we improved our performance on the six and 18 week standards for access to psychological therapies, we are still behind the England average. In addition, the proportion of people who completed treatment through psychological therapies and were moving to recovery in Greater Manchester during 2017/18 was 48.9%; the recovery rate across the whole of England was higher at 50.8%.
4.9.3. We have included a local case study here from Bolton that outlines the approach being taken in that locality on mental health crisis care.

**Locality Case Study – Bolton – Mental Health Crisis Care**

**Background**

Using Transformation Fund monies, partners in Bolton have launched a new Mental Health Crisis Care service at Royal Bolton Hospital. The new service includes an A&E diversion service post-triage and mental health ambulatory care area (the Rivington Unit) to provide care and support to people experiencing a mental health crisis in a safe and appropriate environment outside of the Emergency Department, thereby preventing unnecessary attendance at A&E.

**A New Approach**

The benefits of this new way of working include:

- Providing a therapeutic mental health ambulatory care area that is more conducive to improved patient care and experience;
- Efficient and effective identification of patients presenting to A&E who can be managed in a more appropriate service and sign posting them based on patient need;
- Reduced pressure on Rapid Assessment, Interface and Discharge (RAID) services. RAID is a mental health service that specialises in understanding the link between physical and mental health. Reducing the pressure on RAID releases capacity to support more complex or high acuity patients;
- Driving a longer term culture change in A&E in the management and treatment of people experiencing a mental health crisis, improving their outcomes and experience;
- Improved integration of mental health crisis services, including RAID and The Sanctuary, a safe space to talk and seek support when in crisis.

**Impact of the new Mental Health Crisis Care service**

The service is working efficiently to assess and support patients in a timely manner. 91.3% of patients referred were seen within 1 hour of referral from A&E. A positive impact has been seen on the Bolton health and care system. Most notably, the service has supported a 23.6% reduction in non-elective admissions to hospital for patients presenting with a mental health condition. The benefits of developing an integrated model with RAID and the Sanctuary have been demonstrated through significant improvement in the number of emergency referrals to RAID assessed within one hour to 91.3% in March 2018.

4.10. Dementia

4.10.1. We know that dementia will be a growing challenge as our population ages. Our strategy, Dementia United, aims to make Greater Manchester the best place in the world to live for people with dementia.

4.10.2. In Greater Manchester, we consistently achieve higher rates of dementia diagnosis than the national average. As at March 2018 our estimated rates are at 76.4% whilst the national average is 67.5%. But we are ambitious to do much more to improve the quality of care and support for people with dementia.

4.10.3. In 2017/18, we agreed our work plan for Dementia United with all partners in Greater Manchester – and backed this with an investment of over £2m.
4.10.4. The range of projects within the work plan are shown below:

4.11. Cancer

4.11.1. Around 16,000 people in Greater Manchester are diagnosed with cancer every year. We know that people here have a greater chance of getting cancer than the national average. Around 800 fewer people here would have the disease if our incidence were the same as the England average. Despite this, our patient outcomes and system performance in many areas are among the best.

4.11.2. Our vision is for people in Greater Manchester to have the best chance of avoiding or surviving cancer and we have a comprehensive plan in place. This year we have taken some vital steps to deliver that plan. We have:

- Working with community and voluntary sector partners, pioneered the Cancer Champions movement. We launched this initiative in January 2017 and now have over 2,000 Cancer Champions in Greater Manchester;

- Early detection of cancer greatly improves the chances of successful treatment. We are developing, in conjunction with the University of Manchester, an innovative online system to allow individuals to refer themselves to a GP for further investigations for suspected cancer;

- In 2017, The Christie opened a new £7.6m Integrated Procedures Unit (IPU), a state of the art unit that brings a number of day patient services under one roof. It aims to shorten waiting times for patients and has longer opening hours to make it easier for patients who need to fit appointments around work. Work
also continued to develop the ground-breaking proton beam (a specialist form of radiotherapy that can target cancers more precisely) therapy centre at the Christie.

- Carried out a pilot lung health check programme led by University Hospital of South Manchester NHS Foundation Trust (now part of MFT) and Macmillan focused on deprived areas. People received an invitation to a Lung Health Check, which was less likely to cause anxiety than ‘lung cancer screening’. This led to a significant increase in early stage lung cancer being diagnosed. The pilot has illustrated that more than 750 lung cancer patients could be diagnosed much earlier if the programme were rolled out across Greater Manchester.

- Confirmed Greater Manchester as part of the NHS England Cancer Vanguard, leading the way in developing new ways of caring for patients with cancer. Our involvement in this initiative has brought in an additional £2.3m in funding.

4.11.3. The 2017 annual National Cancer Patient Experience Survey showed that we have an average rating of 8.8/10 – which is better than comparable city regions – and we continue to improve each year.

4.11.4. There are challenging national standards for cancer that are set nationally – including that patients should be treated definitively within 62 days in the vast majority of cases. This year, 85.0% of patients in GM were first treated within 62 days of referral. This was higher than England as a whole (82.2%) but we will always strive to improve further on this.

4.12. **Person and Community-Centred Care (PCCA)**

4.12.1. In Taking Charge we made a commitment to support individuals and communities to take more control over their own health and wellbeing. The PCCA programme has begun to bring this commitment to life.

4.12.2. In 2017/18 we agreed a strategy and investment of over £1 million for our PCCA programme focused on social prescribing; asset-based approaches; person-centred care and support planning and integrated personal budgets. Our focus next year will be working with the 10 localities to deliver this programme

4.12.3. The case study below from Manchester illustrates how making community connections can help tackle growing problem of social isolation.
4.13. Diabetes

4.13.1. We know that up to 25% of the Greater Manchester population are expected to develop diabetes in their lifetime. The main reason for this rise is the increased numbers of people with Type 2 diabetes, a preventable disease, linked to poor diet and lack of exercise.

4.13.2. We have developed the Greater Manchester Diabetes Clinical Best Practice Strategy which articulates a vision of best practice for diabetes care in GM and proposes actions and interventions aimed at achieving that vision.
4.13.3. This initiative is the first time that the diabetes care system has come together across the whole of Greater Manchester to develop and agree a comprehensive and consistent strategy for improvement.

4.13.4. This year also saw us continue the successful roll-out of the National Diabetes Prevention Programme ‘Healthier You’.

4.14. **Palliative and End of Life Care**

4.14.1. This programme aims to support people to live well and with dignity, in the place of their choosing, during their last year of life.

4.14.2. During National Dying Matters week 2017 we successfully promoted a campaign called the Art of Dying to encourage people to talk more openly around the subject of death, dying and bereavement.

4.14.3. We encouraged localities to submit works of art to an online gallery, where the public could view and vote for their favourites. The website received 14,607 votes and around 180 pieces of art were submitted. The 10 artists receiving the most votes on the website were invited to display their art alongside a large canvas that each locality had created at the Whitworth Art Gallery. This drew over 1,200 visitors.

4.14.4. Working with specialist palliative care education centres in the North West, we have successfully bid for funding to improve the skills and confidence of the workforce in delivering end of life care. This will see one day courses being delivered to front line staff across Greater Manchester.

4.15. **Cardiovascular Disease (CVD) Improvement Programme**

4.15.1. Cardiovascular Disease is one of the major health issues facing is in Greater Manchester. In Taking Charge we set an ambition to reduce the number of people who will die early from CVD - resulting in 600 fewer deaths by 2021.

4.15.2. To move us towards this goal in 2017/18 we:

- Commenced the rapid access to coronary angiography project (RAACS) to ensure all appropriate patients have an angiogram within 24 hours of their first medical contact. The new pathway, which has been piloted, will now be rolled out across Greater Manchester by 2019;

- Co-ordinated the formation of the Out of Hospital Cardiac Arrest Steering Group. We have set out what should happen from the point of resuscitation to management within designated treatment centres at Manchester Royal Infirmary and Wythenshawe Hospital;

- Set out our plans to establish a Greater Manchester Cardiac & Stroke Strategic Clinical Planning and Oversight group – which will come into place in 2018/19.
4.16. **Emergency Planning and Response**

4.16.1. The terrible atrocity of 22nd May 2017 saw 59 patients transported by North West Ambulance Service (NWAS) to GM hospitals and 22 people losing their lives. Ten of those who lost their lives were aged between eight and nineteen years old.

4.16.2. The GM healthcare system treated 154 patients who attended emergency departments for tissue injuries. Approximately 300 people were eventually treated at hospitals and/or in the community across the country.

4.16.3. We implemented our existing mass casualty plan and hospital data suggest that plan had been implemented successfully.

4.16.4. Many of the victims needed three to four weeks to complete all definitive physical treatment and it was two months before the operational and financial performance of the most impacted hospitals in Manchester could return to ‘business as usual’.

4.16.5. For those who had lost loved ones Family Liaison Officers and Bereavement Nurses offered a vital service. We established the Resilience Hub to support people whose mental health or emotional wellbeing has been affected and this team has worked with over 3,100 people with 21% under 16 and continues to offer support to those affected.

4.16.6. We continue to revise and review resilience plans and arrangements with partners to ensure we maintain our preparedness for unforeseen events and risks building on the learning from the Kerslake Review – the independent report into the emergency response to the Manchester Arena attack.

5.0 **ENABLING BETTER CARE**

5.1. We will only be able to achieve the radical changes we are seeking with the right supporting infrastructure in place. This includes research and innovation, digital, and most importantly a skilled workforce.

5.2. **Research and Innovation**

5.2.1. This year, we brought together Manchester Academic Health Science Centre (MAHSC) and Greater Manchester Academic Health Science Network (GMAHSN) into a single umbrella organisation - Health Innovation Manchester. This brings together the entire discovery-care continuum from research to implementation under the umbrella of a single entity; working in partnership with industry to drive research and innovation that is aligned to health and social care needs.

5.2.2. We have, through Health Innovation Manchester (HInM), developed a single innovation pathway for the entire Greater Manchester health and care system - simplifying the landscape for researchers and industry innovators.

5.2.3. Our new, more systematic approach to research and innovation is beginning to deliver results. This year we have:
• Put in place an innovative approach to managing Chronic Obstructive Pulmonary Disease (COPD) to avoid the need for hospital admission – piloted with 11 Manchester GP practices;

• Commenced a major programme on Hepatitis C elimination – working to the standard set out by the World Health Organisation;

• Continued to develop a programme called Healthy Hearts – working to make sure that those at high risk have the right statin dosage, targeted stroke prevention and blood pressure detection control;

• Worked collaboratively to deliver local improvements on Atrial Fibrillation (AF) management and detection. This has already prevented an estimated 13 strokes in Greater Manchester and resulted in 468 patients being offered treatment with specialist pharmacists, and where necessary assessment in primary care.

• Deployment of ERAS+, a pre-and post-operative surgery programme to optimise patient recovery. Implementation at one trust has reduced post-surgery pulmonary complications by 50% resulting in a 3-day reduction in length of stay. A £500k grant award has been secured from the Health Foundation to take this work forward including the roll-out across six trusts in Greater Manchester;

• Established the Greater Manchester Research Hub to provide an integrated approach for research delivery across the city region. This provides a one-stop for interested parties to access clinical trials expertise and infrastructure.

• Created a Health Innovation Manchester - National Institute for Health and Care Excellence (NICE) DataLab. Linking different data-sets together and using state-of-the-art analytics, the DataLab is testing how big data can provide evidence relating to the effectiveness of new and existing treatments.

5.3. Digital progress

5.3.1. Our ambition in Greater Manchester is to be a top-five European digital region. The Health and Social Care Partnership is playing a full role in this.

5.3.2. In 2017/8, we established The Digital Collaborative Portfolio and Implementation Plan. The IM&T Strategy was approved and progress against made against prioritised projects, including:

• An agreed Greater Manchester wide contract for electronic document transfer extending usage for Pharmacy/Dentistry/Optometry and Local Authorities was approved;

• Awarded primary care capital investments into a number of localities to support the creation of integrated digital care records;
• We also agreed a single Wi-Fi standard for health and social care across GM enabling connection from any location;

• £10m of funds have been awarded and spent on a range of digital projects across localities including providing health visitor staff with electronic devices supporting mobile working.

5.3.3. Our comprehensive digital strategy has put us in a strong position to attract national funding. For example, Greater Manchester will become a Local Health and Care Record Exemplar (LHCRE) to establish an integrated health and care record across our city region. Our success in this national process means £7.5m investment for Greater Manchester.

5.3.4. There are numerous examples of local digital innovation in Greater Manchester – the case study below from Tameside is a good example of this.
5.4. **Workforce**

5.4.1. The Greater Manchester Health and Social Care Workforce Strategy and Implementation Plan was finalised in 2017. The Workforce Collaborative was set up to deliver this.
5.4.2. Partners across Greater Manchester agreed four key priorities for the workforce plan. These are shown below:

5.4.3. This year we have taken some important steps to deliver the plan, including:

- The first ever Greater Manchester Health and Care Champion awards will take place on 13th July 2018 – a microsite was created to support nominations and received over 3,000 unique visits;

- Commissioned a report on incentives for Nursing and Allied Health Professional careers to improve recruitment, retention and return to practice in Greater Manchester. We have a good platform to build on as Greater Manchester performed well this year on nursing recruitment – and this included securing more than 240 nursing associate places;

- First ever Greater Manchester Health and Social Care Labour Market Intelligence Report developed. This has supported four in depth reports on hard to fill work areas: radiology; urgent and emergency care; maternity and children’s; and social care/social work;

5.5. Estates

5.5.1. We will only be able to transform health and social care if our estates are fit for purpose and deliver value for money. We are working in partnership across the public sector in Greater Manchester with a one public estate approach.

5.5.2. We have a number of projects which are already underway. These include:
We are supporting work to develop Local Care Organisations across Greater Manchester. In some cases, this will involve the creation of physical hubs which will bring together community and primary care services;

We are reviewing our public sector estates across Greater Manchester. This will help us understand whether there are any opportunities for further investment and for us to rationalise our estate;

We are linking in with colleagues in hospitals to look at how we could change the way we use the space at hospital sites to support innovative ways of working in future;

We are looking at how we can make the best use of our existing estates. This includes looking at opportunities to bring more services together and support joined up working.

5.5.3. In addition to these individual schemes we continue to work closely with colleagues across Greater Manchester to ensure we have the most appropriate premises from which to deliver our vision for integrated health and care. This work includes reviewing all locality assets, completing master planning work on the main hospital sites across Greater Manchester, developing a robust pipeline for future capital investment across the region and where investment is required identifying and sourcing the most appropriate funding for those developments.

5.5.4. A significant amount of our funding has also been secured from external sources, such as the Department of Health, and so brought much needed investment into Greater Manchester. We successfully bid for £63 million for Healthier Together – a project which involves hospitals across Greater Manchester working more closely together. We have also been awarded £30 million to construct a new Major Trauma Centre at Salford Royal.

5.6. Commissioning Reform

5.6.1. In 2017, we conducted a detailed review and options appraisal of health and care commissioning functions and future form across Greater Manchester. This is focused on the three areas below.

5.6.2. Place based commissioning - localities have produced their key milestones in developing a SCF (Social Commissioning Function) in their area.

5.6.3. Commissioning at Scale - this includes commissioning of some services once at the Greater Manchester, where it makes sense to do so. A GM Commissioning Hub was established in December 2017.

5.6.4. Commissioning Support – this includes the design of commissioning support services that that are responsive and effective, in the context of the newly shaped commissioning landscape.
5.7. **Clinical and Corporate Support Services**

5.7.1. Clinical and Corporate support services are instrumental in joining up systems and services to deliver the best possible care.

5.7.2. To allow the seamless sharing of images across Greater Manchester – any image, available to any appropriate clinician, at any time - the GM Collaborative Imaging Procurement has been approved by all GM Radiology providers.

5.7.3. A strategic outline case for the consolidation of laboratory services across Greater Manchester has been produced and approved by a newly formed Pathology Programme Board. This is our first step to implement our agreed vision for pathology services in 2022.

5.7.4. Significant progress has been achieved in establishing a unified hospital pharmacy supply chain model across Greater Manchester. The key element of the proposed operating model is the implementation of a single consolidated pharmacy supply chain ‘hub’ that delivers efficiencies across hospital sites.

5.7.5. ‘Your Medicines Matter’ has surpassed its campaign target by encouraging more than 60% of patients across Greater Manchester to bring their own medicines into hospital thus helping to improve safety, reducing the associated costs of duplicate medicines, reducing medicine waste and therefore delivering additional annual savings of around £1m.

5.8. **Greater Manchester Transformation Fund**

5.8.1. Greater Manchester’s £450m Transformation Fund (awarded by NHS England over five years) aims to help us transform services across all GM areas and deliver long-term clinical and financial sustainability.

5.8.2. By the end of 2017/18, all of the 10 localities had secured multi-year funding to support delivery of their locality plans. The funding awarded in 2017/18, following on from that awarded the previous year, was:

- Bury £19.2m
- Rochdale £23.9m
- Oldham £21.9m
- Trafford £23m
- Salford Population Health £3.4m
- Wigan (Second Phase) £15.1m

5.8.3. Additionally one-off development funding of £8m was awarded to a number of themes, cross cutting programmes and enablers to support the development of transformation plans in 2017/18 and into 2018/19.
5.8.4. All of the investments will be underpinned by a formal agreement with the GM Partnership that commits the recipient of the funding to the delivery of a series of milestones and metrics, including a crucial focus on reducing acute activity levels allowing for cashable efficiencies to be made.

6.0 FINANCE & ANNUAL ACCOUNTS

6.1. The 17/18 financial year represents the second year of GMHSC Partnership as a devolved system. In line with the Accountability Agreement, we are accountable to NHS England in delivering financial performance in line with agreed system control totals for GM.

6.2. For 17/18, financial control totals were agreed for all NHS bodies i.e. NHSE GM local office, CCGs and NHS Providers in accordance with the Business Rules set out in the NHS Operational Planning Guidance 2017-2019 jointly published by NHSE and NHSI. Our Local Authority partners are not subject to the NHS business rule requirements although are statutorily required to set a balance budget and deliver a break-even position at year end. All GM Local Authorities planned for a balanced budget for the elements of their budgets which fall within the remit of health and social care.

6.3. It is the responsibility of GMHSC Partnership to ensure effective financial management is maintained across all sectors in managing financial performance and robustness of assumptions used in forecasting at an individual organisation, locality and a GM level.

6.4. During the year, the financial performance of all sectors within GM was routinely monitored and reported to the Finance Executive Group (FEG) in discharging their oversight role of the financial performance of GM against its control total, expressed as a surplus / (Deficit) Plan. A suite of financial dashboards and indicators are routinely presented to FEG setting out financial performance at an organisational level, Locality, sector and consolidated at GM level.

6.5. Financial Position 17/18

6.5.1. GMHSC had an agreed control total target set as an £18.5m deficit for Greater Manchester against which the financial performance of GMHSC would be measured in line with the Accountability Agreement with NHS England. The table below sets out the Plan surplus / (deficit) target across each of the sectors:
6.5.2. In accordance with 17/18 Business Rules, all CCGs were required to plan for break-even and to set aside 0.5% risk reserve to support management of in-year financial position and released at request of NHS England.

6.5.3. Throughout 17/18, unavoidable financial pressures have challenged all sectors within GM from a variety of sources ranging from increases in unplanned /emergency admissions into hospital, unprecedented increases in certain drugs costs due to supply side constraints and increased demands on Children’s services.

6.5.4. Given the financial pressures that have challenged Greater Manchester, most of which are in line with those impacting at a national level, it is a great reflection on GM working together as both Localities and wider GM system that all sectors have met or improved on their Plan position.

6.6. **Year End Position**

6.6.1. GM has delivered an outturn position better then Plan in 17/18 which is excellent performance given the financial challenges faced across all sectors during the year. The table below shows the financial performance against Plan for each of the sectors within Greater Manchester.

<table>
<thead>
<tr>
<th>Sectors</th>
<th>17/18 Plan surplus / (deficit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMHSCP Direct Funding</td>
<td>£0.0</td>
</tr>
<tr>
<td>Clinical Commissioning Groups (CCGs)</td>
<td>£3.1</td>
</tr>
<tr>
<td>NHS Providers (Acute &amp; Mental Health)</td>
<td>(£21.6)</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>£0.0</td>
</tr>
<tr>
<td><strong>Total GM Position</strong></td>
<td>(£18.5)</td>
</tr>
</tbody>
</table>
6.6.2. GM has delivered a surplus of £89m which represents an improvement of £107.5m against Plan. The NHS Provider sector delivered the majority of this improvement at £87.7m which reflects the improvement in performance by a number of Trusts which has attracted additional funding from the national Sustainability and Transformation Fund of c£57m. This surplus is retained by Trusts to support investment in capital schemes in future years.

6.6.3. Despite the in-year challenges faced by our CCGs, financial performance has also been pleasing given the collaborative nature of managing in year pressures within the sector. This approach has secured an improvement of £18.7m against Plan which broadly reflects the 0.5% risk reserve held back and released into financial positions at year end. All surpluses achieved by CCGs will be carried forward as ‘accumulated surplus’ although access to this still remains subject to national policy decisions and affordability.

6.6.4. It is pleasing to report that Local Authorities have been able to manage significant in-year pressures which have been mitigated through use of savings measures and access to reserves.

6.6.5. Looking ahead into 2018/19, GM is again required to deliver against national business rules, at a GM level and NHS Providers are required to agree to a control total set by NHSI in order to be eligible to receive Provider Sustainability Funding. The financial outlook in 18/19 will remain challenging with some NHS Providers still yet to agree to their control total and on the Commissioner side, both CCGs and Local Authorities have significant savings programmes at c£140m and c£80m respectively. However, the GM system has well established governance in place around financial performance and close working between all sectors of the GM system.
7.0 RECOMMENDATIONS

7.1. The Greater Manchester Health & Care Board is asked to:

- Endorse the 2017-18 Annual Report.
Two years in........

On 1 April 2016 Greater Manchester took charge of the £6billion spent on health and social care in our 10 boroughs, following our devolution deal with the government. We were also given an extra £450million to help transform services.

Devolution has given us the freedom and flexibility to do things that benefit everyone in Greater Manchester. We are making our own decisions. We’re tackling serious conditions like cancer and heart disease, and looking at bigger problems that affect our health.

In this document, we’ve highlighted some of the achievements over the last two years that have been started - or in some cases speeded up - by our ability to use our devolved powers and ways of working to do things differently in Greater Manchester. It also talks about our challenges ahead and the next steps towards our goal to see the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8m people of Greater Manchester.

What’s changed in 2017-18?

Two years after taking control of our health and social care budgets, we are starting to see some very positive changes that are making a difference to the lives of people in Greater Manchester.

Vital time was spent in this year and the year before working to come up with the right strategies, structures and governance. It was also spent sharing the money to make changes across all areas of Greater Manchester to ensure that the money is spent in the right way in local communities.

We have again demonstrated strong financial management and performance, increased investments and support to people to stay well.

It was also an exciting time as many of the plans were being put into action and we have started to see some benefits or ‘devolution differences’. You can read a few of these here.

Who’s steering the work?

Greater Manchester Health and Social Care Partnership is leading the transformation programme. It includes all Greater Manchester’s NHS organisations and councils, primary care, voluntary, community and social enterprise groups. NHS England, Healthwatch, the police and the fire service.

The Partnership is run by an executive team and our Health and Care Board (membership from all our partners) agrees and monitors the changes. You can find out what’s going on by attending, watching online or reading the board papers at www.gmhsc.org.uk.
Change on your doorstep

New models of care are now in every area joining up health and social care, budgets and resources.

Giving children a better start in life

Getting a great start in life makes you more likely to do well at school and get a good job. Yet we know that a third of our children aren’t ready to start school which can affect the rest of their time at school and their whole lives.

We are starting to see the benefits of our work with families to get children ‘school ready’. For example, in Wigan ‘Start Well’ workers help families to deal with issues like employment and housing problems that have an impact on their health. This support has seen parents getting back into education or employment, build stronger friendships in their communities and create better surroundings for their children to learn and grow up in.

Supporting people to live well

We want to support people at key stages of their lives when they can be most strongly influenced on how to look after their physical and mental health.

Greater Manchester has now become the first region committed to the Daily Mile – nearly half of our schools are already taking part.

We have made steps towards helping to tackle unemployment by helping people who are at risk of dropping out of work due to ill health.

We also launched our ‘making smoking history’ work through a major TV and multimedia campaign and by providing intensive support to smokers in hospitals.

After a huge effort throughout the winter months Greater Manchester has the highest rates of flu vaccination for vulnerable groups such as the elderly and young children.
Working very closely across health and social care is a very important step towards providing a more efficient service that meets the needs of everyone across Greater Manchester.

Examples of joint working include improving the quality of care homes this year. We know that there is still a lot more to do, however Greater Manchester is one of the most improved areas in the country.

Also, in 2017-18 we saw fewer patients face delays in being discharged from hospital. This has been achieved by closer working across health and social care through services.

Cancer can have a devastating impact on peoples lives. We want to help prevent it and make sure people get the fastest and best treatment available.

For example, in Manchester a mobile screening programme was piloted diagnosing people with lung cancer early – by 2020 this will be available across the whole of Greater Manchester.

We have a fast growing network of ‘cancer champions’ out and about in our communities helping spread the message about prevention, spotting the signs and having regular checks.

Hospitals are working together on a much greater scale to ensure that hospital care is of a consistent quality. For example, our stroke centres are top-rated and we estimate that over 200 lives have been saved because of the specialist care. We were also above the England average for hospital referrals and treatment within the 18 week national target.

We now have an ‘urgent and emergency care hub’ which helps us to monitor activity at all our hospitals so that we can help to predict and respond to high volumes of patients in Accident and Emergency.

Despite this, it was a very challenging year for urgent and emergency care therefore intensive work continues to make the improvements we need to.

Social care

Working very closely across health and social care is a very important step towards providing a more efficient service that meets the needs of everyone across Greater Manchester.

Examples of joint working include improving the quality of care homes this year. We know that there is still a lot more to do, however Greater Manchester is one of the most improved areas in the country.

Also, in 2017-18 we saw fewer patients face delays in being discharged from hospital. This has been achieved by closer working across health and social care through services.
Good mental health is as equally as important as good physical health.

In July 2017 we invested £134m to tackle mental health – it’s one of the biggest and most ambitious plans in the country. Nearly 60% of the investment is dedicated to children, young people and new mothers.

This year we launched a pilot in 31 primary and secondary schools to provide mental health and wellbeing training to build confidence, coaching in key life skills such as growing self-esteem, lessons to improve creative thinking skills and coping strategies for challenges. The plan is to roll-out this programme across Greater Manchester.

Working with the Mayor of Greater Manchester we have been identifying ways in which we can make things better for people experiencing homelessness. For example, all our hospitals ensure that, where possible, patients with no accommodation are not discharged onto the street. Our GPs are also taking on homeless patients.

We’re spotting and treating dementia quicker – seven more people a day are diagnosed with dementia, and getting the help and support they need.

We have, for the second year, helped people with a learning disability to move out of hospital environments and resettled them into new homes with the support they need. Our 24 hour specialist support team is also now in place to working with Community Learning Disability Teams.
The road ahead
Many of our plans are now in place and we have a number of things that we are aiming for in 2018-19:

Start well

- The best start in life means giving pregnant women and new mothers all the help they need.
- Safer births in our maternity units.
- For example, we have invested £1.7m in support to women and their partners who smoke in pregnancy. This year we would like to see an additional 1,250 babies who are born smoke free.
- At least 1,680 women to be able to access specialist community mental health support.
- We aim to have 75% of our schools taking part in the daily mile.

Live well

- We will be helping to tackle unemployment through providing support to up to 14,000 residents who are at risk of dropping out of employment due to ill health.
- We will be holding a ‘big alcohol conversation’ with the people of Greater Manchester, aimed at finding the best ways to reduce the harm caused by alcohol to our children and young people as a result of parental substance misuse.
- Improving uptake of flu vaccinations amongst people with long term conditions (like asthma and diabetes).

Age well

- Working with Greater Manchester’s transport system to ensure that public transport is more ‘dementia friendly’. This includes training to improve awareness of dementia among transport staff.
- To help older people to be supported to live independently and understand their long-term conditions so that they can stay well at home without reaching crisis and requiring hospital admissions.
In 2018 the Christie will be home to one of only two high energy NHS proton beam therapy (PBT) centres in the UK. PBT is an advanced form of radiotherapy used for the treatment of complex and hard-to-treat cancers in children and adults.

Cancer survival – we aim to save 1,300 lives by end March 2021 by improving 1-year survival to above 75% by 2020.

We are developing standards to increase the quality of our care homes across Greater Manchester.

Support with homecare with the aim of keeping people well and independent at home.

Mental Health

To continue to improve services for young people with eating disorders. Already young people across Greater Manchester are having a better, more consistent experience of eating disorder services.

To ensure that children and young people with Attention Deficit Hyperactivity Disorder (ADHD) have the same high standards of treatment across Greater Manchester.

To roll out our mentally healthy schools programme more widely.

Cancer

In 2018 the Christie will be home to one of only two high energy NHS proton beam therapy (PBT) centres in the UK. PBT is an advanced form of radiotherapy used for the treatment of complex and hard-to-treat cancers in children and adults.

Cancer survival – we aim to save 1,300 lives by end March 2021 by improving 1-year survival to above 75% by 2020.

Primary Care

There will be more ‘out of hours’ appointments with doctors and other primary care professionals available. We want 100% of our population to be able to access out of hours services.

Aiming for all babies to have a dental check by the age of one.

Social Care

We are developing standards to increase the quality of our care homes across Greater Manchester.

Support with homecare with the aim of keeping people well and independent at home.
Keeping you involved

We want to keep learning from your experiences and hearing your views and ideas. We’ll let you know what’s happening and how it may affect you.

You can visit our website at www.gmhsc.org.uk or get in touch with us directly:

Email: gm.hscinfo@nhs.net
Tweet: @GM_HSC
Call: 0161 625 7791 (during office hours)
Address: 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN
Date: 13 July 2018

Subject: GMHSC Partnership Business Plan – 2018/19


SUMMARY OF REPORT:

The Health & Social Care Partnership’s Business Plan sets out our priorities for 2018/19.

KEY MESSAGES:

The key messages are described within the executive summary on page 3 of the document.

PURPOSE OF REPORT:

The Health & Social Care Partnership’s Business Plan sets out our priorities for 2018/19 – the third year of delivery of Taking Charge.

The Plan was presented in draft form to the Health and Social Care Partnership Executive Board in April – and a more detailed version, taking into account comments from partners, was supported at that meeting in June.

The Board received an overview of the Business Plan in May – and we now present the final version for approval. Enclosed are:

- The full Business Plan 2018-19 plus appendices;
- A summary document – covering both the Plan and our Annual Report for 2017-18

RECOMMENDATIONS:

The GM Health & Care Board is asked to:

- Endorse the Business Plan for 2018/19
CONTACT OFFICERS:

Paul Lynch, Deputy Director – Strategy & System Development, GMHSC Partnership
paul.lynch@nhs.net
EXECUTIVE SUMMARY

This is the third year of delivery of Greater Manchester’s Strategic Plan for Health and Social Care Taking Charge. This Plan sets out our priorities for financial year 2018-19.

2018-19 sees us move fully into the third phase of our operation as a devolved system. The first phase – lasting until April 2016 – was focused on establishing the devolved settlement for health and care in GM; the second – broadly until autumn 2017 – saw us embedding our governance, strategies and programme structures as well as supporting the allocation of the majority of the Transformation Fund; the third has an absolute focus on implementation of our plans.

With this in mind, and to sharpen our focus on the work that will drive the outcomes we set out in Taking Charge, we undertook a prioritisation of our Transformation Portfolio with all of the constituent elements of the Partnership over the winter of 2017-18. This Business Plan is based mainly on that exercise.

In particular, the plan describes how our programme of reform will lead us to the system architecture in GM that will be in place as a legacy of Taking Charge:

- The establishment of 10 Local Care Organisations (LCOs) integrating provision;

- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten localities;

- New models of hospital provision seeing hospitals working together in Greater Manchester at a much greater scale than ever before to a set of consistent quality standards;

- A Greater Manchester-wide architecture where it makes sense to do things at greater scale – including the GM Commissioning Hub, Health Innovation Manchester, a Digital Collaborative and a Workforce Collaborative.

The major steps towards this architecture in 2018-19, described in this plan, include:

- The continued support of LCO development through the LCO Network – including implementation of the actions arising from the peer review process carried out in early 2018;

- Continuing to hold local systems to account for delivery of the milestones relating to their local care models and the activity shifts set out in their Transformation Fund Investment Agreements;

- The translation of GM-level programmes into neighbourhood delivery within LCOs. This will include parts of the Population Health Programme, Mental Health, Adult Social Care Transformation, Learning Disability, Person and Community Centred Approaches and the Housing and Health programme;
• Accelerating the pace of the review of models of care as part of our programme of Standardising Acute and Specialist Care – including modelling the impact of change across Greater Manchester;

• Delivering the first phase of our Urgent and Emergency Care Improvement Plan;

• Agreeing our plans for maternity services, diabetes, medicines, children’s health and end-of-life care;

• Supporting the development of Single Commissioning Functions (SCFs) through a peer review process;

• Developing the GM Commissioning Hub and working with all partners to confirm its scope and functions;

• Delivering Health Innovation Manchester’s work programme in its first full year of operation.

We do not underestimate the headwind in which this large-scale transformation is taking place. Finances remain constrained, we face some severe workforce shortages, and services across Greater Manchester face many other challenges.

All of these factors, and more, exert considerable pressure on our performance in Greater Manchester. In particular, we know that we must improve our Urgent and Emergency Care performance as failure to do so risks undermining the tenets on which our transformation programme rests.

We also know that there is too great a degree of variation across Greater Manchester – both in terms of performance and transformational change. For example, the pace of LCO and SCF development varies considerably in different localities. Whist recognising the differing circumstances in each locality, we will hold each other to account, and challenge and support within the Partnership, to close this gap.

As we move towards the next Government Spending Review, we must begin to prepare for the next phase of our work. This year will see our work on a Target Operating Model for the Partnership intensify and we will continue our dialogue at national level to secure further freedoms to serve the people of Greater Manchester.
**Contents Page**

1.0 Introduction ................................................. page 7
2.0 Delivering Our Transformation in 2018/19 ............... page 7
   The Transformation Portfolio .............................. page 7
   Our Approach to the 2018/19 Planning Round ............ page 8
3.0 Our 2018/19 Priorities ....................................... page 9
4.0 Improving the Health of all GM Residents ................ page 9
   Start Well .................................................. page 10
   Live Well .................................................. page 11
   Age Well .................................................. page 13
   Public Health Commissioning ............................. page 13
5.0 Transforming Care and Support ............................ page 14
   Local Care Organisations ................................ page 15
   Mental Health ............................................. page 17
   Primary Care ............................................. page 18
   Dental ..................................................... page 19
   Optometry ............................................... page 19
   Pharmacy ................................................ page 20
   Cancer ..................................................... page 20
   Learning Disability ....................................... page 21
   Adult Social Care ......................................... page 22
   Cardiovascular Disease (CVD) Improvement Programme page 23
   Diabetes ................................................... page 23
   Dementia ................................................. page 24
   Palliative and End of Life Care ............................. page 25
   Person Centred and Community Approaches (PCCA) .... page 25
   Housing and Health ...................................... page 26
   Urgent and Emergency Care ............................... page 27
   Standardising Acute and Specialist Care ................ page 28
6.0 Enabling Better Care ......................................... page 30
   Health Innovation Manchester ............................ page 30
   Digital ..................................................... page 31
   Workforce ................................................ page 31
   Estates ..................................................... page 32
   Commissioning ............................................ page 32
   Specialised Commissioning Services ..................... page 33
   Clinical and Corporate Support Services ................ page 34
7.0 Delivering our System Management Accountabilities ...... page 35
   The Greater Manchester Accountability Agreement ........ page 35
   Ensuring the delivery of High Quality Services .......... page 35
   Ensuring Financial Sustainability – Financial Plan 2018/19 page 36
   Context .................................................... page 36
   Summary .................................................. page 37
8.0 Measuring our Progress in 2018/19

Key Risks to Delivery
Evaluation

List of Appendices to Support the Business Plan
1.0 INTRODUCTION

1.1. In April 2016 Greater Manchester took charge of its health and care system as one Partnership spanning NHS and local government, commissioners and providers and physical and mental health. In doing so, we embarked upon the most radical health and care transformation programme in the country.

1.2. We are now approaching the third year of the delivery of our strategy Taking Charge. Two years into our journey, we can see a health and care landscape in Greater Manchester that looks fundamentally different.

1.3. Our approach to this change has been guided by a core principle: identifying who contributes to health creation and how they can be better connected.

1.4. Through our programme of reform and investment we now see our way to the system architecture in GM that will be in place as a legacy of Taking Charge. This will comprise these recognisable and consistent features - and in this document we describe the steps we will take towards each in 2018/19:

- The establishment of 10 Local Care Organisations (LCOs) integrating provision;
- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten localities;
- Supporting hospitals throughout Greater Manchester to work together across a range of clinical services, to make sure expertise, experience and efficiencies can be shared widely so that everyone can benefit equally from the same standards of specialist care;
- A Greater Manchester-wide architecture where it makes sense to do things at greater scale – including the GM Commissioning Hub, Health Innovation Manchester, a Digital Collaborative, a Workforce Collaborative and a ‘one public service estate’ strategy.

1.5. This, our Business Plan, sets out our programme of work for this financial year ensuring that we deliver our ambition for transformation alongside delivering our accountabilities to NHS England as set out in our Accountability Agreement.

1.6. Our Annual Report for 2017/18 will be available in July 2018 and should be read alongside this document to provide the look back on our progress in 2018.

2.0 DELIVERING OUR TRANSFORMATION AMBITION IN 2018/19

The Transformation Portfolio

2.1. We have formulated our plans for 2018/19 and beyond through a comprehensive review of the transformation portfolio in which all parts of the Greater Manchester system were engaged.
2.2. This review aimed to:

- Ensure that we are maximising the opportunity to deliver the fastest improvements in health and wellbeing whilst securing the clinical and financial sustainability of the system;

- Clarify the implementation status of all projects/programmes within the portfolio;

- Inform the business planning approach for 18/19 and to ensure that commissioners have built in funding and implementation resource for GM programmes - aligned to locality programmes of delivery.

2.3. The review has categorised all of the projects within the programmes outlined above in the portfolio as:

- **Already embedded within implementation**: those projects approved through governance, which localities and GM programmes are actively pursuing, and are understood across the system;

- **Being considered for acceleration**: those projects that have been identified as a priority to be implemented with a GM standard (if affordable) to ensure consistency of offer;

- **For consideration in 19/20**: projects which require implementation to support the delivery of Taking Charge but are not yet fully designed. These commitments are also likely to require realignment of existing resources.

2.4. The projects already in implementation and those being accelerated are outlined in detail within Appendix 1.

2.5. The combination of these projects, plus those being accelerated will also ensure that Greater Manchester delivers the national mandatory improvements outlined in Annex A of the 2018/19 NHS planning guidance.

**Our Approach to the 2018/19 Planning Round**

2.6. Gearing up for the planning round, each locality in Greater Manchester was asked to consider the alignment between operating plans for 18/19 and Transformation Fund Investment Agreements. Specifically, each locality considered if any ambitions within existing plans need review in order to enable the agreement of a single locality plan as we go into the new financial year and beyond.

2.7. Greater Manchester guidance has been given that the locality plans and associated investment agreements (IAs) must be the primary focus and driver of the operational plans and associated contracts.

2.8. To support the operational plan sign off process, the Partnership Team met with all ten localities to discuss the operating plan submissions, and the alignment with the Investment Agreement. This process identified a number of areas where there
is misalignment for 2018/19 for a variety of reasons: for example, coding, implementation delays, data sources.

2.9. The Partnership Team worked closely with localities to strengthen and consolidate the information gathered from each locality – including Executive to Executive meetings.

2.10. The operational plans submitted for the planning round for each point of delivery are based on the starting point of a 2017/18 forecast outturn, provided by NHS England analytics. Each CCG had the opportunity to tweak the forecast outturn where appropriate, to incorporate local knowledge and evidence based projections.

2.11. Further to this, the CCGs incorporated provision for counting & coding changes, demographic growth and transformational deflections, culminating in the 2018/19 operational activity plans.

2.12. These underlying assumptions have been tested and challenged. Joint NHSE/NHSI triangulation tools have been made available to inform some of the challenges, and in terms of assuring the transformational deflections, detailed narratives sought as part of the Executive to Executive meetings.

2.13. Finally, the five year financial plans and investment agreements will be updated during the first quarter to reflect the final 18/19 operating plans and any other changes to assumptions in subsequent years. We will then roll up the updated financial forecasts into an overall revised position for Greater Manchester through to 2020/21.

3.0 OUR 2018/19 PRIORITIES

3.1. Based on the Portfolio Review, this business plan sets out our main priorities for 2018/19, which are organised under the following headings:

- Improving the health of all Greater Manchester residents;
- Transforming care and support;
- Enabling better care.

3.2. This section is supported by Appendix 1 – setting out in greater detail the work areas highlighted below and how they will support delivery of the national ‘must do’s’ in 2018/19.

4.0 IMPROVING THE HEALTH OF ALL GREATER MANCHESTER RESIDENTS

4.1. Our transformation of the health and care system starts with Population Health. We are now firmly into the implementation of our Population Health Plan and are making major targeted investments to improve health and well-being across the city region.
4.2. In delivering the plan, we are taking a life course approach: starting well; living well; and ageing well. We have also described our plans for Public Health Commissioning in 2018/19.

Start Well

4.3. Taking Charge recognised that ensuring children in Greater Manchester start school ready to learn is essential to our future success as a city region. We share the Mayor of Greater Manchester’s view that this is a pre-eminent priority.

4.4. We have established a Children’s Health and Well Being Board to provide coordination and oversight of the children’s health agenda. The Board has identified ten objectives for the development of a Greater Manchester Children’s Health and Well Being Framework.

<table>
<thead>
<tr>
<th>Children’s Health and Well Being Framework Objectives</th>
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<tr>
<td>1) To develop all relevant plans, policies and programmes with children and young people and their families, reflecting the realities of their experiences and based upon a Children’s Charter.</td>
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<tr>
<td>2) To support the early life course of a child, starting with pre-conception right through to a child’s early years, enabling children to be school ready.</td>
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<td>3) To invest in mental health and resilience for children and young people, from pre-school right through to young adulthood.</td>
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<td>4) To protect children and families at risk and strive to ensure that disadvantaged children become healthy and resilient adults.</td>
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<tr>
<td>5) To work in partnership with schools to equip them to play a pivotal role in improving children’s physical and mental health, education and to keep our children safe.</td>
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<tr>
<td>6) To reduce unnecessary hospital attendances and admissions for children and young people particularly those who have long term conditions such as asthma, diabetes and epilepsy.</td>
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<td>7) To ensure that transition of care for young people to adult services meets their needs and ensures continuity of high quality care.</td>
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<tr>
<td>8) To develop a modern, effective, safe and sustainable workforce that delivers children and young people’s services, ensuring we have the right people with the right skills and values in the right places.</td>
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<tr>
<td>9) To use the power of digital technology and a commitment to joining up services to give children, young people and their families more control over how and when they receive services.</td>
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<tr>
<td>10) To be transparent in sharing accessible information that will be useful to children, young people and their families in making choices about services and which will also help hold us to account for our performance.</td>
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- Work with our ten areas to develop plans for a whole family early intervention approach at community level – including a standardised high needs pathway and a consistent offer for antenatal evidence-based parenting classes;

- Implement a consistent, evidence-based oral health improvement programme across the four localities in GM with the poorest child oral health;

- Pilot the implementation of a Community Children’s Hub. Rochdale will develop and trial a paediatric community hub framework, operational from


Greater Manchester Health and Social Care Partnership
January 2018. Oldham and Salford will pilot hub working as part of a package of measures to prevent avoidable admissions;

- To move us towards our target to reduce smoking in pregnancy from 13% to 6% by 2021, we will put in place the BabyClear model which follows NICE guidance on smoking in pregnancy and pilot the Smokefree Pregnancy incentive scheme that focuses on support for women living in communities where smoking rates are highest;

- Our plans to increase physical activity include a focus on children and young people and, in particular, children aged 5-18 out of school hours. In 2018-19, we will continue the roll out of the Daily Mile programme across schools in Greater Manchester.

- Work with schools to identify their requirements to better support children with long-term conditions (such as asthma and diabetes). A toolkit of best practice will be developed to support schools by October 2018.

- To increase safety in maternity services, we will establish and support the Local Maternity System (LMS) to oversee programmes such as development of a Maternity Service Specification; standardisation of the NHS Newborn & Infant Physical Examination (NIPE) exam; and the introduction of standardised personalised care plans.

Live Well

4.6. The primary aim of the Live Well theme is to support people at key stages of their lives when physical and mental health can be most strongly influenced, ensuring that we give all of our residents the opportunity to connect to economic growth in Greater Manchester.

4.7. Focused Care offers a place-based service model operating out of primary care in areas of deprivation. We aim to deliver Focused Care at a greater scale over the next three years to test the model and build a clear evidence base for deploying this method to targeted demographics within GM.

4.8. Our Working Well service helps people who are out-of-work primarily due to health problems – and is at the forefront of national development in this area. This
1.2 year, we will put in place an Early Help version to help prevent people with health conditions from falling out of the labour market, and if newly unemployed with health conditions, to support them to return to work quickly.

4.9. We have one of the most developed health and justice programmes in the country. We will continue this work in 2018/19 by finalising the first Greater Manchester Health and Justice Strategy. To inform this, we will carry out a review of current health and justice provision this year.

4.10. Our aim in Greater Manchester is to end all new cases of HIV within a generation. This year, we will review and map out current HIV testing approaches and related interventions. We will then test and evaluate conurbation-wide initiatives focusing on the health and economic benefits of HIV eradication.

4.11. Increasing levels of physical activity across our conurbation is essential to the delivery of our Population Health Plan: \textit{GM Moving} is our overarching strategy for this. In 2018/19, we will embed physical activity within the transformational work in GM across all of the 12 priority areas set out in the programme.

4.12. We are also working with Sport England as a Local Delivery Pilot to increase physical activity in three priority groups: children and young people aged 5-18 out of school hours; people out of work or at risk of becoming workless due to health conditions; and people aged 40-60 with long term conditions.

4.13. In July 2017 the Mayor of Greater Manchester launched the GM Making Smoking History strategy aiming to reduce smoking at a pace and scale faster than any other major global city. Our ambition is to reduce smoking by a third to 13% by 2021 and deliver a tobacco free generation.

4.14. Building on our \textit{History Makers} public engagement we will further explore opportunities to extend smokefree public spaces and license tobacco retailers. New programmes of work include a crackdown on illegal tobacco, a focus on maximising outcomes from primary care interventions and engaging and empowering young people.

4.15. A single Greater Manchester Drug and Alcohol Strategy has been developed, which sets out GM’s collective ambition to reduce the risks and harms caused by drugs and alcohol. As part of the delivery of the strategy we will hold the ‘Big Alcohol Conversation’ with GM residents aimed at engaging the wider population.

4.16. We will also run a programme of work which contributes to reduce the harm experienced by children and young people in Greater Manchester as a result of parental substance misuse, with specific activity aimed at reducing alcohol-exposed pregnancies and, as a consequence, eliminating new cases of Foetal Alcohol Spectrum Disorder (FASD).

4.17. Working with Public Health England (PHE), we will test a new approach in two localities to the nationally-mandated NHS Health Check Programme. This new approach will provide a targeted offer which invites those most at risk for a face-
to-face check utilising a neighbourhood model approach and supports those at lower risk with advice and signposting through a digital offer.

4.18. In order to truly put Population Health at the heart of everything we do we have developed, and are implementing, the first ever dedicated GM Population Health Outcomes Framework as part of a single integrated assurance process. This innovative, web-based framework will allow us to identify priorities for action, monitor trends over time, know if we are making the difference that we need to make and form the platform for locality and GM outcome based commissioning.

Age Well

4.19. In March 2018, Greater Manchester became the UK’s first age-friendly city region, as recognised by the World Health Organisation. We will continue to play our full part in meeting the challenges and opportunities presented by an ageing population.

4.20. In 2018/19, we will:

- Develop a single plan to improve care pathways to manage frailty – building on the work of a task force that has drawn on best practice from around the world;
- Put in place a community-based, non-clinical approach to identifying malnutrition amongst older adults aged 65+, following the innovative approach developed in Salford;
- Embed a consistent framework to support localities in refining their practice in falls prevention. This programme will be characterised by collaborative leadership across the public, independent, voluntary, community and social enterprise and academic sectors. We will implement a set of evidence-based standards including primary and secondary prevention (Fracture Liaison Services);
- In 2018/19, we will publish the GM Frailty Charter with a clinical focus to align with the GM Ageing Well Strategy. Articulating a vision for high quality consistent service levels across GM, this will focus on the key areas of: identification of frailty; frailty interventions; and care planning.
- The Health and Social Care Partnership will also play a full role in the Greater Manchester Festival of Ageing in July.

Public Health Commissioning

4.21. We work with Public Health England to protect and improve the health of the population. This includes more than thirty screening and immunisation pathways across GM, including:

- National cancer and non-cancer screening programmes;
• National immunisation programmes;

• Child Health Information Services.

4.22. Our priorities for 2018-19 are:

• Undertaking extensive service reviews to identify opportunities to improve commissioning and provision including identifying under-represented groups and supporting them to make an informed choice about accessing screening and immunisation services;

• Commissioning a community-based engagement service to improve cancer screening uptake in under-represented groups and to provide a stronger a commitment to person and community-centred approaches.

• Implementing the legacy for the prevention elements of the GM Cancer Vanguard;

• Work closely with General Practice to protect vulnerable children and families with the intention that all General Practices meet national targets for childhood routine vaccinations and pre-school flu vaccinations;

• Make better use of the available data to prioritise support to address inequalities and issues of quality arising in screening and immunisation programmes;

• Implementing opportunistic Human papillomavirus (HPV) vaccination in sexual health clinics for men who have sex with men;

• Work closely with key partners including PHE on the future implementation of the change in test used within the Bowel Cancer Screening Programme;

• Continue the rollout of the shingles vaccination programme to patients aged 70 years, and as a catch-up to those patients aged 78 years;

• Extend the school flu vaccination programme to include Year 5 from September 2018;

• Screening for all relevant sexually transmitted infections in the Sexual Assault Referral Centre from April 2018.

5.0 TRANSFORMING CARE AND SUPPORT

5.1. The resetting of the health and care landscape in Greater Manchester stems from a recognition that our system is too often weighted towards reactive services that respond to crisis or exacerbation with insufficient focus on models to keep people well at home and in their communities.
5.2. We are changing this through transforming the way that care and support is provided across Greater Manchester. This starts with Local Care Organisations.

Local Care Organisations

5.3. The implementation of the LCOs as full population health models in in each of our localities is the most important of the steps we are taking to change the balance of the system in Greater Manchester. 2018/19 will be a vital year as LCOs move from a setting up phase into scaled implementation.

5.4. What has become clear through the LCO framework peer review process carried out in the winter of 2017 is that this transformation in delivery is largely taking place at the neighbourhood level serving populations of 30 to 50,000 – structured around the GP registered list and multi-disciplinary team working.

5.5. As such, neighbourhood models are increasingly emerging as the main, clearly identifiable delivery unit for health and care transformation and the reform of wider public services in Greater Manchester.

5.6. A clear LCO operating model which describes the composition and crucially, the co-location of the teams is being established. This includes:

- Community nursing;
- Adult social care;
- Occupational Therapy;
- Mental Health;
- Enhanced Support for Care Homes;
- Integrated Discharge Teams;
- Wider public services – for instance, housing and leisure;
- The Voluntary, Community and Social Enterprise Sector.
5.7. A summary of the 10 Local Care Organisations is illustrated below:

**BOSTON**
- 18/19 as a transition year with TPEDs including refining the model and implementing phase 1 arrangements in shadow form.
- Initial phase of LCO to include adults social care, acute, community and primary care with mental health in phase two.
- Strong emphasis on neighbourhood working and integration.

**BUCK**
- LCO board in place.
- LCO is providers facilitating joint planning and transformation of services.
- Mutually binding contract in development and to be in place in April 18.
- Integrated Neighbourhood teams by April 19.

**ROCHDALE**
- LCO established.
- Single integrated commissioning function in place.
- LCO board established.
- Lead provider contract in place, which reflects demand management and ambitions as outlined in our Transformation Plan.
- LCO Chief Officer appointed and leadership/management arrangements in place.

**WIGAN**
- Healthier Wigan Partnership Alliance Agreement in place, including care health providers & commissioners, Wigan Council and GP.
- Healthier Wigan Partnership Programme defined.
- Gh and wider services alignment at 30-50,000 populations.
- Finalised health and care public service model operating on a service delivery footprint.
- Integrated Community Services in place.
- Start Well Phase 2 design under consultation.
- Wigan GP Collaborative formed.

**SALFORD**
- Commissioning model budget, LCO and Saltford Primary Care Together in place since 2016.
- Joint LCO and SPCT Provider Board together with VQM in place.
- Transformation programme implementing neighbourhood teams, improving primary care access, supporting people at home and pathway redesigns for adults during 2018/19.
- Integrated programme of work for children well established.

**TRAFORD**
- Mar: Local Care Alliance 7 originating providers to sign MoU, shallow form from Apr.
- GPCL 20/22.
- Completion of Outcomes consultancy work leading to KPI baselining.
- Operating model & Governance developed through live testing 4 LCA transformation pathways.
- Define 4 neighbourhoods delivery model(s).

**MANCHESTER**
- Manchester Local Care Organisation launched (01.04.18); Partnering Agreement in place.
- NLCO Target Operating Model developed.
- 12 GP Neighbourhood leads in place, 18/19 priorities identified, wider INT to be operational in 18/19.
- TF-funded new care models commissioning, benefit impact assessment underway.
- Plan for safe transition of year 1 services in place.
- Staff and partner engagement programme underway.

**OLDHAM**
- Shadow LCO and services in place – April 2018.
- Establishment of an Alliance Agreement.
- CCG align with SCF.

**STOCKPORT**
- Provider Alliance Board and Alliance Agreement in place.
- Joint management structure in place.
- Neighbourhood leadership infrastructure in place.
- Procurement concluded with decisions to remain as Alliance.
- Conducted formal public consultation successfully.

5.8. The establishment of LCOs also provides an anchor point in the system for the delivery of pan-GM initiatives and we will increasingly see the delivery of GM programmes through the LCOs in 2018/19.

5.9. The LCO peer review has generated a set or priorities for the LCO Network in 2018/19. These are areas where localities have identified that we can make faster progress via locality collaboration and learning and Partnership Team support. The first four agreed priorities are:

- The Neighbourhood Operating Model;
- New Contracting Arrangements & Incentives;
- LCO Outcome Framework;
- Culture and Organisational Development

5.10. There are a number of other issues on which the LCO Network will engage in 2018/19. These include the development of neighbourhood-level metrics; the translation of GM-level programmes into LCOs – including urgent and emergency care, health protection arrangements and clinical pathway redesigns; and some of the technical barriers to integration – including VAT and taxation arrangements.
Mental Health

5.11. Parity of esteem between physical and mental health is paramount if we are to enable people to stay well and live independently at home and in their communities. To that end, in 2017 we announced an investment of £134m for mental health. This is the largest investment in mental health and well-being anywhere in the country.

5.12. In 2017/18, we set up three Children and Adolescent Eating Disorder (CAEDS) teams to work across Greater Manchester. In 2018/19, we will continue to develop a flexible specialist Children and Adolescent Eating Disorder (CAEDS) service model, delivered through multidisciplinary community based teams.

5.13. We will continue to roll out specialist perinatal community mental health services across Greater Manchester.

5.14. Our work this year will also include the implementation of Greater Manchester Attention Deficit Hyperactivity Disorder (ADHD) standards for children and young people.

5.15. We will roll out 24/7 community-based access and crisis care for children and young people and, in respect of mental health liaison, we will ensure all-age core compliant support for acute hospitals with 24/7 A&Es and a modified core-24 service in hospitals with Urgent Care Centres.

5.16. To improve mental health support in schools in Greater Manchester, we will incentivise every school and college to identify a designated senior lead for mental health. Equally, all children and young people’s mental health services will identify a link for schools and colleges. This link will provide rapid advice, consultation and signposting.

5.17. In addition, we will develop options for new mental health support teams, supervised by NHS children and young people’s mental health staff, to provide specific extra capacity for early intervention and ongoing help. The work will be managed jointly by schools, colleges and the NHS.

5.18. The Manchester Resilience Hub will continue to deliver support for those affected by the Arena attack, both in GM and nationally, through a collaborative model whereby all the GM mental health trusts contribute staff and expertise. The coordination of emotional and wellbeing support for both members of the public and professionals affected will continue.

5.19. We will move ahead with the implementation of iThrive: a whole system workforce development and transformation programme to ensure care is delivered for children and young people and their families at the right level of intensity, at the right time and in the right place.

5.20. We will improve access and waiting time standards in Early Intervention and Prevention (EIP) and recovery in Improving Access to Psychological Therapy (IAPT) services through the adoption of clinical guidance and the introduction of
innovative workforce modelling to make best use of resources. We will review third sector provision of IAPT services to improve and expand that provision.

5.21. We will develop a set of standards for services to ensure that people with personality disorders receive consistent care and treatment wherever they are in Greater Manchester.

Our Mental Health programme will contribute to:

- The national requirement for 70 new or extended community eating disorder services funded and commissioned;
- Making further progress towards delivering the 2020/21 waiting time standards for children and young people’s eating disorder services, with 95% of patients receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases;
- Ensuring that an additional 49,000 children and young people receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. The GM ambition is for 3,920 (70,000 nationally or 35%) more children will access evidence-based mental health care interventions – including better access for ADHD, eating disorders and those with disabilities;
- Increased access to specialist perinatal mental health support in all areas, allowing at least an additional 30,000 women each year nationally to receive evidence-based treatment, closer to home, when they need it. The GM ambition is that by 2021, we will reach at least 1680 more women;
- The requirement to deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay and will be as close to home as possible;
- Delivery against multi-agency suicide prevention plans, working towards a national 10% reduction in the suicide rate by 2020/21.
- Improve the GM position on IAPT recovery – which was 47.5% in the latest published figures against a standard of 50%
- Improve the GM position on EIP waiting time standards and NICE concordant care- two week wait was 60.1% in the latest published figures against a standard of 50%.

Primary Care

5.22. A reformed primary care system is essential to the changes we are making in Greater Manchester. To increase the pace and scale of that reform we have invested an additional £41m in primary medical care in Greater Manchester linked to a set of clear delivery milestones for each locality.

5.23. This programme of reform is underpinned by the primary care contracting function ensuring appropriate provision of services from general practice, primary care optometry services, community pharmacy and dental services.

5.24. This transformation programme will continue in 2018/19, building on the strong foundations delivered last year:
• We will implement the GP Excellence programme, delivered in partnership with the Royal College of General Practice, supporting resilience in general practice and quality improvement within primary care;

• We will accelerate the pace of the primary care at scale programme – including the 10 high impact changes designed to free up GP time for direct patient care;

• Develop a consistent GM approach for urgent primary care that is straightforward to navigate for patients and staff and integrated into the wider urgent care system;

• Confirm seven day additional access hubs in each locality with pre-bookable routine and same day appointments outside of core hours (18.30-20.00 Monday to Friday) and pre-bookable routine and same day appointments for a minimum of four hours per day at weekends;

• Embed a programme within schools to increase awareness of eye care and encourage referral of children who may be suffering from vision difficulties for sight tests;

• Roll-out of GM Healthy Living Framework across primary care providers, delivering dementia support and targeted public health campaigns. Within dental services, this programme will be underpinned by embedding of quality toolkits in practice.

Dental

• Working with developing neighbourhoods and LCOs around ensuring an integrated, collaborative approach to the delivery of dental and oral healthcare provision within the local population;

• Children’s Oral Health continues to be a high priority, ensuring access to care for young children through promotion of the Dental Checks by One Message;

• Focus on developing models for Older People’s oral health and dental needs with partners to deliver holistic person-centred care;

• Ensuring consistency of offer and quality for specialist dental care through GM-wide clinical networks across primary and secondary care;

• Procurement of Urgent Dental Care Services, building on the review of Primary Urgent Care undertaken last year.

Optometry

• Work with localities for the roll out of the Primary Eye Care Service Framework.
• Implement an Information Technology programme to connect optometry practices with other health care providers.

• Continue the roll out of the “See More, Learn More, Go Further” programme to all localities working with local optical practices.

Pharmacy

• Continued roll out of the Healthy Living Pharmacy programme to all localities in Greater Manchester

• Working with our community pharmacy colleagues and medicines optimisation leads to help patients manage their medicines effectively.

• Work with locality commissioners and community pharmacy to ensure pharmaceutical services are aligned and integrated with neighbourhoods.

Our primary care reform programme across General Practice will support:

• Our ambition for 100% geographical coverage for every practice to be part of a local primary care network, serving populations of at least 30,000 to 50,000;

• Implementation of a proprietary appointment booking system at particular GP practices, 50% of integrated urgent care services and 50% of UTCs (Urgent Care Treatment Centres) by May 2018, supported by improved technology and clear appointment booking standards;

• Our ambition for 100% of the population to be able to access 7 day services. The 18/19 requirement is to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.

• The GM contribution to the national primary care workforce commitments in 18/19.

Cancer

5.25. Our vision is for people in Greater Manchester to have the best chance of avoiding or surviving cancer. An important part of this will be to ensure that 85% of patients continue to meet the 62 day cancer waiting time standard. We are aiming to implement the ’10 high impact actions’ for meeting the 62 day standard across all trusts.

5.26. Our transformation programme for cancer includes the following areas of delivery for 2018/19:

• Working in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide social movement focused on cancer prevention;
• Ensuring patients have access to Greater Manchester Cancer agreed follow up pathways of care for Breast cancer and Prostate and Colorectal cancer;

• Engaging with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree optimal pathways and Greater Manchester service specifications for each tumour type.

5.27. In a hugely significant step for Greater Manchester, the Christie will be home in 2018 to one of only two high energy NHS proton beam therapy (PBT) centres in the UK. PBT is an advanced form of radiotherapy used for the treatment of complex and hard-to-treat cancers in children and adults.

Learning Disability

5.28. In 2018/19 we will finalise a Learning Disability Strategy for Greater Manchester to support a joined up approach to improve the quality of life and services for people with learning disabilities.

5.29. Through the Strategy we will:

• Expand the housing options available to people with a learning disability by scaling up the capacity of Shared Lives schemes and encouraging the use of the Home Ownership for People with Long-Term Disabilities (HOLD) model;

• Increase the numbers of people with a learning disability in employment, apprenticeships, traineeships and internships by developing and promoting a best practice standard and working with schools, colleges and employers to increase opportunities available;
• Develop new more efficient and bespoke commissioning arrangements across GM which will strengthen personalisation approaches, improve outcomes for people and deliver efficiencies;

• Engage with voluntary and community organisations to increase the support available to people with learning disabilities to make friends, have relationships and speak up for themselves.

5.30. The strategy will build on our work in Transforming Care Programme – where we will continue to complete deliver inpatient discharges and prevent admissions to ensure that more people can live with greater independence outside institutional care. To support this we will provide new intensive and crisis support services and improve diagnostic and post-diagnostic support services for people with autism.

Our programme on Learning Disability will contribute to:

• New and expanded community teams to support people with a learning disability at risk of admission to hospital. We have established a specialist support service to work with community teams to provide intensive support for those in crisis and recently discharged, to prevent admission to hospital.

• Continue to reduce inappropriate hospitalisation of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by March 2019. As part of achieving that reduction we expect a particular emphasis on making a substantial reduction in the number of long-stay (5 year+ inpatients). GM March 2019 targets are: 35 CCG commissioned inpatients; 51 Specialised commissioning inpatients (37 5yr+ patients).

Adult Social Care

5.31. In Greater Manchester, we have more joined up working between health and social care than anywhere else in the country. Our Adult Social Care Transformation programme will gather greater pace in 2018/19.

5.32. We want to reduce the reliance on acute health care services and institutional forms of care by co-producing a range of options that will enable more people to live independently for as long as possible, access community opportunities and live the lives they choose to live. People having access to the right support, at the right time, in the right place, and which is of good quality will help us deliver this.

5.33. In 2018-19 we will:

• Continue delivery of our work programme dedicated to improving the quality of care homes – with a focus on reducing avoidable harm, admissions to hospital and delayed transfers of care;
• Establish a provider network to facilitate both GM-level and locality engagement on a strategic level with the social care market. This will further develop strong partnerships with the independent, voluntary and community care sector and enable collaborative working with partners to improve the system for its users;

• Develop the minimum standards required for a teaching care home model in Greater Manchester;

• Implement the programme of work flowing from the agreed Carers’ Charter to provide the best quality support for all carers through an integrated approach;

• Aim to put in place elements of our radical Care 2020 proposition. This will include a new model of care at home as part of Local Care Organisations that aims to keep people well and independent in their own homes and communities of choice.

• Develop and launch a leadership development offer for registered managers based on training needs identified with providers in localities

• In addition, 2018-19 will see us further progress our work on those elements of the adult social care programme that are most suitable for a pan Greater Manchester commissioning approach – via the new Commissioning Hub.

Cardiovascular Disease (CVD) Improvement Programme

5.34. In 18/19 we will establish a GM Cardiac & Stroke Strategic Clinical Planning and Oversight group, working with key stakeholders to articulate the work that GM teams are doing to deliver the "Devolution Difference'.

5.35. In 2018/19, we will focus on:

• The roll out of the Rapid Access for Acute Coronary Syndrome (RAACS) project across GM which will provide access to coronary angiography within 24 hours of first medical contact for all appropriate non-ST-elevation myocardial infarction (NSTEMI) patients;

• The development of a common, seamless protocol to support better outcomes, reduce variation of care and improve services for people who suffer an out of hospital cardiac arrest. (OHCA);

• Support the Taking Charge ambition to reduce the number of people who will die early from CVD resulting in 600 fewer deaths by 2021.

Diabetes

5.36. We know that up to 25% of the GM population are expected to develop diabetes in their lifetime. The main reason for this rise is the increased numbers of people with Type 2 diabetes, a preventable disease, linked to poor diet and lack of exercise.
5.37. We have developed the GM Diabetes Clinical Best Practice Strategy which articulates a vision of best practice for diabetes care in GM and proposes actions and interventions aimed at achieving that vision.

5.38. A Diabetes Clinical Network is being established which will support localities and GM-wide improvement initiatives outlined in the Best Practice Strategy.

5.39. Our work plan for 2018-19 will focus on:

- Improving patient outcomes and experience through structured education initiatives;
- Establishing education & training to improve diabetes nursing capacity in GM;
- Devising and implementing a GM lower limb pathway;
- Developing and delivering a programme of diabetes peer support

5.40. In addition, we will continue our successful co-ordination of the roll-out of the National Diabetes Prevention Programme ‘Healthier You’.

Dementia

5.41. We know that dementia will be a growing challenge as our population ages. We have invested over £2m in Dementia United (DU) – a long term plan to improve dementia care and support in Greater Manchester.

5.42. We have an agreed work plan from 2018/19 – 2020/21, this is based on the information gathered from the 2017 locality visits.

5.43. Accountability of the full programme of activity will be the responsibility of the DU Strategic Board. The work plan has nine focus areas; Dementia friendly transport system, Mild Cognitive impairment, Young onset and rarer forms of dementia, End of Life Care, Care Homes, Lived Experience Barometer, Prevention, Post diagnostic support, Under-served populations.

5.44. Our focus in 2018-19 will be on:

- Supporting and influencing the development of a GM-wide transport system that supports the work of Age Friendly GM and the specific needs of People Living With Dementia (PLWD);
- Developing and agreeing a care pathway for diagnosis and support within GM that will ensure the needs of younger people with dementia and those with rarer forms of dementia are met;
- Ensuring services across GM support people with Mild Cognitive Impairment are readily accessible;
- Development of and adherence/ access to Advance Care Planning (ACP) for PLWD;
Continued promotion of the GM dementia standards and development of a data dashboard to measure improvements made;

Development of a mechanism to assess progress toward our ambition of making GM the best place in the world to live for people with dementia by putting in place the Lived Experience Barometer to measure the lived experience of people living with a diagnosis of dementia and their carers.

Palliative and End of Life Care

5.45. This programme aims to support people to live well and with dignity, in the place of their choosing, during their last year of life. In 2018/19, we will:

- Deliver the *Dying Matters* public awareness raising campaign concerning death, dying and bereavement;
- Promote and support the Electronic Palliative Care coordination systems (EPaCCS), to enable the sharing of advance care plan information;
- Develop a system wide framework and implementation plan for Palliative and End of Life Care (EoLC), including standards and supported by a new Board;
- Implement and evaluate the Anticipatory Clinical Management Planning Guidance which incorporates resuscitation decisions.

Person Centred and Community Approaches (PCCA)

5.46. In *Taking Charge* we made a commitment to support individuals and communities to take more control over their own health and wellbeing. The PCCA programme has begun to bring this commitment to life.

5.47. In 2018/19 we will support each of the localities to develop and scale up their own PCCA programmes. This will involve working closely with the Voluntary, Community and Social Enterprise Sector (VCSE) to strengthen and grow the assets in our communities. It will also involve training staff to have different conversations with people using services, leading to person-centred care and support plans that take a holistic approach to people’s social, emotional and physical care and support needs. We will model coproduction methodologies through growing our involvement of people with lived experience to influence the wider development of person and community-centred approaches across the system.

5.48. In our approach to PCCA we will prioritise three groups with complex needs: people with learning disabilities; older people with multiple long-term conditions; and people approaching the end of their life.

5.49. In 2018/19 we will accelerate our progress in rolling out social prescribing programmes across Greater Manchester as a consistent feature of integrated neighbourhood models of care and support. Our aim is that all localities have social prescribing programmes fully implemented by the end of 2019/20.
5.50. We will scale up personal health budgets and, where possible, integrated personal budgets across health and social care with the expectation that all localities will have one offer for local people that gives them a good experience of getting a personal budget and that makes them available to people with complex needs who would benefit by the end of 2019/20.

**Housing and Health**

5.51. We know the importance of the link between good quality housing and health. We have set up an innovative housing and health programme with a cross sector programme board now in place – chaired by a GP.

5.52. This programme includes our commitment to tackle homelessness – which we fully share with the Mayor of Greater Manchester. We have committed to supporting this agenda through improving access to health services for people experiencing homelessness and developed the following priorities.

- Ensuring all people experiencing homelessness can register with a GP;
- Developing a GM Homeless Hospital Discharge Protocol to ensure that, where possible, there is no discharge to the streets;
- Supporting localities to develop outreach of health services into homelessness settings and onto the streets;
- Supporting localities to take a more flexible and joined up approach to commissioning services for people who are homeless or have complex needs;
- Pilot an approach to Mental Health outreach and support localities to develop services based on pilot outcomes;
- Support health and care providers to implement the Homelessness Reduction Act.

5.53. We will work to reform the Supported Housing market in Greater Manchester, building on an audit of current provision and an understanding of our future needs. Working with our housing partners in localities, we will develop models of supported housing and care that respond to the needs of our older population and those requiring support, and enables them to live healthy, safe, fulfilling lives.

5.54. We will take forward work to explore viable models of cross Greater Manchester Home Improvement Agency (HIA) provision. This will look to provide a consistent, cross tenure offer that ensures the home environment promotes independence, supports good health and enables the delivery of care and support in the home.
Urgent and Emergency Care

5.55. Performance on urgent and emergency care is a constant challenge in GM. We know there are a series of improvements that we need to make and these form our work plan for 2018/19.

5.56. We want people to stay well to avoid the need to access the urgent care system. This includes flu vaccination programmes; primary care support to care homes; and telehealth monitoring.

5.57. We are also working to the principle of Home First with the development of initiatives focused on reducing admissions and attendances at the emergency department. These include: implementation of the Nursing Home Triage Tool in all residential and nursing homes; Urgent Treatment Centres operating in all localities with standard acceptance criteria; and a 24/7 integrated urgent care model across GM with 111 direct booking in to primary care.

5.58. We will support the work to identify and manage frailty in the community and primary care and to offer a menu of interventions, all of which will contribute to reductions in emergency attendance and hospital admissions.

5.59. Once patients enter the urgent care system it is essential that their care and support is provided in a timely and effective way. To that end, we will aim to adopt a maximum length of stay of 72 hours and bed occupancy of no more than 90% for acute medical units; develop a set of Greater Manchester standards for patient flow; and agree a zero tolerance approach to ambulance handover delays.

5.60. Another vital strand of our work will be on discharge and recovery. This will encompass delivery of three agreed protocols at locality level: discharge to assess; trusted assessment; and patient choice.

5.61. Underpinning all of our work on urgent and emergency care in Greater Manchester will be the 24/7 Operational Hub providing a single shared data picture and intelligence-driven pro-active demand management.
Standardising Acute & Specialist Care

5.62. It has been clear for some time that simply working our current hospital based model of care harder to meet rising demand is not the answer. Instead, the NHS in Greater Manchester needs to work differently by providing more care in people’s homes and the community and to break down barriers between services. Breaking down barriers means co-ordinating the work of general practices, community services and hospitals to better meet the needs of people requiring care.

5.63. Our vision for the programme is to create and support closer collaboration and integration between hospitals and the community, and create new models of care to meet the needs of the population;

- To improve the quality and reliability of hospital services
- To ensure consistency in the standard of care received
- To make the hospitals in GM more clinically and financially sustainable in order that our hospitals and workforce can continue to provide excellent patient care when and where it is needed.

5.64. The whole transformation programme that we have described, and the investment that we have made in it, will give us the foundation to transform hospitals in Greater Manchester for the future. In partnership with local teams, the programme
in 2018-19 will continue to support localities in helping them to transform an identified number of hospital services. The focus in 2018-19 will be on reviewing 12 models of care, these include:

- Cardiology
- Respiratory
- Musculoskeletal/Orthopaedics
- Benign Urology
- Paediatrics
- Breast Services
- Vascular
- Neuro-Rehabilitation
- Critical Care & Anaesthetics
- Aspects of Clinical Radiology
- Aspects of Clinical Pathology
- Ophthalmology (Specialised)

5.65. Three service reconfigurations were consulted on in 2014/15 as ‘Healthier Together’, this involved the redesign of General Surgery, Acute and Emergency Medicine across Greater Manchester. The implementation of ‘Healthier Together’ has been subsumed into the Standardising Acute and Specialist Care programme.

5.66. Through our prioritisation process, it has been agreed that, in 2018/19, the Standardising Acute and Specialist Care programme, will concentrate on pathway redesigns in: Acute and Emergency Medicine; General Surgery; Oesophageal Cancer (OG); Urology Cancer; and Gynaecology Cancer.

5.67. For the remaining services in scope of the programme, a detailed modelling and options appraisal phase will be undertaken during 2018-19. The modelling will address wider issues including; commissioning spend, provider acute costs, acute hospital activity, acute hospital workforce and acute estates impact.

5.68. Throughout the hospital service review process key stakeholders including clinicians, staff, patients, carers and Healthwatch will be engaged and actively involved in shaping the models of care.

5.69. Our new programme for elective care in Greater Manchester will take hold in 2018/19. We will develop standards for successful referral management which are not prescriptive but ensure smooth transition for patients into assessment,
diagnostics, secondary and tertiary services. At the centre of this will be our Elective Hub – allowing us to also improve data quality across the elective pathway, including live flows and patient tracking.

6.0 ENABLING BETTER CARE

6.1. The scale and pace at which we are able to deliver our transformation programme will significantly depend on the enabling infrastructure we put in place.

Health Innovation Manchester

6.2. We know that we must continually innovate if we are to remain at the cutting-edge of service delivery in Greater Manchester. Health Innovation Manchester’s work is paramount to this.

6.3. Health Innovation Manchester brings together academic research and clinical excellence with industry innovators, creating shorter pathways to enable adoption at scale.

6.4. Health Innovation Manchester has three key strategic objectives:

- Drive prioritised innovations at pace and scale into health and social care in GM and by doing so benefit both the health outcomes of the local population and the impact and competitiveness of local academic initiatives
- Develop Greater Manchester as a key hub of the UK Lifesciences Industry to contribute to national and International Lifescience policy and strengthen the international competitiveness of the UK Lifesciences offering
- Become a key agent in GM to leverage technology to enhance citizen outcomes and make Greater Manchester a great place for digital healthcare industries to do business.

6.5. The delivery programme for 2018/19 will include:

- A Healthy Hearts Programme, which is being delivered in partnership with the GM HSCP and NHS RightCare. This includes management and detection of Atrial Fibrillation, Familial Hypocholesterolaemia, optimal management and detection of hypertension, and high cholesterol
- An innovative approach to managing Chronic Obstructive Pulmonary Disease (COPD) - piloted with GP practices in Manchester;
- Working with acute providers on enhanced surgical recovery techniques;
- A ground-breaking programme to eliminate Hepatitis C;
- National Medicine Optimisation innovation network programmes, including TCAM (Transfers of Care around Medicines) and PINCER (a pharmacist-led
information technology intervention for reducing clinically important errors in general practice prescribing).

Digital

6.6. The facility to share documents across health and social care settings is essential to our integrated care models.

6.7. This year, we will continue to build on the strong foundations that our digital strategy has provided – including securing £7.5m investment via our success in becoming a Local Health and Care Record Exemplar (LHCRE).

6.8. A key part of our work on this is to support partners using the existing DocMan Electronic Document Transfer (EDT) to expand its facility to allow correspondence to be shared between all organisations - this will include GPs and associated primary care teams, hospitals, mental health services, social care, third sector and residents.

6.9. In addition, we will continue to develop the Datawell platform and Graphnet Carecentric integrated digital care record to support exchange of information across geographical and organisational boundaries and consolidate information into a single instance for GM.

6.10. We will expand the existing wireless network across all health and social care locations, enabling staff to access their own organisation's clinical systems from any health and social care location. This will be complemented by having the facility to allow citizens access to the Internet across all health and social care locations within Greater Manchester.

6.11. We will complete an IM&T inventory across GM health and social care organisations to ensure GM has high quality asset registers and understands the assets across all organisations together with a cloud assessment.

Workforce

6.12. A transformed workforce, equipped to work in different ways across the system is also vital to our new care models. To meet these challenges, we have set up a Workforce Collaborative that works to address health and care workforce needs together.

6.13. In 2018/19, we will:

- Establish a single shared gateway providing our workforce with the support, information, guidance, tools and resources to enable upskilling, reskilling and personal development. This will be delivered through development of an integrated health and social care careers hub, linked to the launch of the workforce futures centre (an online platform to link localities to support to deliver their workforce plans);
• Systematically target key skills shortage areas to address short term needs whilst growing long term capacity and capability. This includes support pilots of new roles including Nursing Associates and Physician Associates;

• Build on the Leading GM programme to further invest in leadership & talent development for our front line leaders (including Registered Managers) to develop their competencies and capabilities to lead integrated services;

• Develop an employer brand for Greater Manchester to support organisation and locality brands. This will include the implementation of the continuity of service protocol and the delivery of a Greater Manchester nursing marketing campaign;

• Set up benefits and recognition initiatives at multiple levels providing the opportunities to support, recognise and celebrate the positive contributions of our workforce – including the first Greater Manchester Health and Care Champion Awards ceremony in July 2018.

Estates

6.14. The success of new care models is dependent on the effective and imaginative use of our estate across the public service. We are playing a major role in the One Public Estate work across Greater Manchester.

6.15. In 2018/19 we will undertake a place-based master planning exercise. As part of this, we will carry out reviews of acute sites to look at how the estate could be better used to support LCO models taking into account the wider public service context. We will also review the health and social care and wider estate in specific neighbourhoods within localities.

6.16. We will support localities to improve the utilisation of their existing estate and seek to rationalise the number of non-clinical office sites across Greater Manchester to generate running cost savings to be reinvested in the front line.

Commissioning

6.17. We are fundamentally changing the commissioning picture in Greater Manchester. The advent of Single Commissioning Functions (SCFs) across our 10 localities will steer us away from commissioning activity according to single service silos and towards strategic commissioning based on the needs of the whole population.

6.18. CCGs and local authorities are coming together in many localities to form an SCF (the others are in shadow form) with a broad set of responsibilities across public services. The SCF is responsible for setting the commissioning and place-based strategy, and for leading on local growth and economic reform policies. Working in this way, SCFs are providing system leadership and public service reform, whilst transforming existing commissioner-provider relationships.
6.19. We are also commissioning at GM level (via the Commissioning Hub which was established in December 2017) where it makes sense to do so. This provides us with greater capability to scale initiatives across GM and ensure consistent quality standards across the conurbation.

6.20. A Joint Commissioning Board has been established to make joint decisions for services supporting people across Greater Manchester and, where necessary, to take delegated authority on behalf of the SCFs for specific service commissioning decisions.

6.21. Our work on Incentivising Reform will also facilitate the use of new payment mechanisms in Greater Manchester and this work will accelerate in 2018-19.

Specialised Commissioning Services

6.22. The GM Specialised Commissioning Oversight Group (GM SCOG) is responsible for the oversight of performance within GM devolved Tier 1 specialised services. Tier 1 specialised services are as follows:

<table>
<thead>
<tr>
<th>Internal Medicine</th>
<th>Cancer</th>
<th>Blood &amp; Infection</th>
<th>Trauma</th>
<th>Women’s &amp; Children’s</th>
<th>Mental Health (from April 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Surgery</td>
<td>OG Cancer, Kidney Bladder, Prostate Cancer, Chemotherapy (Adult), PET-CT</td>
<td>HIV (Adult), Specialised Immunology, Specialised Allergy</td>
<td>Specialised Rehab, Neurosurgery (Adult), Specialised Neurosciences, Specialised Orthopaedics, Specialised Ophthalmology, Complex Spinal Surgery, Major Trauma Implantable Hearing Aids (BAHA)</td>
<td>Paed RHEUMATOLOGY, Paed Endocrinology &amp; Diabetes, Paed Respiratory, Paed Allergy, Neonatal Critical Care, Gynae: Endometriosis, Gynae: Urogential/Anerctal, Gynae: Incontinence/Prolapse, Gynae: Cancer</td>
<td>CAMHS Tier 4 General Adolescent, CAMHS Tier 4 Eating Disorders, Adult Inpatient Eating Disorders, Specialised Perinatal Mental Health – Mother and Baby Unit, Low Secure Mental Health, Low Secure and Forensic Support Team Services - Learning Disabilities</td>
</tr>
<tr>
<td>Cardiac MRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac EP and Ablation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac PPCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex IBD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faecal Incontinence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEMS Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Kidney Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.23. A GM SCOG Operational Plan has been developed to monitor progress to deliver a number of new and existing commitments made by key partners and stakeholders in relation to GM’s devolved specialised service portfolio.

6.24. New pieces of work within GM’s Specialised Service Tier 1 portfolio have been prioritised and supported by GMSCOG to be progressed via the GM Commissioning Hub:

- GM HIV treatment – to ensure that HIV treatment services linked to the GM Sexual Health strategy and aligned with Local Authority procurement of sexual health services (contracts due to expire in 2019);

- The development of a GM Gender Identity Service. GM has formally expressed an interest and is ideally placed to become an early adopter to develop a new national model for local service provision. If GM is recognised
as an early adopter, this work will be sequenced with NHS England’s procurement of national Gender Identity Clinics in 2018/19;

- GM Neurosciences - To explore variation in Greater Manchester’s provision when compared to other neurosciences centres nationally;

- GM Devolved Specialised Mental Health Services - priorities will be aligned to the delivery of the GM Mental Health strategy. A ‘GM Specialised Mental Health Commissioning Sub Group’ is in development to support the GM Specialised Commissioning Oversight Group (SCOG) with oversight of clinical service redesign in relation to GM’s devolved specialised mental health services.

Clinical and Corporate Support Services

6.25. Clinical and Corporate support services are the enablers of our organisations and as we move towards a partnership between health and social care. These enablers will be instrumental in joining up systems and services to deliver the best possible care and support for our local communities.

6.26. Doing things better and more efficiently means looking at how GM’s organisations can modernise, join up and share corporate services such as procurement, HR, finance and technology, as well as clinical support services such as hospital pharmacy, radiology and pathology to ultimately:

- Improve the quality of services and save staff time and free up resources for the front line;

- Improve the levels of support so those members of staff reliant on corporate services and hospital support services receive better, more efficient support;

- Use resources effectively, generate efficiencies and provide best value.

6.27. Our programme for 2018/19 includes:

- Creating a shared corporate service offer for Greater Manchester that provides high quality, cost effective corporate services;

- Bringing in Greater Manchester organisations (where it meets their organisational objectives), to the new shared service vehicle to unlock over £3m of quick win efficiencies;

- Working with all organisations in Greater Manchester to help organisations improve their corporate services and acting as a broker to connect organisations with service providers, advice and intelligence;

- Implementing the priorities from the tactical procurement efficiencies work stream to bring savings of up to £2m per annum for the region;
• Embedding a Greater Manchester campaign to drive a consistent message on Your Medicine Matters to patients, carers and healthcare professionals across the region as part of the Hospital Pharmacy work;

• Commencing implementation on a solution to provide seamless image sharing and 24/7 real time access to medical images from any approved location in Greater Manchester for all clinicians.

7.0 DELIVERING OUR SYSTEM MANAGEMENT ACCOUNTABILITIES

The Greater Manchester Accountability Agreement

7.1. The Greater Manchester (GM) Health and Social Care Devolution Memorandum of Understanding (MoU), signed in February 2015, facilitated the establishment of a governance approach that would be responsible for the delivery of the GM vision for Health and Social Care. Within this arrangement, NHS England remains legally responsible for the delivery of its statutory functions within Greater Manchester. To honour the principle of devolution, NHS England delegates internal responsibility for the operational management of the delivery of the NHS constitution and mandate to the Greater Manchester Chief Officer (GMCO) as its employee.

7.2. The assurance processes are based on the following assumptions, which are derived from the MoU:

• GMH&SC intends to deliver the NHS Constitution and Mandate commitments in full;

• GMHS&C intends to deliver the actions set out in the NHS Five Year Forward View;

• GMH&SC will demonstrate, through a business case, how it will be a financially and clinically sustainable system within five years (the CSR period) - assurance of delivery of the 5 year plan should be aligned with assurance of in-year delivery;

• The 33 statutory organisations in GMH&SC (10 CCGs, 10 Local Authorities; 13 provider trusts) will continue to exist as sovereign bodies and hold their existing budgets and accountabilities.

Ensuring the delivery of High Quality Services

7.3. Improving the quality of care experienced by people in Greater Manchester is an integral part of all our plans and services. We have agreed not to separate out quality of care from other aspects of our work, but make sure it is always taken fully into account.

7.4. In October 2016 we re-established the GM Quality Board with revised membership and terms of reference and with a renewed focus on system-wide
improvement. It is increasingly providing support and challenge between localities to share learning and foster continual improvement. Reports are received from localities (and other stakeholders such as CQC) and explored by the Board.

7.5. The GM Quality Improvement (GMQI) Framework was approved in September 2017. This is the first model of its kind to offer a shared view of the components of quality improvement across all of health and social care emphasising the similarities as the foundation for improving together.

7.6. Attention has now moved to considering how plans across GM are embedding quality improvement using the GMQI Framework as the reference point. The Quality Board has now begun considering the fit of locality and cross-system plans with the GMQI Framework.

7.7. An important component of the GM QI Framework is the development of communities of practice. Many of these exist, ranging from those brought together to directly support the Transformation Plan to those that are long since established to support service development and strategy. In autumn 2018 we will hold a GM Clinical Summit bringing together clinical leaders of system wide programmes to consider how they can be best engaged to influence and to contribute to all GM programmes.

7.8. In 2017/18 Care Quality Commission ratings of care providers in Greater Manchester improved overall. The ratings for General Practice were mostly very pleasing and important improvements were achieved in social care and elsewhere. The Partnership will continue to work closely with regulators in 2018/19 to make sure Improvement continues and new services in localities meet service user expectations.

Ensuring Financial Sustainability – Financial Plan 2018/19

7.9. This section sets out a summary of the planned surplus/(deficits) for 2018/19 across all the partner organisations within the GM Health and Social Care Partnership and presents this as a consolidated financial control total for GM against which our financial performance will be measured.

Context

7.10. All NHS partner organisations are required to comply with the national NHS Operational Planning guidance. GM CCGs and Provider Trusts are also required to comply with the national guidance and timetable on 18/19 planning.

7.11. The guidance published jointly by NHS England and NHS Improvement in September 2016 covered a two year planning round up to and including 2018/19. The planning intention for 18/19 was that plans would be refreshed on a ‘light touch’ basis.

7.12. For GM, we acknowledge that this has in most areas re-opened discussions on 18/19 contract given the need to re-visit activity assumptions and consequently for
localities to refresh their Transformation Fund Investment Agreement to ensure alignment with 18/19 operational plans.

7.13. Whilst GM CCGs will continue to have financial performance measured at a GM level, NHS providers will continue to be managed at an individual organisation level in 18/19. However, the planning guidance described how the enhanced Provider Sustainability Fund (PSF), now increased from £1.8bn to £2.45bn nationally, could be linked to the collective delivery of control totals.

7.14. GM assessed the impact of the initial national proposal for a System Control Total offered by NHS England and set up a GM Health and Care Board Executive Working Group to co-design a revision to the original proposal which maintains the spirit of the national guidance and creates an incentive for system performance which also delivers an improved financial bottom line for Greater Manchester and allows additional PSF to be earned by providers.

7.15. In order to aid delivery of the improved financial position required to access the additional PSF, GM have introduced an ‘Accelerated Efficiency Programme' to deliver efficiencies on a GM-wide basis to drive out cash releasing savings from 2018/19 and onwards.

7.16. The process will be led and managed jointly by GM CCG CFOs and Provider (Acute & Mental Health) Directors of Finance and all efficiency measures/schemes identified will have an executive level sponsor. The following are examples of areas already identified as part of the joint working:

- Medical staffing – agency;
- Common Discharge Policy;
- Procurement;
- Medicines Optimisation;
- Review Out of Area placements

Summary

7.17. NHS Acute and Mental Health Providers - each NHS acute and mental health Trust is required to set a plan in line with its control total which then ensures eligibility for receipt of PSF. Provider trusts unable to plan in line with their control total will therefore not be eligible for receipt of PSF.

7.18. For 18/19, NHSI has set control totals for providers which collectively for GM amounts to a c£54m deficit which will attract c£130.5m of PSF should all providers plan to deliver their share of the £54m deficit control total. This will result in GM provider sector delivering a £76.5m planned surplus given PSF.

7.19. For CCGs, budgets are determined against confirmed and anticipated resource limits ensuring that, upon inclusion of efficiency (QIPP) programmes, an overall
balanced position is delivered in-year. It is this in-year performance which is used to measure delivery of the statutory duty to break-even.

7.20. NHSE business rules also require CCGs to maintain a historic surplus of 1% surplus in accordance with the NHS England (NHSE) business rules. Delivery of business rules by CCGs is shown in table 2 below.

7.21. NHSE managed Direct Commissioning budgets - this includes Primary Care budgets (Dental, Ophthalmic and Pharmacy) and Public Health budgets (Screening, Immunisation & Vaccination), the 2018/19 plans show a balanced position.

7.22. Local Authorities - are required to set a balanced budget, formally approved by full Council by 31st March each year. For the purposes of GMHSCP financial planning, only the Adult Social Care elements of LA budgets and/or wider budgets jointly pooled with health bodies are included within the 2018/19 financial plan.

7.23. The table below sets out summary financial plans for 18/19 across each of the three sectors (i.e. CCGs, Acute & Mental Health Providers, Local Authorities and NHSE Direct Commissioned) both at individual organisation level and consolidated into a GM total across each of the sectors.

**GM CCGs**

7.24. Table 1 below sets out the planned surpluses across the 10 GM CCGs for 18/19

<table>
<thead>
<tr>
<th>Table 1 CCG Plans</th>
<th>18-19 Plans Plan Surplus /(Deficit)</th>
<th>Historic surplus (draft)</th>
<th>18/19 b/fwd Plan Surplus /(Deficit)</th>
<th>£'000</th>
<th>£'000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>0</td>
<td></td>
<td>10,793</td>
<td>10,793</td>
<td>2.3%</td>
<td></td>
</tr>
<tr>
<td>Bury</td>
<td>0</td>
<td></td>
<td>6,958</td>
<td>6,958</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>HMR</td>
<td>0</td>
<td></td>
<td>8,542</td>
<td>8,542</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>Manchester</td>
<td>0</td>
<td></td>
<td>27,389</td>
<td>21,389</td>
<td>2.3%</td>
<td></td>
</tr>
<tr>
<td>Oldham</td>
<td>0</td>
<td></td>
<td>9,800</td>
<td>9,414</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>Salford</td>
<td>0</td>
<td></td>
<td>15,417</td>
<td>12,825</td>
<td>2.9%</td>
<td></td>
</tr>
<tr>
<td>Stockport</td>
<td>0</td>
<td></td>
<td>10,831</td>
<td>10,831</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>T&amp;G</td>
<td>0</td>
<td></td>
<td>9,347</td>
<td>9,347</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>Trafford</td>
<td>0</td>
<td></td>
<td>(3,901)</td>
<td>(3,901)</td>
<td>-1.5%</td>
<td></td>
</tr>
<tr>
<td>Wigan</td>
<td>0</td>
<td></td>
<td>12,407</td>
<td>12,407</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>0</td>
<td></td>
<td><strong>107,583</strong></td>
<td><strong>98,605</strong></td>
<td><strong>2.2%</strong></td>
<td></td>
</tr>
</tbody>
</table>

7.25. National policy on CCG historic underspends remains that each CCG must deliver a 1% surplus which will continue to be held centrally. Access to these reserves is on basis of an approved ‘drawdown’ limit allocated by NHSE central team to the GM system which is £9m in 18/19.
7.26. Table 1 above shows that CCGs are planning break even on an in-year basis and plan to deliver their statutory duties. A historic surplus of £107.6m is expected to be brought forward from 17/18 which reduces to £98.6m in recognition of approved drawdown for 3 CCGs. The historic surplus is equivalent to 2.2% of 18/19 allocation which is above 1% national requirement.

GM Provider Trusts

Table 2 – 18/19 Provider Plans & PSF availability

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>18/19 Plan Surplus / Deficit (exc. PSF) £’000</th>
<th>Control Total (exc. PSF) £’000</th>
<th>PSF Planned £’000</th>
<th>18/19 Control Total Surplus / Deficit (inc. PSF) £’000</th>
<th>PSF Allocation £’000</th>
<th>Control Total Plan (inc. PSF) £’000</th>
<th>Plan to Control Total Variance (exc. PSF) £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton Hospital NHSFT</td>
<td>1,623</td>
<td>Yes</td>
<td>13,094</td>
<td>12,717</td>
<td>12,717</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Greater Manchester West Mental Health NHSFT</td>
<td>(200)</td>
<td>Yes</td>
<td>2,492</td>
<td>2,292</td>
<td>(200)</td>
<td>2,492</td>
<td>2,292</td>
</tr>
<tr>
<td>Manchester University NHSFT</td>
<td>(12,084)</td>
<td>Yes</td>
<td>44,931</td>
<td>32,847</td>
<td>(12,084)</td>
<td>44,931</td>
<td>32,847</td>
</tr>
<tr>
<td>Pennine Acute Hospitals NHS Trust</td>
<td>(68,858)</td>
<td>No</td>
<td>(68,858)</td>
<td>(16,877)</td>
<td>25,453</td>
<td>8,576</td>
<td>(51,981)</td>
</tr>
<tr>
<td>Pennine Care NHSFT</td>
<td>(11,186)</td>
<td>No</td>
<td>(11,186)</td>
<td>1,087</td>
<td>2,565</td>
<td>3,652</td>
<td>(12,273)</td>
</tr>
<tr>
<td>Salford Royal NHSFT</td>
<td>(9,313)</td>
<td>Yes</td>
<td>14,687</td>
<td>5,374</td>
<td>(9,313)</td>
<td>14,687</td>
<td>5,374</td>
</tr>
<tr>
<td>Stockport NHSFT</td>
<td>(33,820)</td>
<td>No</td>
<td>(33,820)</td>
<td>(8,689)</td>
<td>10,699</td>
<td>2,010</td>
<td>(25,131)</td>
</tr>
<tr>
<td>Tameside Hospital NHSFT</td>
<td>(25,668)</td>
<td>No</td>
<td>(25,668)</td>
<td>(9,379)</td>
<td>8,442</td>
<td>(1,437)</td>
<td>(15,789)</td>
</tr>
<tr>
<td>The Christie NHSFT</td>
<td>6,687</td>
<td>Yes</td>
<td>2,102</td>
<td>8,789</td>
<td>6,687</td>
<td>2,102</td>
<td>8,789</td>
</tr>
<tr>
<td>Warrington, Wigan and Leigh NHSFT</td>
<td>(6,378)</td>
<td>Yes</td>
<td>8,060</td>
<td>1,682</td>
<td>(6,378)</td>
<td>8,060</td>
<td>1,682</td>
</tr>
<tr>
<td>Provider Total</td>
<td>(159,197)</td>
<td>83,366</td>
<td>(75,831)</td>
<td>(54,023)</td>
<td>130,525</td>
<td>76,502</td>
<td>(105,174)</td>
</tr>
</tbody>
</table>

7.27. GM providers have planned for a collective deficit of £75.83m including PSF. There are four providers that have not accepted their Control Total which would, collectively, be required to improve their plan position by £105.2m in order to deliver the £76.5m surplus control total for GM as required by NHSI.

NHSE Direct Commissioned Services

7.28. Table 3 below gives a summary of the Direct Commissioning (DC) plan for 18/19. The table demonstrates that DC budgets have planned for an in year break even position, whilst maintaining historic surpluses.

7.29. DC budget will receive additional growth £4.69m recurrent allocation to support budget pressures from 2017/18. In addition to this DC expenditure plans are expected to reduce by £6.1m from the 2017/18 level due to planned changes to independent contractor contracts, all of which were notified in the planning assumptions provided by the national team.

7.30. The combination of the additional growth funding together with expected reduction in spending plans, allow DC to plan for a balanced budget. The balanced budget including a 0.5% contingency reserve of £1.72m, investment reserves of £1.18m and requiring a £0.68m QIPP target to drive through efficiencies within Direct Commissioning contracts.

7.31. The accuracy of these figures is heavily reliant on the national planning assumptions being delivered. There remains an inherent risk that not all national contract changes will deliver the savings as planned and therefore these
assumptions have been highlighted as a financial risk to ensure that they are closely monitored throughout the year. Any deviations from plan will need to be identified and quantified.

7.32. Failure to achieve planning assumptions may potentially lead to a financial pressure for GM with mitigation offered by the contingency of £1.72m and / or retained investment reserves of £0.56m. This is summarised in the table below.

<table>
<thead>
<tr>
<th>2018/19 DC Allocation</th>
<th>Primary Care</th>
<th>Public Health</th>
<th>Health &amp; Justice</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’m</td>
<td>£’m</td>
<td>£’m</td>
<td>£’m</td>
</tr>
<tr>
<td>Total Recurrent Allocation/Budget</td>
<td>290.57</td>
<td>49.91</td>
<td>3.74</td>
<td>344.22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/19 Spend budget</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC Budget Commitments</td>
<td>(289.09)</td>
<td>(49.18)</td>
<td>(3.72)</td>
<td>(341.99)</td>
</tr>
<tr>
<td>Investment Reserve - available immediate</td>
<td>(0.34)</td>
<td>(0.29)</td>
<td>(0.63)</td>
<td></td>
</tr>
<tr>
<td>Investment Reserve</td>
<td>(0.37)</td>
<td>(0.19)</td>
<td>-</td>
<td>(0.56)</td>
</tr>
<tr>
<td>0.5% Contingency Reserve</td>
<td>(1.45)</td>
<td>(0.25)</td>
<td>(0.02)</td>
<td>(1.72)</td>
</tr>
<tr>
<td>QIPP</td>
<td>0.68</td>
<td>-</td>
<td>-</td>
<td>0.68</td>
</tr>
<tr>
<td>Total Application of Funds</td>
<td>(290.57)</td>
<td>(49.91)</td>
<td>(3.74)</td>
<td>(344.22)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surplus/ (Deficit)</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/19 Risks</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
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<tbody>
<tr>
<td>Contracts</td>
<td>(0.99)</td>
<td>(0.43)</td>
<td>-</td>
<td>(1.42)</td>
</tr>
<tr>
<td>Planning Assumptions</td>
<td>(0.83)</td>
<td>-</td>
<td>-</td>
<td>(0.83)</td>
</tr>
<tr>
<td>Non Delivery of QIPP</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Risks</td>
<td>(1.82)</td>
<td>(0.43)</td>
<td>-</td>
<td>(2.25)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/19 Mitigations</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency &amp; General Reserve</td>
<td>1.82</td>
<td>0.44</td>
<td>-</td>
<td>2.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/19 Net Surplus/(Net Risk)</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
<th>£’m</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Historic Surplus C/fwd</th>
<th>£’m</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC Historic Surplus C/fwd into 2017/18</td>
<td>36.37</td>
</tr>
<tr>
<td>2017/18 Primary Care Surplus - Pre audited accounts</td>
<td>0.60</td>
</tr>
<tr>
<td>Total Anticipated C/fwd surplus for 2018/19</td>
<td>36.97</td>
</tr>
</tbody>
</table>

Local Authorities

7.33. Local Authority budgets for 2018/19 are in the process of being ratified via local governance processes and are expected to be in place by the end of May 2018. For the purposes of 18/19, the planning assumption is that all Adult Social Care and wider pooled budgets (including Children) are expected to deliver a balanced position in 18/19.

7.34. Table 4 below sets out which LA budgets have been included within GMHSCP envelope noting that the financial value of these is yet to be advised.
Table 5: Summary of GM Draft Financial Plan 18/19

<table>
<thead>
<tr>
<th>Status</th>
<th>CCG</th>
<th>Providers</th>
<th>NHSE (DC)</th>
<th>LA</th>
<th>GM Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan requirement</td>
<td>0</td>
<td>(54,023)</td>
<td>0</td>
<td>0</td>
<td>(54,023)</td>
</tr>
<tr>
<td>Plan submission</td>
<td>0</td>
<td>(159,157)</td>
<td>0</td>
<td>0</td>
<td>(159,157)</td>
</tr>
<tr>
<td>Variance</td>
<td>0</td>
<td>(105,174)</td>
<td>0</td>
<td>0</td>
<td>(105,174)</td>
</tr>
<tr>
<td>Historically spends b/fwd</td>
<td>107,583</td>
<td>36,973</td>
<td></td>
<td></td>
<td>144,556</td>
</tr>
<tr>
<td>Drawdown</td>
<td>(8,978)</td>
<td></td>
<td></td>
<td></td>
<td>(8,978)</td>
</tr>
<tr>
<td>Accumulated position 31/3/19</td>
<td>98,605</td>
<td>36,973</td>
<td></td>
<td></td>
<td>135,578</td>
</tr>
</tbody>
</table>

Capital Funding

7.35. GMHSCP is awaiting confirmation of 3 sources of capital for 18/19:

- NHSE Capital Funding – GP Primary Care c£19m;
- Digital Funding – c£10m;
- Strategic capital: GM bid against strategic capital to support Healthier Together and Major Trauma scheme – c£93m

7.36. Sources of capital funding for schemes outside of this process continue to be explored by GM with emphasis being put on public private partnerships and the prudential borrowing code.

7.37. It continues to be the GM Partnership’s position that the current capital funding system – for digital and estates – does not accord with the principles of devolution and acts as a drag on the service transformation process. We will continue to argue for change.

Ensuring delivery of minimum national standards of performance

7.39 The following principles are being applied in the arrangements for CCG assessment within GM which include:

- Through delegation to the GM Chief Officer, GM will be assessed once as a place, for delivery of the Five Year Forward View, NHS Constitution and mandate, financial control and quality;
- We aim to move the focus of assessment to quality of care and experience and outcomes for the population of GMH&SC;
Being aligned and developing alongside the assurance and regulation processes being developed and agreed with NHS Improvement is key to our success;

We expect CCGs to demonstrate plans in a number of clinical and service areas (not least against the Five Year Forward View and the priorities in the NHS England business plan). The Chief Officer will need to provide assurance that these plans are in place and robust enough to deliver the stated objectives;

Local plans will need to be consistent with the Sustainability and Transformation Plans (STP – “Taking Charge” for GM) as developed by the GMH&SC and in support of the NHS Five Year Forward View.

8.0 MEASURING OUR PROGRESS IN 2018/19

8.1. As part of the Portfolio review, we have established a process to measure the progress and effectiveness of delivery at locality and Greater Manchester programme level for 2018/19.

8.2. The Greater Manchester dashboard has been developed to include a series of indicators relating to:

- Population health;
- Process inputs;
- Process outputs;
- User/ staff satisfaction.
8.3. The scorecard is built up and assured as follows:

### System Management Assurance processes

<table>
<thead>
<tr>
<th>GM Scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Population health outcomes</td>
</tr>
<tr>
<td>- Transforming the health and social care system to help more people stay well and take better care of those who are ill</td>
</tr>
<tr>
<td>- Aligning our health and social care system to education, skills, work and housing</td>
</tr>
<tr>
<td>- Creating a financially balanced and sustainable system</td>
</tr>
<tr>
<td>- Making sure our services are clinically safe throughout</td>
</tr>
</tbody>
</table>

- **Quarterly review by SPEE**

- **Individual Transformation Programmes** (including CCG IAF and locality IA metrics)

- **Performance Indicators**
  - **Monthly review by P&D**

- **Quality Indicators**
  - **Monthly review by Quality Board**

- **Finance Indicators**
  - **Monthly review by FES**

8.4. A vital element of our monitoring approach in 2018/19 will focus on the Transformation Fund investment agreements. In order to ensure that the whole system is clear on how delivery against investment agreements will be monitored, a formal assurance escalation process has been approved via our governance. This includes a consistent escalation process.

8.5. Alongside this approach, we are working with all localities to align investment agreements, operating plans, and contracts.

8.6. As well as maintaining the assurance function of the Partnership, we will enhance business intelligence across Greater Manchester. In 2018/19, we will move towards a single collaborative platform for business intelligence, so that we can establish high-quality information flows which serve multiple functions. This will include the metrics required to measure both our constitutional.

**Key Risks to Delivery**

8.7. Our performance monitoring systems will facilitate a more co-ordinated response when key indicators of the health of our system are not on track.

8.8. Our risk management approach has been reviewed so that we now have a combined function to ensure that both Partnership Board Executive and NHS. Through the Board Assurance Framework, risks are profiled on a quarterly basis, with an assessment being undertaken by the lead Executive within the Partnership Team.
8.9. Based on the position in 2017/18, a key risk will be A&E performance in Greater Manchester. Our wide-ranging work on Urgent and Emergency Care, described earlier in this document, will support an improvement in the position in 2018/19 – but we recognise that this will be challenging.

8.10. Other key performance risks that we will need to tackle will be the high levels of stranded patients in Greater Manchester as a proportion of total bed days (a stranded patient is someone who has been in hospital over seven days) and meeting all eight of the national cancer standards.

Evaluation

8.11. As part of the devolution agreement with NHS England, we committed to undertake a comprehensive evaluation of our strategic plan for health and social care.

8.12. A quantitative evaluation across Greater Manchester is already underway, funded by the Health Foundation and led by the University of Manchester.

8.13. In January 2018, we agreed our approach to the qualitative evaluation of the locality plans and GM-level programmes. This evaluation will commence in 2018/19 following a procurement process.

List of Appendices to Support the Business Plan

<table>
<thead>
<tr>
<th>No.</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Programmes and projects for implementation during 18/19: The GM response to annex A of the planning guidance</td>
</tr>
<tr>
<td>2</td>
<td>Constitutional Standards</td>
</tr>
<tr>
<td>3</td>
<td>Quality Improvement Framework</td>
</tr>
<tr>
<td>4</td>
<td>Definition of the Transformation Portfolio</td>
</tr>
<tr>
<td>5</td>
<td>GM Operational Plan 2018/19</td>
</tr>
<tr>
<td>6</td>
<td>Process to Assure Delivery</td>
</tr>
</tbody>
</table>
# 10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

## PROJECTS FOR IMPLEMENTATION IN 18/19

### 1.1 Acute Services Transformation: GMS Implementation Priority Area

| Locality and HM Treasury funded with locality implementation | 1 | Acute & Emergency Medicine:  
* A&E consultant cover at surgical hub sites: minimum 16 hours/7 days, Major Trauma Centre 24 hours  
* A&E consultant cover at non-surgical hub sites: minimum of 12 hours/7 days.  
* Acute Medical Units at each site with 12 hours consultant cover/7 days. |
| --- | --- | --- |
| General Surgery:  
Hub sites established at Salford Royal, Stepping Hill Hospital, Manchester Royal Infirmary, and Royal Oldham Hospital which will manage all emergency high risk general surgical patients and high risk elective general surgical patients, e.g. patients with colorectal cancer.  
* All low risk elective surgery to be offered by all sites based on local population requirements.  
* Colorectal MDT process to be established at a sector level, ready for the transfer of high risk elective patients.  
* ERAS+ programme to be established to support high risk elective patients.  
* CPET to be established to provide estimation of risk pre-operatively.  
* Redesign of GI bleeds pathways in line with the reconfiguration.  
* The provision of Paediatric General Surgery to be aligned within sector single services, with pathways redesigned to support this. |
| Funded by GM and implemented at locality level | 3 | Oesophago-gastric (OG) cancer surgery  
Single site for Oesophago-gastric OG cancer resections with the Lead Provider being Salford Royal Foundation Trust. Patient transfers from Manchester Foundation Trust agreed as starting from 9 July 2018. |
| 4 | Urological Cancer (formally known as Urology Cancer)  
Single service with Lead and Key Provider. MFT, Wythenshawe site for kidney and bladder and The Christie for prostate. |
| 5 | Gynaecological Cancer  
The creation of a single service for specialised gynaecological cancer surgery with Manchester Foundation Trust as the Lead Provider and The Christie as the Key Provider. |

### 1.2 Adult Social Care: GMS Implementation Priority Area

| Locality engagement in GM funded programmes of work | 1 | Learning Disability Strategy: (Learning Disability Programme)  
The development of a strategy which will support a joined up approach to improve the quality of life and services for people with learning disabilities in GM. Co-production, independence, enablement and citizenship will be key themes and the strategy will also work across existing programmes e.g. Transforming Care, Personalisation and adult social care to support coherency and effective utilisation of resources.  
Expected completion July 2018 |
| --- | --- | --- |
| 2 | Market shaping / engagement / strategic management of the adult social care system  
Enabling work aligned to the adult social care transformation programme.  
Being delivered as part of BAU. |
### 1.3 Cancer

| Locality awareness of GM funded programmes of work | 1 | **NATIONAL PLANNING GUIDANCE PRIORITY AREA**
Ensure 85% of patients continue to meet the 62 day cancer waiting time standard. Work towards achievement of the 28-day faster diagnosis standard. Ensure sufficient capacity for timed pathways for lung and HPB to deliver a
• 50-day standard
• 42-day standard
Implementation of 12 point action plan to support delivery of cancer standards.

This contributes to the national requirement to ensure all eight waiting time standards for cancer are met, including the 62 day referral-to-treatment cancer standard. The ‘10 high impact actions’ for meeting the 62 day standard should be implemented in all trusts, with oversight and coordination by Cancer Alliances. The release of cancer transformation funding in 2018/19 will continue to be linked to delivery of the 62 day cancer standard. |

### 1.4 Clinical Support Services

| Locality awareness and provider engagement | 2 | Hospital Pharmacy: Your Medicine Matters
Delivering a Greater Manchester Patients’ Own Drugs campaign across GM to drive a consistent message to patients, carers and healthcare professionals across the region
Alternative funding sources being explored. |
| --- | --- | Radiology: Greater Manchester Collaborative Imaging Procurement (GMCIP)
To deliver a procurement of a strategic Enterprise Imaging solution to provide seamless image sharing and 24/7 real time access to medical images from any GM Trust for all clinicians |

### 1.5 Children and Young People

| Locality | 2 | Piloting the implementation of community children’s hub
Rochdale will develop and trial a paediatric community hub framework, operational from January 2018. Oldham and Salford to pilot hub working as part of a package of measures to prevent avoidable admissions 18/19. Evaluation will inform JCB in the wider commissioning to prevent avoidable admissions for children (inc O&A, CCNT, community hub, paediatric phone line, clinical pathways).
Following CHWBB deep dive into preventing avoidable admissions for children with asthma, epilepsy and diabetes, working groups have been established to develop potential solutions. This is resulting in a suite of recommendations including paediatric community hub, clinical pathways, Observation and assessment units, children’s community nursing teams, paediatric phone line for GPs to use. These will be trialed and evaluated at Salford, Rochdale and Oldham in 2018. Evaluation will help inform JCB and services. Not all localities |
| --- | --- | Developing a GM young people’s data dashboard |
The GM children’s and maternity data dashboard will give an overview of performance across GM for the GM Children’s and Maternity Board. It will enable localities to compare data for their areas in relation to other GM localities, similar localities from around the country and trends for retrospective comparison. It is funded and developed by GM. Locality CCGs will have access to the dashboard via N3 connection from spring 2018. Roll out to localities to be via local champions, which they will nominate.

1.6 Dementia (numbers with bracket are the GM dementia standard reference)

<table>
<thead>
<tr>
<th>Funded by GM and implemented at locality level</th>
<th>NATIONAL PLANNING GUIDANCE PRIORITY AREA</th>
</tr>
</thead>
</table>
| 1                                              | Diagnosing well (Work plan focus area – Mild Cognitive impairment, Young onset and rarer forms of dementia, Under served populations and Post diagnostic support):
1) Achieve dementia diagnosis rates comparable with the top 20% nationally  
2) People receiving an initial assessment and diagnosis will feel this is timely  
3) People will receive a comprehensive assessment of mental and physical health issues as part of the diagnostic process and at regular intervals subsequently  
4) People will be offered medication in line with NICE guidelines  

This contributes to the national requirement for CCGs to continue to meet the dementia diagnosis standard, which was at 66.7% (February 2018) and improve post diagnostic care for 18/19.

2                                              | Dying well (Work plan focus area – End of Life Care):
15) All people with a diagnosis of dementia will have their choices and preferences a preferred place of death recorded in their care record, including place of care and death.

3                                              | Preventing well (Work plan focus area – Prevention and Under served populations):
NHS health checks with dementia screening specifically documented

4                                              | SCN Evidence Based Interactive Toolkit (Work plan focus area – Post diagnostic support):
Reduces variation, single pathway and sharing best practice across all GM dementia standards

5                                              | Supporting well (Work plan focus area – Post diagnostic support, Dementia friendly transport systems, Young onset and rarer forms of dementia and Lived experience barometer):
9) Information and signposting to peer support group(s) and networks available that are appropriate to needs and preferences of people with dementia  
10) People with dementia will have their living well plan reviewed at least annually  
11) People with dementia will be offered access to a structured group cognitive stimulation programme (or equivalent)  
12) Information and signposting to peer support group(s) and networks available that are appropriate to needs and preferences of carers of people with dementia  
13) Carers of people with dementia will be offered evidenced-based therapy’s and multicomponent interventions suited to the
| Differing circumstances of dementia carers and assessed as helpful, such as Strategies for Relatives (START).  
14) Carers and people with dementia will be able to access appropriate multi-disciplinary support at times of crisis through a clear single point of contact |
|GM funded with locality awareness and provider engagement |
| Implementation - Delivering well (Work plan focus area – Post diagnostic support, Dementia friendly transport systems and Care Homes):  
5) All hospitals will commit to improving the experience of people living with dementia and their carers during a hospital stay e.g. becoming dementia friendly environments  
6) All hospitals will adopt John’s Campaign and allow open visiting for people living with dementia and their carers during periods of acute hospitalisation by Financial Year 2017-2018  
7) Care/Nursing/Residential homes improvement project |

### 1.7 Diabetes

| NHSE North and GMSS funded with locality implementation |
| Co-ordination & assurance of the roll-out of the NDPP Wave 2 across GM |

### 1.8 Estates

| Funded by GM and implemented at locality level |
| Supporting Locality Strategic Estates Groups  
Providing support including specialist estates advice and guidance to Strategic Estates Groups including supporting localities with recruitment processes. Our team also provides leadership and input on key estates projects arising from our programme themes in localities, such as the work on the Withington and Burnage hubs or the Shire Hill optimisation project. |
| Locality engagement in GM funded programmes of work |
| Develop GM Mental Health Estates Strategy:  
First draft of Mental Health Estates Strategy to be published in April 2018. |
| GMHSCP coordinate programme of master planning at sites across and commission external support to undertake master planning.  
Place-based Master planning: Undertaking reviews of acute sites to look at how the estate could be better used to support the locality plan taking into account the wider public service context.  
Capital Financing; Development and Prioritisation of Investment Pipeline. Capturing the need for changes to estate across Greater Manchester and supporting localities to prioritise their projects.  
Localities providing data. |
| ETTF funded with locality providing data |
| GM Data Mapping: Mapping key health and social care sites to inform strategic planning of estate. |
| ETTF and One Public Estate funded with |
| Neighbourhood Asset Reviews  
Undertaking reviews of the health and social care and wider estate in specific neighbourhoods within localities. The intelligence from this exercise will inform strategic planning of the estate and identify opportunities for improvement. |
10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

| locality providing data | 7 | Utilisation
Supporting localities to improve the utilisation of their estate. This includes influencing a number of enablers of utilisation e.g. centre management and having online booking systems. |
|------------------------|--|--|
| ETTF funding with locality implementation | 8 | NHS Office Rationalisation:
Rationalisation of number of (non-clinical) office sites across Greater Manchester to generate savings on running costs. |
| NHS Property Services funding with locality engagement | 9 | Surplus land disposals and housing numbers
Identifying land that is likely to become surplus and planning for disposal. This looks at opportunities to release land for housing or employment opportunities where possible. Established as part of the MOU with the Department of Health. |
| No funding required, locality providing data | 1 | PHASE 1 Homelessness
Homelessness is a Mayoral and Greater Manchester priority with a commitment to end rough sleeping and reduce homelessness by 2020. GM Health and Social Care Partnership has committed to supporting this agenda through the development of a work plan which will address access to health services, reshaping of service delivery and commissioning where required and developing our workforce.
The Homelessness and Health programme has the following priorities;
Ensuring all people experiencing homelessness can register with a GP
Developing a GM Homeless Hospital Discharge Protocol, to ensure that where possible there is no discharge to the streets
Supporting localities to develop outreach of health services into homelessness settings and onto the streets
Supporting localities to take a more flexible and joined up approach to commissioning services for people who are homeless or have complex needs
Pilot an approach to Mental Health outreach and support localities to develop services based on pilot outcomes
Support health and care providers to implement the Homelessness Reduction Act. |
| No funding, locality engagement | 2 | PHASE 1 Supported Housing
The Supported Housing programme is an integral part of Adult Social Care Transformation. The programme aims to develop a clear vision and strategy for a supported housing market that responds to the needs of our older population and those requiring support, and enables them to live healthy, safe, fulfilling lives.
The Supported Housing programme is developing activity in a number of areas; Age friendly housing; Learning disability and mental health; Improving our evidence base; Intermediate Care; Enabling planning and delivery and Technology Enabled Care. |
| 1.10 IM&T (Digital) | 1 | Electronic document sharing
Expansion of the existing PCTI DocMan Electronic Document Transfer (EDT) mechanism to allow correspondence to be shared bi-
## 10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

<table>
<thead>
<tr>
<th>Locality level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>directionally between all organisations - this should include GPs and associated primary care teams, Acute, Community, Mental Health, Social Care, Third Sector and the Citizen.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funded by GM and implemented at locality level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Datawell</td>
<td>Connects with local integrated records to support exchange of information across geographical and organisational boundaries</td>
</tr>
<tr>
<td>3 Digital Funds to support locality and GM transformation</td>
<td>The Digital Transformation Fund is part of a wider funding pot that NHSE has secured to support provider digitisation. It is related (through the NHSE “Driving Digital Maturity Programme”) to a fund already secured by NHSE for Global Digital Exemplars (GDE). GM has been allocated a significant share of the provider digitisation funding, to form the first tranche of the GM Digital Transformation Fund. This sits alongside the existing GM Transformation Fund to contribute capital and revenue funding for the delivery of IM&amp;T elements of Locality Plans, and GM wide IM&amp;T programmes and priorities.</td>
</tr>
<tr>
<td>4 GM Patient Wi-Fi Facility to allow citizens access to the Internet across all health and social care locations</td>
<td></td>
</tr>
<tr>
<td>5 Single Wi-Fi SSID across entire public sector</td>
<td>Expansion of existing wireless network across all health and social care locations, facilitating the access of all staff to clinical systems within their own organisation from any health and social care location</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locality engagement in GM funded programmes of work</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Assets, consolidation and collaboration</td>
<td></td>
</tr>
<tr>
<td>Complete IM&amp;T inventory across GM health and social care organisations to ensure GM understands the assets across all organisations together with a cloud assessment. This will allow a standardized architectural approach to technology right across GM, looking for reduced costs and increased capabilities.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Locality engagement in locality funded programme of work</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 GM Imaging Procurement</td>
<td></td>
</tr>
<tr>
<td>The project aims to deliver an operationally and technically resilient standards based enterprise archive and clinical radiology reporting/viewing solution to facilitate image and report sharing across GM, enabling collaboration between clinicians and facilities and providing clinical workflow platform to support organisational and regional transformation. An additional programme of work is required to deliver the transformation and benefits.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>National funding with locality implementation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 High availability resilient network/Migration from current N3 to HSCN</td>
<td></td>
</tr>
<tr>
<td>Collaborative procurement of HSCN connectivity services for all Greater Manchester health and social care organisations allowing for the reduction of duplication across Network infrastructures, ensuring that all locations have a suitable connection that has resilience and can be utilised by all organisations/services that operate from each location, opposed to having a connection per organisation.</td>
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</table>

<table>
<thead>
<tr>
<th>Business Intelligence</th>
<th>Description</th>
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<tbody>
<tr>
<td>9 Business Intelligence Hub</td>
<td></td>
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<tr>
<td>We will work with organisations with joined datasets to get a true holistic picture of population requirements at both aggregate and (non-identifiable) person level through risk stratification solutions. Enabling outcomes and benefits to be tested across a whole system and shared wider to maximise the benefits.</td>
<td></td>
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### 1.11 Learning Disabilities
### NATIONAL PLANNING GUIDANCE PRIORITY AREA

**Approach to case management for Transforming care:** including dynamic risk registers and CTRs

Continue to deliver inpatient discharges and prevent admissions to deliver GM inpatient reduction target of 35 CCG commissioned inpatients and 51 spec comm commissioned inpatients. Maintain dynamic risk registers and deliver Care and Treatment Reviews in line with national guidance. Support new working arrangements and care pathways between local CLDTs and new GM Commissioned Specialist Support Service and acute LD beds.

This contributes to the following national requirements:

1. New and expanded community teams to support people with a learning disability at risk of admission to hospital, backed by £10 million transformation funding. GM have established a specialist support service to work with community teams to provide intensive support for those in crisis and recently discharged, to prevent admission to hospital.

2. 6% reduction in inappropriate hospitalisation of people with a learning disability, autism or both, between March and November 2017, totalling a 14% reduction since March 2015. In addition, over 100 people previously in hospital for 5 years or more were discharged between March and November 2017. GM March 2018 targets is 120 inpatients. Actual: 116 (43 CCG commissioning, 67 adult spec comm inpatients, 6 CYP spec comm inpatients).

3. Continue to reduce inappropriate hospitalisation of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. As part of achieving that reduction we expect CCGs and TCPs to place a particular emphasis on making a substantial reduction in the number of long-stay (5 year+ inpatients). GM March 2019 Targets are:
   - 35 CCG commissioned inpatients
   - 51 Spec comm commissioned inpatients
   - (37 5yr+ patients)

Make further investment in community teams to avoid hospitalisation, including through use of the £10 million transformation fund. The GM plan is subject to the decision on Transformation Fund bid to support development of autism and CYP services.

| Locality engagement in GM funded programmes of work | 2 | Workforce - develop strategy and support existing workforce
 Develop and implement GM LD Workforce Strategy as part of GM Workforce Plan with HEE, Skills for Care, CCGs and Local Authorities. |

### 1.12 Mental Health: GMS Implementation Priority Area

| Funded and implemented at locality level | 1 | CYP Community Eating Disorders Services: Flexible specialist Children and Adolescent Eating Disorder (CAEDS) service model, delivered through Multidisciplinary community based teams |

This contributes to the national requirement to for 70 new or extended community eating disorder services funded and
10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

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<tbody>
<tr>
<td>1</td>
<td>commissioned nationally. Community Eating Disorder services for GM will be delivered via a cluster model based on recommended population size. This will also help to make further progress towards delivering the 2020/21 waiting time standards for children and young people’s eating disorder services, of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases.</td>
</tr>
<tr>
<td>2</td>
<td>Implementation of GM ADHD standards: Support the embedding of 12 GM agreed standards of care for CYP with ADHD across GM. This includes but not limited to the establishment of a multiagency pathway including education, specialist ADHD teams to consistent of Paeds and CAMHS professionals, and have nurse led specialist ADHD clinics. This will be done through sharing learning and experience across GM localities.</td>
</tr>
<tr>
<td>Funded by GM and localities and implemented at GM and locality level</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>NATIONAL PLANNING GUIDANCE PRIORITY AREA</td>
</tr>
<tr>
<td></td>
<td>24/7 community-based access and Crisis Care (children and young people): By improving the capacity of children, young people, adults and communities to deal with difficult emotions and experiences and reducing social isolation people will develop greater confidence and live happier lives. This contributes to the national requirement to ensure that an additional 49,000 children and young people receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people’s mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs. The GM ambition is for 3,920 (70,000 nationally or 35%) more children will access evidence-based mental health care interventions – including better access for ADHD, eating disorders and those with disabilities</td>
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<tr>
<td>4</td>
<td>GM iThrive Network and CYP MH Workforce development (NHS, LA, and VCSE): The GM Employment &amp; Health Programme will support the integration of health, skills and employment systems to enable delivery of improved health outcomes and economic growth as set out in the Greater Manchester Strategy and the GM Health and Social Care Strategy. The programme objectives will create a system response to ensure: An effective early intervention system available to all GM residents in work who become ill and risk falling out of the labour market Early intervention for those newly out of work who need an enhanced health support offer Better support for the diverse range of people who are long-term economically inactive Development to enable GM employers to provide ‘good work’, and for people to stay healthy and productive in work</td>
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<tr>
<td>Locality engagement in GM funded programmes of work</td>
<td>5</td>
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<td></td>
<td>NATIONAL PLANNING GUIDANCE PRIORITY AREA</td>
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<td></td>
<td>Liaison Mental Health - Core 24 access GM: Liaison mental health will ensure all-age Core-24 compliant support for acute hospitals with 24/7 A&amp;Es and a modified Core-24 service in hospitals with Urgent Care Centres. Implementation and roll out will begin with specialist hospitals to improve early detection and treatment of mental health problems in people with existing physical health problems/ medically unexplained symptoms and people attending acute hospitals in a mental health crisis. The benefits of this are reduced inappropriate inpatient admissions, shorter lengths of stay, fewer delayed discharges and reduced re-admissions. There will</td>
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be a phased approach to expansion of Liaison MH services in all Acute hospitals in GM to achieve staffing levels that as a minimum meet the Core 24 standards.

This contributes to the national requirement to deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds. This also links to continuing to meet the waiting time standard for early intervention in psychosis, and is the reason for the GM £13m+ investment in the CYP Crisis Care Pathway – where the successful submission for delegation of GM MH commissioning noted:

The GM place-based commissioning and investment approach is clear with:
- A commitment to completely “front load” community services/family support;
- 24/7 provision of multi-disciplinary crisis care;
- Multi-disciplinary gatekeeping of inpatient admissions and facilitation of early discharge;
- Appropriate linkages to EI services;
- Eradication of waiting times;
- Consistent access to “Adolescent IAPT”;
- Age appropriate care for 16-18 year olds and an end to the “transition gaps” by developing community/inpatient service models up to 25th birthday;
- Collaborative commissioning across community and inpatient provision;
- Single GM outcomes framework across community and inpatient services;
- Collaborative multi-agency partnerships with local authority, education, police and youth justice system;
- GM provider partnership offer and managed clinical networks across health partners;
- Use of i-Thrive Framework;
- Empowering CYP and families- least restrictive treatment bias option;
- Accessibility for families- local provision;
- Age appropriate and culturally sensitive provision;
- Single point of access to provide triage and bed management;
- Transparency and shared accountability;
- Maximise access to scarce and costly resources by:
  o Use of trusted assessment framework;
  o Use of evidence-based practice;
  o Consider alternatives to inpatient admission first;
  o Information systems to support effective care management (integrate with GM Connect);
- Training and workforce development as part of GM strategy.

MH support in Education Settings: A 6 month Rapid pilot across GM to capture the socio-economic and socio-cultural diversity (aligned to the pre developed School Cluster model); specifically looking at the two features below:
1. We will incentivise every school and college to identify a designated senior lead for mental health to oversee the approach to mental health and well-being. All children and young people’s mental health services should identify a link for schools and colleges. This link will provide rapid advice, consultation and signposting.

2. We will fund new mental health support teams, supervised by NHS children and young people’s mental health staff, to provide specific extra capacity for early intervention and ongoing help. The work will be managed jointly by schools, colleges and the NHS. These teams will be linked to groups of primary and secondary schools and colleges. They will provide interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing.

### NATIONAL PLANNING GUIDANCE PRIORITY AREA

GM Perinatal and Parent-Infant MH: By 2020/21, there will be increased access to specialist perinatal MH support in Greater Manchester, in the community or in-patient mother and baby units, allowing at least an additional 1,680 women each year to receive evidence-based treatment, closer to home, when they need it. This will support:

- Community Parent-Infant MH Early Help Hub Programmes
- Developing and Sustaining GM Perinatal Infant MH Model
- GM Integrated Mother Baby Unit - GM Specialist Perinatal MH Teams
- Specialist in-patient/outreach
- Local Parent-Infant MH Early Help/Attachment Programmes
- Extended Fast-Track IAPT Access

This contributes to the national requirement to expand specialist perinatal care, with over 5,000 additional women accessing these services between April and December 2017. Nationally contracts have been awarded for four new Mother and Baby Units. The GM ambition by 2021, is for at least 1,680 (30,000 nationally) more women each year, to be able to access evidence-based specialist CMHT input and additional input from local parent-infant pathways and Perinatal IAPT.

This project will also contribute to the national requirement to continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19, so that overall capacity is increased by 49%. The GM ambition is for at least 1,680 (30,000 nationally) more women each year to be able to access evidence-based specialist perinatal mental health care, and additional local parent-infant MH support pathways

### 1.13 Person and Community Centred Approaches
<table>
<thead>
<tr>
<th></th>
<th>Funded and implemented at locality level</th>
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<tr>
<td>1</td>
<td>Commissioning asset-based approaches from the VCSE (Partnership model with VCSE &amp; GM localities): Person and Community-Centred Approach is not rolling out a single GM specified standard programme or model of care. It is designed to support each of the localities to develop their own PCCA programme of asset and community-based approaches, the ambition for which features in all locality plans. Different localities have different focus and priorities, and are at different stages of developing and implementing PCCA. Money to support the expansion and delivery of PCCA is held by localities within the Transformation Fund. The GM PCCA team will act as a critical friend, facilitator and adviser to localities on PCCA development and delivery. The H&amp;SCP has established an MOU with the VCSE. A programme of work has been commenced with the VCSE to look at how the statutory health/care sector ensures a viable range of community- asset-based support is available to support people's non-medical needs.</td>
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<tr>
<td>2</td>
<td>Person centred care for people with complex needs To prioritise and scale up of the roll-out of person and community-centred approaches across all ten Greater Manchester localities for three priority groups with complex needs: 1) people with learning disabilities, especially those at risk of being institutionalised; 2) older people with multiple long-term conditions, which may include dementia; 3) people approaching end of life. This would be a minimum core offer for PCCA, but wouldn't prevent localities focusing on other population groups as well.</td>
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<td>3</td>
<td>Person-centred care &amp; support planning To support the development of genuine person-centred thinking and practice in health and social care through skills development, coaching, training and team and individual mentorship approaches. We will see the number of person-centred planning conversations for individuals increase substantially, through advanced care plans for people at End of Life and enhanced supportive care; person-centred plans for people with high needs and a learning disability; person-centred plans for people with long-term conditions accessing support from neighbourhood teams, and person-centred care plans for people getting a personal budget approach. This will result in better experience of care; better outcomes and quality of life; more resilient support that results in reduced crises and institutionalisation.</td>
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<td>4</td>
<td>Social prescribing &amp; Connecting There is an increasing evidence base testifying to the benefits of a social prescribing approach that connects people accessing statutory health and care services with VCSE and community based support around social and environmental factors affecting people’s health and wellbeing. Most social prescribing models centre on primary care services, but they can work equally well linking to social care, mental health, acute or community health settings, and should be a consistent feature of 30-50,000 population integrated neighbourhood multi-disciplinary teams. There are a number of locally developed models and approaches but no consistent offer across GM. This project aims to support all GM localities to have implemented social prescribing programmes by the end of 19/20.</td>
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<tr>
<td>5</td>
<td>Integrated Personal Budgets This project will support the scaling up of personal health budgets and the establishment of integrated personal budget approaches across health and social care, with the expectation that, as a minimum, they will be offered to people in the three complex needs priority population cohorts by end 19/20. The benefits of personal health budgets, if introduced well, are an increase in quality of life related outcomes, and a reduction in use of other health services. For high cost packages, there is also a reduction in direct costs.</td>
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### 1.14 Population Health: GMS Implementation Priority Area

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<th>Funded by GM and implemented at locality level</th>
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<tbody>
<tr>
<td>1</td>
<td>Cancer prevention and early detection</td>
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<td></td>
<td>In 2015 NHS England established the Independent Cancer Taskforce to look at how cancer services are currently provided and to set out a vision for what cancer patients should expect from the health services. GM was designated as part of the National Cancer Vanguard in 2015. The two-year vanguard programme has allowed the testing of clinical innovations and the design of a new approach to the commissioning of cancer and delivery for the GM population. Central to the GM programme is a prevention workstream, which incorporates primary and secondary prevention projects as well as a focus on screening. The four specific objectives are to: 1. Develop new GM-wide social marketing strategies to scale up prevention and earlier detection (Y1 bowel screening; Y2 increasing smoking quits); 2. To nurture a social movement across the entire cancer prevention spectrum that is ultimately self-sustaining; 3. To improve access to and uptake of 3 x national screening programmes among the GM eligible population; 4. To develop a GM-wide service model that increases tailored lifestyle support for those surviving cancer, focusing on reducing the chance of secondary cancer (metastasis).</td>
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<td>2</td>
<td>Focused care</td>
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<td>GM has an increasing number of multiple morbidity patients with growing complexity and long-term conditions generating significant demand on the health and social care system. To combat this growing demand in a more sustainable way GM are actively supporting the scaled trial of an alternative model of care that seeks to address these particular cohorts in a system that is still designed on singular pathway service delivery models. Focused Care offers a place-based service model operating out of the Primary Care setting in areas of deprivation. It is a service model that centres on the patient and their household, helping both navigate their local health and social care systems through an experienced worker/facilitator. The aim of this project is to deliver Focused Care at a greater scale over the next 3 years to test the model, analyse the results and build a clear evidence base to present a case for deploying this method of care to targeted demographics within GM.</td>
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<td>3</td>
<td>Nutrition and hydration</td>
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<td></td>
<td>The aim of this project is to develop a community-based, non-clinical approach to identifying malnutrition amongst older adults aged 65+, following the innovative approach developed in Salford over the past 2-3 years, which includes the paperweight armband tool and a range of self-care support materials and information about simple ways to fortify the diet and improve fluid intake. There are numerous objectives to the programme, but the primary goals are to raise awareness about the risk, signs and symptoms of unplanned weight-loss, malnutrition and dehydration in later life at an individual, family and community support level; and develop a local malnutrition and dehydration pathway or network of support to respond to this which can divert the need for GP or dietetics referral.</td>
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<td>4</td>
<td>Oral health</td>
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<td></td>
<td>The aim of this Project is to support the establishment of a consistent, evidence based oral health improvement programme across the four localities in GM with the poorest child oral health – to deliver “what we know works”, at scale. The proposed interventions of supervised brushing in all early years settings and reception classes, distribution of free-toothbrush and toothpaste packs through health visitors, and increasing the application of fluoride varnish in dental practices have been chosen because of they have the strongest evidence base, highest return on investment, and highest feasibility of implementation.</td>
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</table>
### PHASE 1 Early Years

The Start Well Early Years Strategy was approved by the GM Strategic Partnership Board in June 2016 and sets out the GM vision for transformational system change and a long-term and sustainable shift from expensive and reactive public services to prevention and early intervention. The overall objective of this work is to increase the number of GM children who are school ready, and over the next five years we intend to close the gap between current GM performance and the national average. The GM Early Years Delivery Model comprises three key components: 1. an eight-stage assessment pathway 2. a range of multi-agency pathways and 3. a suite of evidence based assessment tools and targeted interventions. Implementation of the EYDM has progressed at different rates across all areas of GM with a single proposition now being developed that will outline the system wide investment required to delivery EY outcomes and support the full implementation of the early years strategy across GM. As part of that proposition GM will lead the delivery of the following three areas in 18/19:

- **High Needs Pathway:** Localities to work with GMHSCP & GMCA to build on locality best practice to co-produce and implement a set of standards for a High Needs Pathway. This may require service redesign to enable services to respond to complex issues in an integrated place based way e.g. early assessment of need in midwifery.
- **Prevention and antenatal care:** Localities to work with GMHSCP & GMCA to co-produce and implement a set of antenatal evidence based parenting classes to develop a consistent offer across GM. To include a universal and targeted approach focused on prevention and early intervention. This will be a multi-sector model and require workforce development.
- **Parent Infant Mental Health (Aligns with Mental Health transformation commitments):** locality commitment required to implement PIMH pathways developed by the GM system. This will require workforce development.

### Smoking in pregnancy

The programme vision is to reduce smoking in pregnancy across, and within GM, through a standardised smoke free pregnancy pathway with investment in workforce development, equipment provision and a targeted intervention aimed at our highest risk population. Our agreed GM target is to reduce smoking in pregnancy from 13% to 6% by 2021. The proposed scheme includes:

- System wide support for smoking cessation in pregnancy (delivered via the babyClear model. BabyClear is an evidence based approach, developed by the Tobacco Control Collaborating Centre (TCCC) to systematise and embed organisational change in line with NICE guidance and other policy recommendations to reduce the rates of smoking in pregnancy. It also includes a unique risk perception intervention for mums who continue to smoke at their booking scan.
- The smokefree pregnancy incentive scheme targets a defined group of vulnerable women (teenage pregnancy, living in areas of high deprivation, living in areas of high smoking rates, smoked at point of delivery in last pregnancy) living in communities where smoking rates are highest, and who would find it hardest to maintain a quit without additional support.

### Locality engagement in GM funded programmes of work

Tobacco Control

The Project encompasses a broad range of measures involving multiple stakeholders including government, local authorities, the NHS, housing, voluntary, community, social enterprise sectors and others. A commitment from stakeholders to take ownership of different elements of the programme to support and engage those who smoke to quit, stop young people and adults starting and change social norms around smoking is paramount to the success of achieving a smoking prevalence of 13% by the end of 2020. Tobacco control is cost effective and an area of public health that has a strong and consistent evidence base. Our strategic partnership approach, the GMPOWER model, will save lives, reduce poverty, ill health and disability, close the gap in inequalities.
and provide substantial savings to locality and city region economies.

### 1.15 Primary Care: GMS Implementation Priority Area

<table>
<thead>
<tr>
<th>Funded and implemented at locality level</th>
<th>NATIONAL PLANNING GUIDANCE PRIORITY AREA</th>
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<tbody>
<tr>
<td>1</td>
<td>Delivery of primary care at scale</td>
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<td></td>
<td>This programme will ensure that primary care is firmly embedded into the development of emerging Local Care Organisations by supporting localities to deliver primary care at scale. This will include:</td>
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<td></td>
<td>• Stimulate implementation of the 10 high impact changes in order to free up GP time to care (as detailed in the GPFV)</td>
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<td></td>
<td>• Share best practice from within/outside GM of how primary care at scale is working and the benefits at both an individual GP, practice and system level as well providing a standardised, consistent offer to patients</td>
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<td></td>
<td>• To work with localities to identify GM wide challenges which could be managed at a GM level therefore ‘do only once’</td>
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<td></td>
<td>• Facilitate inter-professional working with wider primary care, ensuring opportunities to incorporate into the neighbourhood model</td>
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<td></td>
<td>• Support the Practice Management Development Programme</td>
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<td></td>
<td>• Ensure take up of all opportunities from GM, NHS E, HEE, etc. in respect of Primary Care/practice development</td>
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</table>

This contributes to the national requirement to actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000. The GM ambition is for 100% geographical coverage.

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<tr>
<th>2</th>
<th>NATIONAL PLANNING GUIDANCE PRIORITY AREA</th>
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<tbody>
<tr>
<td></td>
<td>GM approach to urgent primary care provision</td>
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<td></td>
<td>To develop a consistent GM approach for urgent primary care that is simple for patients and staff and integrated into the wider urgent care system. This will be achieved through the following objectives:</td>
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<td>• To capture a detailed understanding of current urgent and out of hours primary care provision across GM and within the 10 CCGs</td>
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<td>• To provide examples of local, national and international best practice for urgent primary care drawing on successful systems</td>
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<td></td>
<td>• To develop and embed a set of urgent primary care design principles for an integrated urgent primary care system</td>
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<td></td>
<td>• To facilitate the implementation of national requirements for urgent primary care</td>
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This contributes to the national requirements:

1. To have 110 Urgent Treatment Centres (UTCs) designated according to the revised standard specification. GM has identified 4 potential sites in 17/18 which could work towards the revised standard specification.
2. To contribute to the national requirement which has seen 105 Trusts receiving capital funding of £96.7 million to implement front-door clinical streaming. Over 90% of Trusts now have this in place. In GM Streaming is in place in all acute trusts.
3. Access to enhanced NHS 111 services to 100% of the population, with more than half of callers to NHS 111 receiving clinical input during their call. Every part of the country should be covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 and GP out of hours service provision. This will include direct booking from NHS 111 to other urgent care services. Testing of 111 direct booking in 4 GM areas is starting during March 18.
4. By March 2019, CCGs should ensure technology is enabled and then ensure that direct booking from IUC CAS into local GP systems is delivered wherever technology allows. This is a national initiative and is tracked by each CCG - at present the stats available from NHS England are not functioning correctly to give accurate figures on this. Localities are aware and report on this quarterly.

5. Designate remaining UTCs in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care. GM is working with all localities to understand their trajectories to implement UTCs, and aiming for the delivery of national requirements by the national target of December 2019. A pipeline for rollout will be developed during 18/19, some of which will also be mobilised within this timeframe.

6. Implement a proprietary appointment booking system at particular GP practices, 50% of integrated urgent care services and 50% of UTCs by May 2018, supported by improved technology and clear appointment booking standards issued by December 2018. This will be delivered alongside point 5 above.

Funded by GM and implemented at locality level

<table>
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<tr>
<th>Primary Care Medical Standards (refreshed)</th>
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<tr>
<td>• Assess the role of the primary medical standards</td>
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<tr>
<td>• Consider a common approach to pricing</td>
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<tr>
<td>• Have the conversation around affordability</td>
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<tr>
<td>• Agree a common approach to contracting and new models of care</td>
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<tr>
<td>• Undertake a review of the scope of local schemes in an attempt to make some general comparisons;</td>
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<tr>
<td>• Be able to respond to the increasing challenge of one area paying more than another;</td>
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<tr>
<td>• Develop an approach to devising an average cost for the core requirements of the GM standards</td>
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<tr>
<td>• Consideration of the infrastructure required, physical resource, IM&amp;T, quality improvement methodology in order to truly embed the changes</td>
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<tr>
<td>• Align to other GM work streams such as the assurance framework and GM quality dashboard for primary care.</td>
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**NATIONAL PLANNING GUIDANCE PRIORITY AREA**

7 day additional access hubs in each locality

This project intends to facilitate GM wide provision of additional access to general practice during evening and weekends through:

• Facilitation of a neighbourhood delivery model serving populations of c30-50k, providing;
• Pre-bookable routine and same day appointments outside of core hours 18.30-20.00 Monday to Friday
• Pre-bookable routine and same day appointments for a minimum of 4 hours per day at weekends
• Target vulnerable groups, prevent avoidable admissions and facilitate discharge from hospital over the weekend as well as contributing to wider system resilience.
• Act as an enabler to proactively support and manage more complex patients, both in hours and out of hours and provide the means to:
• Flex consultations and provision of longer consultations in core hours
• Involve a wider multidisciplinary team and wider skill mix
• Proactively case finding and connecting with those people with unmet needs
• Manage patient flow and demand across 7 days, for example, booking more acute activity in to the 7 day access hubs to allow core
<table>
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<tr>
<th>10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019</th>
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<tbody>
<tr>
<td>general medical services to manage LTCs, chronic conditions etc. where continuity of care is important</td>
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<tr>
<td>• Share best practice from within GM and elsewhere in order to utilise this additional capacity in order to respond to the challenges faced across GM.</td>
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<tr>
<td>This contributes to the 17/18 national requirement for 52% of the country to benefit from extended access including appointments on evenings and weekends, beating the target of 40% for 2017/18. The GM ambition is for 100% of the population to be able to access 7 day services. The 18/19 requirement is to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.</td>
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<tr>
<td>NATIONAL PLANNING GUIDANCE PRIORITY AREA</td>
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<tr>
<td>GP Excellence Programme</td>
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<tr>
<td>• Identify best practice and areas of excellence from elsewhere, supporting practices to develop these models locally.</td>
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<tr>
<td>• Offer a coherent and consistent offer in terms of rescue, resilience and improvement.</td>
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<tr>
<td>• Provide a systematic response at a locality level however must also be responsive to individual practice requirements and crisis response.</td>
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<tr>
<td>• Embrace the excellent practice which is taking place across Greater Manchester, ensuring mechanisms to share best practice.</td>
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<tr>
<td>• Adopt a proactive approach to identifying improvements earlier rather than in the reactive sense, e.g. following CQC inspection.</td>
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<tr>
<td>• Have an understanding of the needs of practices in order to be able to respond.</td>
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<tr>
<td>• Support practices in undertaking the diagnostic tool to identify improvements.</td>
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<tr>
<td>• Foster a sharing and learning environment across GM which will include a repository or portal of best practice, case studies and standard documentation that practices and commissioners can access.</td>
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<tr>
<td>• Develop our clinical leaders to enable them to offer peer support or more formal arrangements to support general practice.</td>
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<tr>
<td>• To drive excellence across GM which will be enabled by business intelligence in order to facilitate peer to peer discussions, comparative analysis, identification of best practice and the development of quality pathways.</td>
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<tr>
<td>This contributes to the national requirement to ensure that 75% of 2018/19 sustainability and resilience funding allocated is spent by December 2018, with 100% of the allocation spent by March 2019. Also to ensure every practice implements at least two of the high impact ‘time to care’ actions.</td>
</tr>
<tr>
<td>Improving quality in primary care</td>
</tr>
<tr>
<td>• Development of a GM Primary Care Business Intelligence tool to:</td>
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<tr>
<td>• Provide primary care contribution to system wide assurance</td>
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<tr>
<td>• Provide a business intelligence platform to drive quality improvement at individual practice level, neighbourhood and locality</td>
</tr>
<tr>
<td>• Development of high level metrics for general practice, dental, optometry and pharmacy</td>
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<tr>
<td>• Roll out of consistent dashboard with a common set of indicators to all 468 GP practices</td>
</tr>
<tr>
<td>• Ensure alignment to the GP Excellence programme and GM standards</td>
</tr>
<tr>
<td>• Facilitate best practice and shared learning and highlight areas for improvement</td>
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</table>
• Understand locality approaches to quality improvement and assurance of primary care to facilitate and share best practice

7

Proactive children's dental management
The aim of the Baby Teeth DO Matter Programme is to ensure all young children in GM have access to proactive general dental care by
• Increasing the proportion of children below the age of 5 years who regularly attend a general dental practice
• Increase proportion of children under 5 receiving 'DBOH advice' using benchmarking and feedback on BSA indicator
• Increase proportion of children under 5 receiving Fluoride varnish using benchmarking and feedback on BSA indicator

The Buddy Practice Scheme aims to bring dentistry and oral health education to children and their families and building relationships
• To create a link between a school or early years setting and a local general dental practice
• To provide sessions to bring the identified GDP and the non-attending children and their parents together
• To ensure parents of non-attenders are supported to establish a habit of routine dental attendance and given home care advice

The Dental Checks by One (DCby1) is a national programme that aims to get parents of babies to bring them to the dentist before their first birthday. This is to provide preventive dental advice, prevent dental problems early & establish a longer term relationship with dental care.

8

NATIONAL PLANNING GUIDANCE PRIORITY AREA

Workforce
To develop a GM framework for primary care workforce planning and development which can then support and inform Locality workforce plans. Objectives:
• To determine the primary care workforce across Greater Manchester
• Identify the immediate, medium term and long term pressures – produce a heat map across localities
• Optimise the opportunities available to enhance the primary care workforce, i.e. HEE support, international recruitment, national development programmes, new roles, etc.
• Respond to the ask of the Five Year Forward View in respect of recruitment and retention (5k GPs and 5k other staff)
• Consider how the workforce will change as a result of primary care at scale/new models of care and share learning and best practice
• Define the ‘ask’ of the GM enabling workstream for workforce
• Development/roll out of a GM evaluation of primary care workforce to be undertaken by CLAHRC at the University of Manchester

The contributes to the national requirements for the Primary care workforce:
• Over 770 additional GP trainees started specialist training since 2015 baseline (3,157 in total in 2017/18);
• Begun GP international recruitment, with the first 100 GPs being recruited;
• Launched the GP Retention Scheme;
• Recruitment of an additional 505 clinical pharmacists, in addition to the 494 already in post.

And also contributes to the 18/19 national requirement to delivering their contribution to the workforce commitment to have an extra
5,000 doctors and 5,000 other staff working in primary care. CCGs will work with their local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19. At national aggregate level we are expecting the following for 2018/19:

- CCGs to recruit and retain their share of additional doctors via all available national and local initiatives;
- 600 additional doctors recruited from overseas to work in general practice;
- 500 additional clinical pharmacists recruited to work in general practice (CCGs whose bids have been successful will be expected to contribute to this increase);
- An increase in physician associates, contributing to the target of an additional 1000 to be trained by March 2020 (supported by HEE);
- Deliver increase to 1,500 mental health therapists working in primary care.

### Dental managed clinical networks

The aim of the MCN is to offer a way of working where clinicians from all settings across the clinical care pathway can focus on patient services. Through:

- Increased flexibility and more efficient use of the skills within clinical teams and of the available resources.
- Improved communication between service providers and between providers and referrers to benefit patients.
- Development and implementation of needs-led and evidence-informed care pathways across primary and secondary care to improve equity of access and ensure parity of outcome.
- Contribution and support of implementation of audit/outcome assessment programmes to benchmark provider performance in order to identification and support for commissioners to address sub-standard performance as well as recognise excellence.
- Provide specialist advice to LDNs and commissioners to support the commissioning function and influence service specifications to seek high value and quality service.

### Increased uptake of sight tests

- Develop and embed an awareness programme within schools to increase awareness of eye care and encourage referral of children who may be suffering from vision difficulties for sight tests.
- Develop and embed an awareness programme with GM employers (including the NHS) to increase awareness of eye care in working age population.
- Link with school screening system and community orthoptic services to reinforce the message of regular sight tests starting at an early age and ensure access to and uptake of sight tests for children in special education needs (SEN) schools.
- Improve uptake of sight tests for hard to reach groups such as those with learning disabilities and dementia.
- Share the signs and symptoms of sight problems with social care services to promote timely access to sight tests for at risk groups.

### Clinical pharmacists in General Practice

This programme will support Phase 2 of the Clinical Pharmacist in General Practice pilot by:

- Facilitation of Phase 2 bid process
- Oversight of the overall programme
- Sharing of lessons leaned and best practice
### 1.16 Strategic Organisational Development: GMS Implementation Priority Area

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>LCO Development</strong>&lt;br&gt; LCOs (and HGs) are responsible for the outcomes of a defined population, incentivising coordination and integration. This includes the responsibility of undertaking all tactical commissioning previously undertaken by CCGs and LAs including: elements of market management across a network of providers; financial and contract management; planning and delivery; monitoring performance; and stakeholder engagement.</td>
</tr>
<tr>
<td>2</td>
<td><strong>SCF Development</strong>&lt;br&gt; CCGs and LAs will come together to form a single, small and strong Strategic Commissioning Function (SCF) with a broad set of responsibilities across public services. The SCF is responsible for setting the commissioning and place-based strategy, and for leading on local growth and economic reform policies. Working in this way, SCFs will provide system leadership and public service reform, whilst transforming existing commissioner-provider relationships.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Establishment of GM Commissioning Hub</strong>&lt;br&gt; The Joint Commissioning Board will discharge the GM commissioning function on behalf of all SCFs via the GM commissioning hub which will include</td>
</tr>
</tbody>
</table>
### 10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

| Locality funding with locality and GM implementation | • A central team which pools commissioning expertise, captures learning and scales up good practice
• Dedicated commissioning capacity to provide control and maximise efficiencies of GM-wide commissioning
• Building on the existing GM Joint Commissioning Board, with shared decision-making authority to effectively discharge the commissioning of |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------|

| 4 | NHS and Corporate Support Services Review
Localities need to specify the support services they require and decide where to secure these. Working collectively, there is a desire to share transactional services, so as to maximise economies of scale. |

### 1.17 Stroke

| SCN funding with locality engagement | Establishment of GM Strategic Stroke Network and oversight of Stroke Operational Delivery network. |

### 1.18 Workforce: GMS Implementation Priority Area

| Locality engagement in GM funded programmes of work | 1 | Careers Hub and workforce futures centre
Establish a single shared gateway providing GM workforce with the support, information, guidance, tools and resources to enable upskilling, reskilling and personal development. This will be delivered through development of an integrated health and social care careers hub and launch of the workforce futures centre (online platform to support link localities to support to deliver their workforce plans). |

| 2 | Targeting skills shortages and workforce planning
Systematically target key skills shortage areas to address short term needs whilst growing long term capacity & capability, nationally piloting ‘STAR’ approach with Health Education England (focussing on supply, upskilling, new Roles , new ways of working and leadership). Project includes: production of reports on hard to fill roles e.g. social workers; supporting workforce implications of the urgent and emergency care programme; supporting pilots of new roles e.g. Nursing Associates and Physician Associates; considering implications of reports on hard to fill roles and input around next steps identified. |

| 3 | Leadership Programme
Build on the Leading GM programme to further invest in Leadership & Talent Development for our front line leaders (across Health & Social Care including Registered Managers) to develop their competencies and capabilities to lead integrated services. Project to include development of a leadership programme for Registered Managers in Social Care and embedding of GM leadership principles,-as supported by the OD practitioners in each locality part of the public sector OD network. |

| 4 | Employer brand
Develop an employer brand for Greater Manchester to support organisation and locality brands. This will include the implementation of the Continuity of service protocol and the delivery of a Greater Manchester nursing marketing campaign. |

| 5 | Supporting themes 1 to 4 - workforce
Ensuring GMHSCP themes and work areas have appropriate and effective workforce plans in place which support the delivery of Taking Charge and the GM Workforce Strategy. Workforce reference groups to be set up in 18/19. |
### Apprenticeships

<table>
<thead>
<tr>
<th>6</th>
<th>Apprenticeships</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Working towards target of GM delivering one of the largest apprenticeship programmes in the UK with a clear and compelling career path for all – existing staff and new apprentices. Developing a Public Sector GM approach to apprenticeships, led by GMCA. Localities to engage with GM programme through joint HRD forum and increase delivery of apprenticeships to maximise use of apprenticeship levy.</td>
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</tbody>
</table>

### Other funding with locality engagement

<table>
<thead>
<tr>
<th>7</th>
<th>Benefits and recognition</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Set up benefits and recognition schemes at multiple levels across GM providing the opportunities to support, recognise and celebrate the positive contributions of the GM workforce – individually and collectively. The first Greater Manchester Health and Care Champion Awards ceremony will be held in July 2018. A benefits package will also be developed as well as ‘deals’ for hard to fill role areas.</td>
<td></td>
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</tbody>
</table>

### 1.19 Frailty

<table>
<thead>
<tr>
<th>1</th>
<th>Produce the GM Frailty Charter.</th>
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<tbody>
<tr>
<td></td>
<td>A range of potential interventions are currently under discussion as part of the Frailty Charter development process (to complete in June 2018). Once this process is complete and the result of the TF funding bid if known, a full workstream list can be developed. The draft indicative list currently includes:</td>
</tr>
<tr>
<td></td>
<td>• Pilot a ‘Care Navigator’ model</td>
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<tr>
<td></td>
<td>• Develop a ‘Patient Passport’ (Frailty)</td>
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<tr>
<td></td>
<td>• Develop an integrated GM Frailty Pathway</td>
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<tr>
<td></td>
<td>• Frailty Care Planning</td>
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<tr>
<td></td>
<td>• Pilot Key Worker model</td>
</tr>
<tr>
<td></td>
<td>• Pilot Group Consultations for patients with mild/moderate frailty</td>
</tr>
<tr>
<td></td>
<td>• Pilot Ageing Well assessment in primary care</td>
</tr>
<tr>
<td></td>
<td>• Benchmarking &amp; Gap analysis</td>
</tr>
<tr>
<td></td>
<td>• Develop Frailty Training for Housing, Transport, Supported Housing Staff etc</td>
</tr>
<tr>
<td></td>
<td>• Develop Frailty Network and Steering Group</td>
</tr>
</tbody>
</table>

### 1.20 End of Life / Palliative Care, all diseases/frailty.

**Currently SCN programme commissioned by localities, and supported by localities. (2017-2020)**

Maturity status 2 currently.

- Early identification, palliative care registers, MDT approach.
- Personalised care planning (PHBs) and advance care planning, choice of place of care and death.
- Anticipatory clinical management planning (inc resuscitation decisions)
- Electronic record sharing; implementation of fully functional Electronic Palliative Care Coordination Systems (EPaCCS) e.g Hospice, NWAS, out of hours services.
- Care of the dying person, inc pain and symptom management.
| supporting standards and implementation plan, building on palliative and end of life care ambitions baseline audit work (2017) | • Timely access to medicines and equipment  
• Care after death and bereavement support  
• Workforce education and training E.G train the trainer communication skills training, care home education  
• Public awareness campaigning "dying matters"  
• Development of a dashboard of metrics and measurement.  
• Evaluation of aspects of the programme, e.g Advance Care Planning. |
### PHASE 1 & 2 PROJECTS TO BE CONSIDERED FOR ACCELERATION IN 18/19

#### 2.1 Acute Services Transformation: GMS Implementation Priority Area

<table>
<thead>
<tr>
<th>DEVELOPMENT OF AN OUT OF HOSPITAL OFFER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-Rehabilitation (covers hyper-acute, acute and post-acute services but not community rehabilitation services)</td>
</tr>
<tr>
<td>The Community Neuro-Rehabilitation service specification has been agreed with a view to addressing the current variation in provision across GM and tackle issues such as access, waiting times, capacity to in-reach into hospitals and capacity to provide daily therapy. A decision has recently been taken to now refocus the work on hospital-based services (acute and specialised care). Community Pathways Standards will be picked up by elective, Primary Care, and LCO programmes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IN HOSPITAL OFFER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-Rehabilitation (covers hyper-acute, acute and post-acute services but not community rehabilitation services)</td>
</tr>
<tr>
<td>Redesign the Neuro-Rehabilitation services across GM to improve patient outcomes, flow and service efficiency. Scope of the workstream is focussed on brain injury patients rather than progressive or congenital neurological conditions. Further work may therefore need to be undertaken to ensure that these key patient groups needs are met, especially if community services are not reviewed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transform and standardise community rehab services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish SLA and delivery model for access to diagnostics on all sites</td>
</tr>
</tbody>
</table>

#### 2.2 Adult Social Care: GMS Implementation Priority Area
<table>
<thead>
<tr>
<th>GM Provider Engagement (Residential and Nursing Care Programme)</th>
<th>Establishment of a provider network to allow GM and its composite locality commissioning functions to engage strategically with the social care market.  Delivery Point: GM independent care sector network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care 2020 (New Deal) (Care at Home Programme)</td>
<td>To work across geographical and organisational boundaries and construct a new deal for domiciliary care in Greater Manchester. Specifically, providing the right care, at the right price, with a valued workforce for people in their own home, that supports people to be active in their communities and as independent as possible.</td>
</tr>
<tr>
<td>Enhanced Primary Care Access (Residential and Nursing Care Programme)</td>
<td>Excellent connections between care homes and primary care building upon existing good practice from across GM. The work will identify a model (or different models) that can be utilised across GM to improve the level of primary care access across GM. This work will be delivered through the primary care transformation programme.</td>
</tr>
<tr>
<td>Quality improvement and best practice (Residential and Nursing Care Programme)</td>
<td>A practical, operational focus bringing together health, social care and independent sector representatives to drive improvements across GM and deliver outcomes across three broad areas; quality in care, quality of life and individual experience and partnerships. Building on good practice in the nationally and localities, roll out processes that enable ‘the right care in the right place at the right time’, improve safety when a person is moving between care settings and identify and evaluate tools to support quality assurance systems across GM. Delivery point: Adult Social Care Transformation and Quality improvement Team</td>
</tr>
<tr>
<td>Teaching Care Homes (Residential and Nursing Care Programme)</td>
<td>Exploration of an approach and associated business case to support the development, implementation and minimum standards required for a teaching care home model in GM. Delivery Point: Quality Improvement Team Testing of a Teaching Care Home model to elevate the quality of care within the GM care home settings, reduce social isolation/loneliness, increase the educational programme to up skill, enhance and develop all employees within the care home setting, establish a route for the introduction of student nurse placements to enhance the offering of a career path within the social care setting. Also, enhancing the day to day living of the residents within the settings and enabling the care homes to become the hubs of the communities.</td>
</tr>
</tbody>
</table>
| **Identification of Carers**  
(Support for Carers Programme) | Through the development of, and sign up to, a commitment to carers and carers charter, GMHSCP, Local Authorities and Voluntary & Community organisations will demonstrate a commitment to working together in partnership to provide the best quality support for all carers through an integrated approach of identification, assessment and meeting of Carers’ health and wellbeing needs. Through early identification and easy access to help, advice and information, all carers will receive the right support, at the right time, in the right place, including when caring comes to an end. |
| --- | --- |
| **Improving Health and Wellbeing**  
(Support for Carers Programme) | Development of an extended and consistently available universal support offer for all carers across GM leading to improved (measurable) well-being, including: Carers having choice and control about their caring role, getting the personalised support they need as a carer to meet their family’s needs; carers being able to stay healthy and well, and for their own needs and wishes as an individual to be recognised and supported; carers to be socially connected and not isolated; and an improvement in the independence, physical and mental health of all Carers and their families. |
| **Registered managers**  
(Residential and Nursing Care programme delivered through the enabler programme of workforce) | A leadership programme for RMs will drive forwards the standard of quality within residential and nursing homes, reducing the level of professional isolation and creating a supportive network |
| **2.3 Cancer Project** | Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide social movement focused on cancer prevention |

Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to test a GM wide social movement focused on cancer prevention.
<table>
<thead>
<tr>
<th>Prescribe drugs that are effective in preventing cancers</th>
<th>Prescribe drugs that are effective in preventing cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Offer targeted screening to those at high risk</strong></td>
<td><strong>NATIONAL PLANNING GUIDANCE PRIORITY AREA</strong></td>
</tr>
<tr>
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<td>Offer targeted screening to those at high risk</td>
</tr>
<tr>
<td></td>
<td>This contributes to the national requirement to participate in pilot programmes offering low dose CT scanning based on an assessment of lung cancer risk in CCGs with lowest lung cancer survival rates.</td>
</tr>
<tr>
<td><strong>Improve access to, and uptake of, three national cancer screening programmes (bowel, breast, and cervical)</strong></td>
<td><strong>NATIONAL PLANNING GUIDANCE PRIORITY AREA</strong></td>
</tr>
<tr>
<td>Improve access to, and uptake of, three national cancer screening programmes (bowel, breast, and cervical)</td>
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</tr>
<tr>
<td><strong>NATIONAL PLANNING GUIDANCE PRIORITY AREA</strong></td>
<td>Ensure a locality contribution to the overall GM targets of:</td>
</tr>
<tr>
<td>Ensure a locality contribution to the overall GM targets of:</td>
<td>Ensure a locality contribution to the overall GM targets of:</td>
</tr>
<tr>
<td>• Achieve bowel cancer screening uptake (FIT and scope) of 75%</td>
<td>• Achieve bowel cancer screening uptake (FIT and scope) of 75%</td>
</tr>
<tr>
<td>• Increase cervical screening coverage to 80%</td>
<td>• Increase cervical screening coverage to 80%</td>
</tr>
<tr>
<td>• Increase breast screening coverage by 10% to 75%</td>
<td>• Increase breast screening coverage by 10% to 75%</td>
</tr>
<tr>
<td><strong>NATIONAL PLANNING GUIDANCE PRIORITY AREA</strong></td>
<td>This contributes to the national requirement to support the rollout of FIT in the bowel cancer screening programme during 2018/19 in line with the agreed national timescales following PHE’s procurement of new FIT kit, ensuring that at least 10% of all bowel cancers diagnosed through the screening programme are detected at an early stage, increasing to 12% in 2019/20.</td>
</tr>
<tr>
<td>Improve one-year survival rates to achieve 75%.</td>
<td>Improve one-year survival rates to achieve 75%.</td>
</tr>
<tr>
<td>Improve one-year survival rates to achieve 75%.</td>
<td>Improve one-year survival rates to achieve 75%.</td>
</tr>
<tr>
<td>• Deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two –</td>
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</tr>
<tr>
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</tr>
<tr>
<td>- Agree data collection trajectories with providers to ensure robust and timely staging data collection</td>
<td>- Agree data collection trajectories with providers to ensure robust and timely staging data collection</td>
</tr>
<tr>
<td>- Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to raise awareness of the signs and symptoms of cancer and encourage earlier presentation and advice seeking</td>
<td>- Work in partnership with local Voluntary Community and Social Enterprise (VSCE) sectors to raise awareness of the signs and symptoms of cancer and encourage earlier presentation and advice seeking</td>
</tr>
<tr>
<td>- Help people to understand their individual risk of cancer and self-refer for investigation</td>
<td>- Help people to understand their individual risk of cancer and self-refer for investigation</td>
</tr>
<tr>
<td>• Reduce the proportion of cancers diagnosed following an emergency admission</td>
<td>• Reduce the proportion of cancers diagnosed following an emergency admission</td>
</tr>
<tr>
<td>• Reduce the proportion of cancers diagnosed following an emergency admission</td>
<td>• Reduce the proportion of cancers diagnosed following an emergency admission</td>
</tr>
<tr>
<td>- Contribute towards a GM reduction in the proportion of cancers that are diagnosed as an emergency to below 18%</td>
<td>- Contribute towards a GM reduction in the proportion of cancers that are diagnosed as an emergency to below 18%</td>
</tr>
<tr>
<td>- Implement strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit</td>
<td>- Implement strategies for all patients diagnosed as an emergency to have their cases looked at through a Significant Event Audit</td>
</tr>
</tbody>
</table>

Cancer survival at its highest ever with latest figures showing that one-year cancer survival is up by over 2,000 people a year. Taking Charge and the GM Cancer Plan aim to save 1300 lives by end March 2021 by improving 1-year survival to above 75% by 2020, with reduced variation across CCGs. This contributes to the national requirement to progress towards the 2020/21 ambition for 62% of cancer patients to be diagnosed at stage 1 or 2, and reduce the proportion of cancers diagnosed following an emergency admission.
## Drive earlier diagnosis

**By:**
- Implementing NICE referral guidelines
  - Ensuring primary care adherence to use of updated standardised suspected cancer referral process and forms
  - Support a GM approach to training and education for primary care professionals on cancer symptoms and referral processes
- Ensuring local provision of GP direct access to key investigative tests for suspected cancer
- Developing rapid cancer investigation units

## Implement a pan GM integrated acute oncology service and develop earlier integration of supportive care into cancer care

Implement a pan GM integrated acute oncology service and develop earlier integration of supportive care into cancer care

## Work with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree optimal pathways and Greater Manchester service specifications for each tumour type.

**NATIONAL PLANNING GUIDANCE PRIORITY AREA**

Work with clinical pathway boards, hospital providers, people affected by cancer and other stakeholders to develop and agree optimal pathways and Greater Manchester service specifications for each tumour type.

*This contributes to the national requirement to ensure implementation of the nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers, ensuring that patients get timely access to the latest diagnosis and treatment. Accelerating the adoption of these innovations helps meet the 62 days standard ahead of the introduction of the 28 day Faster Diagnosis Standard in April 2020.*

## Lead the implementation of the Recovery Package through:

- A contribution to the development of a standard Greater Manchester approach, and
- Building the delivery of each of the Recovery Packages elements into commissioning specifications
**Appendix 1: GM Taking Charge Business Plan 2018/2019**

<table>
<thead>
<tr>
<th>Approach, and</th>
<th>NATIONAL PLANNING GUIDANCE PRIORITY AREA</th>
</tr>
</thead>
</table>
| - Building the delivery of each of the Recovery Packages elements into commissioning specifications | Ensure patients have access to Greater Manchester Cancer agreed stratified follow up pathways of care for-
- Breast cancer
- Prostate and Colorectal cancer  
Half of the country’s Cancer Alliances have begun to roll out personalised follow-up after cancer treatment. This contributes to the national requirement to progress towards the 2020/21 ambition for all breast cancer patients to move to a stratified follow-up pathway after treatment. Around two-thirds of patients should be on a supported self-management pathway, freeing up clinical capacity to see new patients and those with the most complex needs. All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring by the end of 2018/19. |

<p>| Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide follow-up protocols and stratified follow up arrangements dependent on risk. | Work with providers, clinical pathway boards, people affected by cancer and other stakeholders to develop and agree system-wide follow-up protocols and stratified follow up arrangements dependent on risk. |</p>
<table>
<thead>
<tr>
<th>Ensure all patients have access to a clinical nurse specialist or other key worker</th>
<th>Ensure all patients have access to a clinical nurse specialist or other key worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support and extend improvements to specialist surgical services</td>
<td>Support and extend improvements to specialist surgical services</td>
</tr>
<tr>
<td>Ensure access to seven-day specialist palliative care advice and assessment</td>
<td>Ensure access to seven-day specialist palliative care advice and assessment</td>
</tr>
<tr>
<td>Explore supported patient decision-making in progressing disease</td>
<td>Explore supported patient decision-making in progressing disease</td>
</tr>
</tbody>
</table>

### 2.4 Children and Young People project

The Below project all directly link to the proposed Children’s Health and Wellbeing Framework wave 1 objectives for delivery:

- Developing the role of schools in managing LTC including the role of school nurses
  - Schools have a significant role in keeping children with LTC well and preventing unnecessary referrals to GP or A&E. We will work with school nurses and schools to identify their requirements (June 2018) to be able to support children with LTC and support the resilience of all school children’s health and wellbeing.
  - This will be closely linked to the MH Schools Education Programme. A toolkit of best practice will be developed to support schools (Oct 2018).
- Health and education working together to develop the school's role in supporting resilience in children's health and wellbeing. This may include PSHE standardisation and implementation, sharing best practice across GM and working with LA commissioners to ensure schools are supported to deliver national guidance.
<table>
<thead>
<tr>
<th>LTc management</th>
<th><strong>GM TF/SCN/Locality funding and implementation</strong></th>
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<tbody>
<tr>
<td></td>
<td>Refreshing GM asthma standards, Ensuring full implementation of standards across GM.</td>
</tr>
<tr>
<td></td>
<td><strong>GM TF/SCN/Locality funding and implementation</strong></td>
</tr>
<tr>
<td></td>
<td>Developing consistent end to end pathways for asthma, diabetes and epilepsy including prevention and transition</td>
</tr>
<tr>
<td></td>
<td><strong>GM TF/SCN/Locality funding and implementation</strong></td>
</tr>
</tbody>
</table>
|                | • Develop and pilot framework for paediatric hot line  
|                | As part of the preventing avoidable admissions programme, the use of paediatrician telephone help lines for the use of GPs and school nurses has been identified. |
|                | **GM TF/SCN/Locality funding and implementation** |
|                | Increasing the confidence of children and young people and their families in self-managing diabetes, epilepsy and asthma more effectively |
|                | **GM TF/SCN/Locality funding and implementation** |
|                | Develop clinical framework for CCNT and O&A |
|                | **GM TF/Locality funded and implementation** |
|                | The below project directly link to the Maternity and Neonatal Implementation Plan for delivery Better Births (national priority for safer more personalised maternity care) |
| GM TF /Locality funded and implementation | Increase in maternity safety: Development of maternity pathways, compliance to Saving Babies Lives Bundle, establishment of process for incident reporting and lessons learnt |
|GM TF /Locality funded and implementation | Maternity pathways for induction, reduced fetal movement, CTG monitoring and VBAC will be developed and agreed by all providers (June 2018). Sites will be identified (Sept 18) to test the implementation of pathways prior to amendment and full rollout (May 2019). Baseline compliance of all providers to SBL (March 2018). All providers to engage in Baby Clear Programme (March 2018 -2020). |
| Increase the availability of Maternity Voices Partnerships for women to access from each maternity provider | Increase the availability of Maternity Voices Partnerships for women to access from each maternity provider |
| Increase the availability of Maternity Voices Partnerships for women to access from each maternity provider | All providers to baseline current MVP provision and work towards ensuring this service is commissioned and provided for women in their locality as per national guidance. Access to MVP to be included in the revised GM&EC Maternity Specification (March 2020). |
| SCN funded Updating of third trimester pregnancy loss guidance and Integrated care pathway | Updating of second trimester pregnancy loss guidance and Integrated care pathway and third trimester still birth guidance and integrated care pathway |
| SCN funded Updating of third trimester pregnancy loss guidance and Integrated care pathway | Clinical Pathway and guidance agreed and was launched in March 2018 |
| SCN Funded Development of women/families with lived experience forum for GMEC | NATIONAL PLANNING GUIDANCE PRIORITY AREA |
| SCN Funded Development of women/families with lived experience forum for GMEC | Development of women/families with lived experience forum for GMEC and development of strategy to ensure co-production and service user voice is heard in all elements of the perinatal and infant mental health work programme. |
| SCN Funded Development of women/families with lived experience forum for GMEC | Women/Families with lived experience forum to be held in Spring 2018. This will be a collaboratively planned event with PNMH transformation project leads and SCN. |
| SCN Funded Development of women/families with lived experience forum for GMEC | This contributes to the national requirement for expanded specialist perinatal care, with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. In 18/19 the national requirement is to continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 |
women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. In GM by 2021 we expect at least 1,680 (30,000 nationally) more women each year can access evidence-based specialist CMHT input, and additional input from local parent-infant pathways and Perinatal IAPT.

| Development of PNMH training and workforce development strategy | NATIONAL PLANNING GUIDANCE PRIORITY AREA
| Development of PNMH training and workforce development strategy | Establishment of task and finish group to establish training needs and develop strategy also ensuring integration with proposed Parent Infant Mental Health training ladder. (PNMH Transformation fund projects)

This contributes to the national requirement for expanded specialist perinatal care, with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. In 18/19 the national requirement is to continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. In GM by 2021 we expect at least 1,680 (30,000 nationally) more women each year can access evidence-based specialist CMHT input, and additional input from local parent-infant pathways and Perinatal IAPT.

| Development and publication of a GM&EC Maternity and Neonatal Strategy | A GM&EC Maternity and Neonatal Transformation Strategy will be drafted (February 2018), shared (March 2018) and published (May 2018). As part of the development process all providers will be involved through existing boards and groups including Provider Federation Board, GM&EC Maternity Board, Heads of Midwifery, AGG

| Increase in personalisation: Enhance person-centred birth environments | Increase in personalisation: Enhance person-centred birth environments

All providers to share information on person-centred birth options (April 2018) to be included in materials for women to access (Sept 2018) to increase awareness of choice available. Audit of current person-centered birth environments to be carried out (March 2019) and standards developed (March 2019). One pilot site to implement recommended standards and evaluate (Dec 2019). All remaining providers to adopt standards following pilot and evaluation (Sept 2020). Personalised care plans to be developed with women to meet their needs (October 2018) and piloted with one provider site (Jan 2019) and fully rolled out to all remaining providers following evaluation (October 2019).
| Increase in personalisation: Introduce continuity of care in antenatal and postnatal period | Increase in personalisation: Introduce continuity of care in antenatal and postnatal period  
Providers to baseline current continuity offer for maternity services and plan to meet the National Planning Recommendation of 20% by March 2019. |
| --- | --- |
A GM&EC Maternity and Neonatal Transformation Strategy will be drafted (February 2018), shared (March 2018) and published (May 2018). As part of the development process all providers will be involved through existing boards and groups including Provider Federation Board, GM&EC Maternity Board, Heads of Midwifery, AGG |
| Development and implementation of integration of PNMH needs within the GMEC Maternity and Neonatal Strategy | NATIONAL PLANNING GUIDANCE PRIORITY AREA  
Development and implementation of integration of PNMH needs within the GMEC Maternity and Neonatal Strategy  
Chapter reflecting perinatal mental health needs to be included in GM&EC Maternity and Neonatal Transformation Strategy (May 2018). PNMH to be included in the detailed implementation plan for GM&EC Maternity Services.  
This contributes to the national requirement for expanded specialist perinatal care, with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. In 18/19 the national requirement is to continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. In GM by 2021 we expect at least 1,680 (30,000 nationally) more women each year can access evidence-based specialist CMHT input, and additional input from local parent-infant pathways and Perinatal IAPT. |
| Scoping of current Perinatal and Parent-Infant MH services within GMEC | NATIONAL PLANNING GUIDANCE PRIORITY AREA  
Scoping of current Perinatal and Parent-Infant MH services within GMEC  
University of Manchester are currently scoping all perinatal mental health services and parent infant mental health services across GM network. Report to be completed in April 2018. (Including IAPT)  
This contributes to the national requirement for expanded specialist perinatal care, with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. In 18/19 the national requirement is to continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. In GM by 2021 we expect at least 1,680 (30,000 nationally) more women each year can access evidence-based specialist CMHT input, and additional input from local parent-infant pathways and Perinatal IAPT. |
women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. In GM by 2021 we expect at least 1,680 (30,000 nationally) more women each year can access evidence-based specialist CMHT input, and additional input from local parent-infant pathways and Perinatal IAPT.

### 2.5 Clinical Support Services

<table>
<thead>
<tr>
<th>Hospital Pharmacy: Utilise a common code for medicines used in patient care</th>
<th>Supporting installation of a common code for medicines used in patient care (dm+d).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Pharmacy: Aseptic Review</td>
<td>Reviewing aseptic production to understand resource and capacity across the region</td>
</tr>
</tbody>
</table>

### 2.6 Dementia Project

| Living well | Living well:  
6) Development of the Lived Experience Barometer to measure the lived exp of people living with a diagnosis of dementia and their carers  
7) Enabling people with dementia to have the same access to community health and care services as others with complex support needs.  
8) People with dementia will receive an assessment for evidence based assistive technology and/or necessary personal 'reasonable adjustments' shortly after diagnosis and on request by carers at other times |
| Implementation - Improving well | Implementation - Improving well:  
1) All localities will publish a local dementia improvement plan and co-design this with people with dementia and carers  
2) Improvement updates will be included in hospital quality accounts and locality updates to the Health and Social Care partnership  
3) All localities will track an agreed dashboard of measures and commit to working on reducing variation in outcomes in particular hospital admission, re-admission and length of stay  
4) Increase the proportion of people living with dementia’s involvement in research trials |
### 10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

<table>
<thead>
<tr>
<th>Reduce inappropriate antipsychotic prescribing</th>
<th>Antipsychotics for non-cognitive symptoms or challenging behaviour of dementia should only be used if the person is severely distressed or there is an immediate risk of harm to them or others. Initially gathering prescribing data across GM. Then developing a plan to reduce inappropriate prescribing.</th>
</tr>
</thead>
</table>

#### 2.7 Elective Demand

<table>
<thead>
<tr>
<th>MSK: In depth assessment of the key standards required to harness maximum impact for MSK services (including: rheumatology, pain management, therapies, triage and shared decision making)</th>
<th>Using established services across GM and nationally, identify standards for out of hospital MSK services in the areas of: rheumatology, pain management, therapies, triage and shared decision making. Prepare a toolkit to share across GM. Use links with Theme 3 workstream to ensure design process complements T3 standards and recommended model of care - particularly in relation to primary / secondary / social care interfaces. Recommendation for first contact practitioners and standardisation of referral pathways into / out of secondary care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastro: Exploration of direct access to scope in the gastro pathway, including the use of FIT testing (faecal immunochemical screening test)</td>
<td>Building on the work already established in Bolton for straight to test (scope) referrals. Develop guidelines for GM. Explore FIT testing as a GM option to reduce demand for scopes.</td>
</tr>
<tr>
<td>Dermatology: Dermatoscope and Tele-dermatology roll out in the Stockport locality</td>
<td>Dermatoscope and tele-dermatology roll out in the Stockport locality as a proof of concept for reform in the dermatology pathway. To include: purchase and training with dermatoscopes, developing a more robust image sharing mechanism, measure impact on a large scale, development of a roll out package for GM.</td>
</tr>
</tbody>
</table>
### 10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019

<table>
<thead>
<tr>
<th>Referral management standards and data quality across the elective pathway</th>
<th>Develop standards for successful referral management which are not prescriptive but ensure smooth transition for patients into assessment, diagnostics, secondary and tertiary services. Explore data quality across the elective pathway, including live flows and patient tracking, develop business intelligence and live information flows through Tableau, making information available across GM. Understand compliance to the GM EUR policy and advise on the potential of implementing the policy across GM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional pathway development</td>
<td>This work programme will continue to explore demand management in different pathways of care over the life of the programme to March 2019. Direction will be set through commissioning priorities.</td>
</tr>
<tr>
<td><strong>2.8 IM&amp;T (Digital)</strong></td>
<td></td>
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<tr>
<td>Active Directory/Office collaboration</td>
<td>Review the options to consolidation/federation of directories/licenses across Greater Manchester, supporting the ability to share systems, documents, hardware and organisational structures, and provides a platform for video conferencing. Platform for moving to ‘Cloud’ technology improving security in relation to storing patient data. Ensuring organisations are on a secure Mail platform</td>
</tr>
<tr>
<td>Theme 4</td>
<td>Theme 4 will consider a sub-set of the projects within the Digital Collaborative programme where there is an objective of collaborative working or standardising function/processes.</td>
</tr>
<tr>
<td>GM Integrated Digital Care Record</td>
<td>Establish a single integrated digital care record across GM and explore GM wide care plans including End of Life, Patient and Community Centred Care and Emergency Plan</td>
</tr>
<tr>
<td>Unified Architecture</td>
<td>Expand current interoperability capabilities including</td>
</tr>
<tr>
<td></td>
<td>• Enterprise Master Patient Index which is required to reconcile citizen records across the full health and wider public sector ensuring identity accurate for record sharing across services, platforms, systems and applications</td>
</tr>
<tr>
<td></td>
<td>• A Record locator service to identify the services available to a citizen and work with other STPs</td>
</tr>
<tr>
<td></td>
<td>Review openEHR standards to support the sharing of information and liberation of data from vendors</td>
</tr>
<tr>
<td><strong>2.9 Meds Optimisation</strong></td>
<td></td>
</tr>
<tr>
<td>PHASE 1 Supporting prevention and self care&quot;</td>
<td>Encouraging a reduced reliance on medicines through promoting and supporting appropriate self-care and prevention. Includes:</td>
</tr>
<tr>
<td></td>
<td>1. Social Prescribing: the process to connect people receiving clinical or medical treatment with wider social support in their community</td>
</tr>
<tr>
<td></td>
<td>2. Utilising the Patient Activation Measure as a tool to support people with the knowledge, skills and confidence to self care</td>
</tr>
<tr>
<td>PHASE 1 Safer use of</td>
<td>Reduce the avoidable harm caused by medicines through the development of a system that learns from experience and reporting of incidents in an open culture. Focus on educated and informed patients, and supportive clinical services, to improve the way in which</td>
</tr>
<tr>
<td>PHASE 1</td>
<td>Standardised, best value care</td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td>Person centred care and support</td>
<td>Establish a systematic approach to standardising and improving the value and outcomes of care.</td>
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<table>
<thead>
<tr>
<th>PHASE 1</th>
<th>Innovation and research</th>
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<tr>
<td>Greater Manchester to be a leader of biomedical research and accelerating adoption of innovation in the UK. Focusing specifically on:</td>
<td></td>
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<tr>
<td>• Transforming the health and wellbeing of the population</td>
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<tr>
<td>• Ensuring the appropriate use of medicines, including flexible and fair funding of innovative medicines</td>
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<tr>
<td>• Driving inward investment to the region using NHS as an economic driver</td>
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<thead>
<tr>
<th>PHASE 1</th>
<th>Enabling the strategy - investment to deliver</th>
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<tbody>
<tr>
<td>Develop a skilled workforce, supported by connected IT, which transforms care by identifying those people and communities most in need of assistance and supports personalised care for their needs. Ambition to reduce variation in system and process across Greater Manchester, to reduced inefficiencies and improve cost effectiveness and patient experience.</td>
<td></td>
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<thead>
<tr>
<th>PHASE 1</th>
<th>Assurance</th>
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<tbody>
<tr>
<td>To assure Greater Manchester that the cultural and operational changes within the strategy are embedding in mainstream clinical care, and ensure financial and clinical sustainability of Greater Manchester linked to the efficient and effective use of medicines.</td>
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<thead>
<tr>
<th>PHASE 1</th>
<th>Meds Optimisation Standards</th>
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<tr>
<td>Major (perceived) changes:</td>
<td></td>
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<tr>
<td>• Interested in consequences of providers not supplying information in a timely or complete fashion.</td>
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<tr>
<td>• The proposal is to adopt the same information schedule that NHS England require of trusts, to assist trusts with reducing complexity, manipulation and bureaucracy by having a single standard, not different versions dependent on commissioner.</td>
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<tr>
<td>• Withhold (or part) payments until data is supplied in the correct format (and responded to if challenged).</td>
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<tr>
<td>• Adoption of Blueteq being specifically named and contracted.</td>
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<tr>
<td>Timescales:</td>
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<tr>
<td>Variations agreed at any point within this 2 year contracting cycle. NHS England have issued the following regarding contract variations prior to Christmas:</td>
<td></td>
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<tr>
<td>2017-19 NHS Standard Contract: updated October 2017</td>
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<tr>
<td>The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.</td>
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</table>
| National Variation update: 'We are reviewing feedback from the consultation and intend to publish the final National Variations as soon as possible. In the interim, commissioners and providers should note that it will no longer be a national requirement that National Variations are implemented locally by 1 January 2018. We will advise of a new timescale for implementation when the final
National Variations are released.

2.10 Mental Health: GMS Implementation Priority Area

Suicide prevention, overcoming MH stigma and Supporting Communities of Identity

NATIONAL PLANNING GUIDANCE PRIORITY AREA
Implementation of suicide prevention strategy for Greater Manchester, including coordinating activities of Local authority based suicide prevention groups with the aim of reducing suicides in Greater Manchester.

*This contributes to the national requirement to deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicide rate by 2020/21. As GM, this means approximately 30 fewer deaths by suicide, although final baseline figures from 2017 not available yet to determine if this is higher or lower.*

From this year, there will be implementation of a suicide bereavement liaison service which is around £580k but no further funding for SP activities has been agreed

2.11 Nonclinical Support Services (Corporate Services)

Release 1 - Asset consolidation and onboarding
Consolidation and onboarding is focused on providing high-quality, efficient corporate services which will bring together our existing GM shared service assets into one NHS owned and managed organisation. This will create a cohesive corporate service offer which can be optimally managed to deliver recurrent savings to the system and improved quality.

Work will be focussed on:
1) Creating the new organisation including identifying a preferred host for the shared service delivery vehicle
2) Consolidating the assets into one organisation to create a cohesive offer
3) Evaluating the existing offerings and ensuring they are commoditised for organisations to adopt, easily and compliantly
4) Develop the customer base by creating an on boarding plan for each participating organisation. It will have a flexible approach whereby customers can take services at a time that suits them.

Release 2 –
- HR
- Procurement
- IM&T

Release 2 will develop a collaborative approach where a shared service offering across GM does not currently exist at scale, the current scope includes HR, Procurement and IM&T

Our priority throughout 18/19 will be to define a target operating model and roadmap for each of the Corporate Functions.

We will look at how we can:
- Benefit from scale - This is where organisations can consolidate services to drive efficiencies through scale and/or use their collective and very significant buying power to get better deals from the market and share the benefit.
- Reduce the volume of transactions across organisations - This is where the volume and associated transaction costs that
exist between organisations can be reduced
- Deliver innovation at pace across the system

To deliver the full potential of benefits across Greater Manchester there will be focus on common standards, systems, interfaces and processes across all Corporate Functions.

2.12 Population Health: GMS Implementation Priority Area

| Eradication of HIV | A 2015 report by Public Health England (PHE) estimated that 103,700 people were living with HIV in the UK in the year 2014. Once people are diagnosed they are able to receive very effective treatment. However, nationally 17% of people living with HIV are unaware of their status. Furthermore, 40% of adults newly diagnosed with HIV were diagnosed late, after they should have started treatment (PHE, 2014).
Late diagnosis reduces health outcomes for HIV-positive people, as well as increasing the likelihood of onward transmission of HIV. In addition to the negative effects of late HIV diagnosis on an individual’s and population’s health, it also makes an impact upon the public purse; the lifetime treatment cost of living with HIV is estimated to be around £360,000. Late diagnosis increases further the cost of HIV treatment by 50%.
The overall objective of this programme of work is to help develop and build upon a GM city-region approach to ending all new cases of HIV within a generation.
Two specific objectives are: 1) Review and map out current HIV testing approaches and related interventions across GM, to inform the ambition of ending all new cases of HIV within a generation. 2) Develop a business case that builds on the robust review and mapping exercise of HIV testing provision and associated interventions, and which demonstrates the economic and health benefits of a GM city-region approach to ending all new cases of HIV within a generation. To then pilot and evaluate a GM city-region approach to eradicating HIV within a generation.
The programme is to be resourced centrally with TF allocation. Investment case due to be reviewed and signed off in February/March 2018 for delivery from 18/19. The programme is GM wide which localities need to be aware of and input into where required, with local commissioners already involved in developing the investment proposition. |
The GM Health and Employment Programme is a joint programme between the GM Health & Social Care Partnership and the GM Combined Authority. It aims to create a system response along the continuum from ‘in work’ through to long-term worklessness, focusing on the following areas:
- An effective early intervention system available to all GM residents in work who become ill and risk falling out of the labour market
- Early intervention for those newly out of work who need an enhanced health support offer
- Better support for the diverse range of people who are long-term economically inactive to prepare for and find work
- Development to enable GM employers to provide ‘good work’, and for people to stay healthy and productive in work

In 18/19 we will be focusing on the delivery of the first priority within the programme, developing a ‘GM Working Well Early Help Service’ to deliver an effective early intervention service to GM residents with health conditions, at risk of falling out of the labour market.

The introduction of the Early Help service is to be resourced centrally with TF allocation. Investment from the TF fund for this programme was signed off in January 2018 with the programme moving into the procurement phase from April 2018 once other funding sources have been secured/agreed (ESF, Joint Work and Health Unit and Reform Investment Fund). The new service is expected to go live from February 2019. The programme is GM wide which localities need to be aware of and input into where required.

A Greater Manchester Drug and Alcohol Strategy is being developed for publication in March 2018. The emergent strategic priorities are:
1. Prevention and early intervention
2. Reducing drug and alcohol harm
3. Building recovery in communities
4. Reducing drug and alcohol related crime and disorder
5. Managing accessibility and availability
6. Establishing diverse, vibrant and safe night-time economies

This will be accompanied by an Investment Proposition to the GMHSCP transformation fund. The focus of this is to be agreed, but is likely to be around:
- The harm caused by alcohol consumption in pregnancy.
- Community based alternatives to formal drug and alcohol treatment

During January and February the emergent proposals will be subject to system wide engagement. Drugs and Alcohol programme, to be resourced centrally with TF allocation. Investment case due to be reviewed and signed off in March 2018 for delivery from 18/19. The programme is GM wide which localities need to be aware of and input into where required.
<table>
<thead>
<tr>
<th>Physical Activity</th>
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<tbody>
<tr>
<td>The GM Ambition is ‘to achieve the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people who live in GM’. Physical activity is central to shifting health at scale. A more active GM will contribute to all of the government’s five outcomes for sport and physical activity – physical health, mental wellbeing, individual development, social/community development, and economic development. GM Moving, The Blueprint for Change was launched in 2015, and was followed in 2016 by an MOU (and programme of work) between GMCA, GMHSCP and Sport England to progress the agenda across GM in relation to physical activity and sport. A refreshed GM Moving Plan was launched in July 2017, in the context of the Population Health Plan, the new Mayoral Manifesto, new national and local evidence, insight and strategies. This is the shared strategy for physical activity and sport across the whole GM system.</td>
</tr>
<tr>
<td>The Sport England local delivery pilot investable proposition for GM to build new approaches to reduce physical inactivity will be agreed by June and implementation of this large scale three year intervention programme will begin in 18/19 and will be fully resourced centrally. The focus will be on 3 priority audiences: C&amp;YP aged 5-18 out of school hours; People out of work, or at risk of becoming workless due to health conditions; and people aged 40-60 with LTCs. Active travel will also be a cross cutting theme.</td>
</tr>
<tr>
<td>Work will also be progressed as part of the broader GM Moving Strategy to deliver whole system change. Delivery workstreams in 18/19 will include: Driving whole school approaches to physical activity including implementation of a GM daily Mile programme; ? physical literacy; Roll out of 10 locality based programmes aimed at supporting those aged 55 plus to become more active; a significant third sector and public engagement programme to support the co-production of the LDP and key elements of GM Moving programmes and enable us to build on personal and community assets; commissioning behavioural insights research to understand the barriers and motivations for our population which underpins the design and delivery of our intervention programmes. All programmes will be centrally resourced.</td>
</tr>
<tr>
<td>GM Moving programme is a multi year programme, to be resourced centrally from TF allocation and reform board investment. Investment case due to be reviewed and signed off in May/June 2018 for delivery from 18/19. In addition there is significant investment via sport england into a three year large scale intervention programme, pan GM which will begin delivery in the latter half of 18/19. These programmes is GM wide which localities need to be aware of and input into where required.</td>
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</table>
Greater Manchester has proposed a GM Wellness Hub to provide its citizens with consistent online and virtual/telephone behaviour change support across diet, physical activity, alcohol consumption, tobacco use and mental wellbeing. In developing a GM Wellness Hub, the intention is to:

• Widen the scope of the GM wellness offer to meet a broader range of support needs, particularly among lower socioeconomic groups
• Increase the scale of offer and capacity in the system to provide behaviour change support to more people
• Realise economies of scale and reduce duplication by commissioning elements of the wellness offer at the GM level wherever appropriate
• Enable existing capacity in locally-commissioned face to face behaviour change services to be targeted at highest risk groups that need them most.

Initial funding has been secured to develop Salford’s My City Health platform during 2017. This will provide qualitative and quantitative evidence to inform a bid to the Transformation Fund for funding to enable other localities to adapt and adopt My City Health and create the GM Wellness Hub. Central to the pilot will be the delivery of the digital smoking cessation offer for GM as committed to in the

Moving forward into 2018 the programme will be resourced centrally with TF allocation. Investment case to pilot approaches due to be reviewed and signed off in May/June 2018 for delivery from 18/19. The programme is likely to be focused on testing in several GM localities which localities need to be aware of and input into where required.
### Health Checks

Scoping changes to the NHS health check to standardise the offer across GM and increase its impact. Proposals to consider include:

- Identifying risk status from the clinical record
- Incorporating a digital offer for low risk people
- Focusing on behavioural and cultural change
- Broadening the health check in the over 65s
- Adding value to the health check by incorporating cancer risk and lung age

Additional asks via this programme will be resourced centrally with TF allocation. Investment case due to be reviewed and signed off in May/June 2018, with preparatory work and Pilot in 18/19 and full implementation likely in 19/20. Needs to be considered through JCB.

### Common Outcomes and Standards

In order to achieve our GM Population Health Outcomes, we must see a more consistent adoption of evidence-based practice to reduce unwanted variation across the conurbation. A Strategic Core Group was established and 8 initial core issue-based priority areas were identified that will help all localities and GM to achieve improved population health outcomes. The group is also exploring the development of a high level suite of standards across the life course and potential additional future priority areas are under consideration.

3 Core Proposals under the Programme:
- GM Population Health Outcomes Framework
- GM Common Goals – Commons Standards; Common Strategies
- Excellence in GM (Improvement Programme)

This is a system enabling programme for population health and should also inform the commissioning agenda at locality level and emerging local care organisations. Final draft GM Outcomes Framework and associated GM Outcomes Dashboard are due to be completed and agreed by GM DsPH in February 2018 alongside Phase 1 topic-based common standards and Headline GM Common Standards.
### Falls

Falls, osteoporosis and fragility fractures are three sides of the same problem and falls and fractures are in theory preventable and manageable with earlier identification and suitable intervention. This programme will identify best practice and create clear guidance on how to maximise and systematise existing system levers, services and approaches to optimise practice across Greater Manchester in the arena of falls prevention, identification, assessment, management and treatment. Part of this project will specifically support the implementation of FLS in boroughs which have prioritised it in their locality plans and develop common standards for existing FLS services.

The Health and Social Care Partnership made several high-level commitments as part of Taking Charge, one of which is to reduce the number of people over 65 admitted to hospital due to falls to the projected England average by 2021, which is calculated as 2,750 fewer falls-related admissions by 2021 (source: New Economy/GMCA).

This programme will directly support the delivery of that objective by developing collaborative leadership across the public, independent, voluntary, community and social enterprise (VCSE) and academic sectors to ensure a truly system wide, expert response to falls, with the right cross-sectoral skills being deployed at the right time. An important aspect of this project will be to achieve system wide communication and recognition that falls are a population health matter, typically associated with older age but not inevitably arising from it, the risk of which is modifiable especially with early identification of risk and appropriate intervention.

In 18/19 localities will work with GMHSCP to reduce unwanted variation by co-producing and implementing a set of evidence-based practice standards and commissioning standards. This will include primary prevention and secondary prevention (Fracture Liaison Services) via the GM Commissioning Hub.

### 2.13 Primary Care: GMS Implementation Priority Area

**Older people’s care-link dental project**

To test the feasibility of commissioning a ‘link’ dental practice to provide an assessment, prevention & treatment co-ordination and referral service for older people who are moderately or highly dependent on care from others due to long term conditions.

**Objectives**

- Design a proposed model for the scope and functions of a care-link dental practice using a Plan-Do-Study-Act (PDSA) approach
- Identify the resources required for a care-link dental practice, including; staff, time, training, equipment, and overall investment
- Establish referral guidance and pathways into general dental practice, domiciliary and special care dentistry as required
- Identify suitable methods of data collection to support commissioning and contract management of a care-link dental practice contract

**Medicines optimisation**

- Map out the Medicines Use Review (MUR) and New Medicines Service (NMS) processes and patient journey from a community pharmacy perspective to feed into the wider pharmacy referral project and seamless care aspiration between community pharmacy, secondary care pharmacy and GP practice.
- Develop a set of quality standards for GM to increase the quality of and outcomes from MUR and NMS service delivery.
- Improve pharmacy contractor and pharmacist delivery of required elements of MUR service (i.e. patient consent, record keeping and proof of accreditation).
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<tr>
<th>10/04/18 Appendix 1: GM Taking Charge Business Plan 2018/2019</th>
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<thead>
<tr>
<th>Primary Eye Care Service Framework</th>
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<tr>
<td>The main objectives of a Greater Manchester wide Primary Eye Care Service are:</td>
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<tr>
<td>• Provision of safe and effective care by appropriately trained and competent professionals.</td>
</tr>
<tr>
<td>• Delivery of high quality clinical services that ensure patient safety and a positive patient experience.</td>
</tr>
<tr>
<td>• Ongoing development of the current and future workforce supported by receipt of feedback to the practitioner following referral.</td>
</tr>
<tr>
<td>• Reconfiguration of patient flows to make best use of available resources and skills.</td>
</tr>
<tr>
<td>• Provision of clinical services in a setting closer to home or work.</td>
</tr>
<tr>
<td>• Reduction of referrals to HES to reduce waiting times for outpatient appointments and/or enable greater capacity for the care of higher risk patients.</td>
</tr>
<tr>
<td>• Empowerment of patients through education and self-care.</td>
</tr>
<tr>
<td>• Elimination of postcode lottery and resolution of boundary issues</td>
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<thead>
<tr>
<th>Eye Health IT enabler project</th>
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<tr>
<td>Improve the quality and availability of data relating to specific disease pathways in secondary care so that service planning may be more effective. There must be a particular focus on electronic referrals and connectivity as well as maintenance of disease registers.</td>
</tr>
<tr>
<td>• Primary and secondary care providers to work together through the network to develop high quality, reliable care pathways that reduce the risk of patients being lost to the healthcare system. This includes the expansion of step down care available in primary and community based care; in particular the monitoring of low risk long term conditions.</td>
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<tr>
<td>• Ensure that patients are aware of services available and for these to be easily accessible in their local community.</td>
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<tr>
<th>Seamless care</th>
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<tr>
<td>This project will:</td>
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<tr>
<td>• Identify the benefits and requirements of an electronic referral system.</td>
</tr>
<tr>
<td>• Develop a specification for procurement initially focusing on referral between hospital and mental health trusts and community pharmacies but with the capability for further development to include pharmacy teams working in general practices.</td>
</tr>
<tr>
<td>• Manage the implementation of the electronic referral system across GM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inhaler technique in children</th>
</tr>
</thead>
<tbody>
<tr>
<td>This project aims to show a measurable improvement in the inhaler technique, and associated health outcomes, of children and young people with asthma in primary and secondary school settings</td>
</tr>
<tr>
<td>Delivered through the following objectives:</td>
</tr>
<tr>
<td>• To assess, and if necessary improve, inhaler technique for each children and young people during one school-based pharmacist consultation and one follow-up consultation.</td>
</tr>
<tr>
<td>• To show a reduction at 8-week follow-up in self- and/or parent-reported school days lost, A&amp;E attendances/admissions, GP/OOH appointments</td>
</tr>
<tr>
<td>• To increase condition control</td>
</tr>
<tr>
<td>• To show an increase in quality of life – in terms of symptoms, activity limitation and emotional function – at follow-up</td>
</tr>
<tr>
<td>• To increase the confidence of CYP, parents and teachers in the use of inhalers</td>
</tr>
</tbody>
</table>
### Sight Loss Service Framework
- Evaluate the availability of current sight loss services across GM.
- Rehabilitation services in social care and voluntary sector to work with primary and secondary care to develop a strategy for long term care of patients with sight loss.
- Explore the use of Information technology and digital solutions to improving outcomes for people with sight loss.
- Work with providers including the voluntary sector to support further collaboration and innovative models of care to ensure an integrated, holistic approach is delivered to support patients across Greater Manchester to maintain independence.

### GM secondary care ophthalmology standards
- Develop a set of secondary care ophthalmology standards and work with providers and commissioners to implement these.
- Working with secondary care providers to develop collaborative models of care across Greater Manchester for ophthalmology services.

### Reduce unwarranted variation & increase uptake in eye health screening services
- Work with commissioners, providers, voluntary sector, patients and other stakeholders to support the improvement in uptake of screening services.
- Ensure access to and align children vision screening services to a single GM operating model to improve transparency and continuity for patients, whilst ensuring access in all primary schools at reception age. With a dedicated pathway for children attending special schools.
- Work with commissioners and providers to ensure good practice in Diabetic screening programmes is shared and scaled up across Greater Manchester.
- Work with commissioners and providers to develop collaborative models of care across Greater Manchester for screening services such as diabetic eye screening, ensuring maximum access resulting in improved outcomes.

### 2.14 Strategic Clinical Network

#### SCN funded / Locality implementation (links to theme 3)

#### Out of Hospital Cardiac Arrest Project
The Objective of the OHCA Steering Group is to foster a common seamless protocol that reduces variation across Greater Manchester whilst improving the quality of service and outcomes.

A staged approach has been adopted, the first stage being “all patients who have achieved ROSC after OHCA should be taken to a recognised centre of care” has as agreed pathway which is now being deployed.

Further stages, expanding the patient catchment criteria, will be delivered in 2018.
1. Take all awake, ST Elevation, ROSC, not ventilated direct to HAC (active now, see section 3)
2. Ventilated, ST Elevation, unconscious (develop during delivery of stage 1)
3. Inclusion of NSTEMI

For patients who are already at the DGH then the following is proposed:
- Ventilated with ST elevation should follow the OHCA pathway.
- Where the patient does not fall directly into the OHCA pathway but the ED/ICU/Cardiac consultant at DGH believes the patient "is suitable for ongoing treatment" then they should call the HAC and if transfer agreed request a vehicle from NWAS.
## 2.15 Urgent and Emergency Care

### Stay Well

Development across GM of initiatives and standards focused on prevention including:
- Primary Care support in to care homes
- Development of neighbourhood teams
- Flu vaccination programmes
- Social care prescribing
- Identification and screening for frailty (frailty units)
- Increased use of voluntary sector
- Development of extensivist model
- Patient activation

### Home First

**NATIONAL PLANNING GUIDANCE PRIORITY AREA**

Development across GM of initiatives and standards focused on reducing admissions and attendances at the emergency department, including:
- Development of a local urgent care response for ambulance category 3/4 calls and urgent GP visits embedded within primary care (Acute Practitioner Model)
- Implementation of the Nursing Home Triage Tool in all residential and nursing homes
- Ambulatory Care operating 14 hours per day, 7 days per week
- Streaming to primary care, UTCs and ABC and direct access
- UTCS in operation in all localities with standard acceptance criteria
- MDT 24/7 urgent response teams in all localities
- Implementation of a 24/7 Integrated Urgent Care Model across GM with 111 Direct Booking in to Primary Care
- Single Point of Access at locality level
- Early identification and management of frailty with assessment by an MDT and commencement of a CGA within 1 hour of arrival
- Enhanced social care presence in EDs
- Mental health liaison teams with EDs 24/7
- Adoption of tele-health
- Development of Directory of Services
- Site Management
- System Escalation

This contributes to the following national requirements:

1. Ambulance Response Programme to be implemented in all English mainland ambulance trusts. In GM APR implemented in NWAS.
2. Work with local Ambulance Trusts to ensure that the new ambulance response time standards that were introduced in 2017/18 are met by September 2018. Handovers between ambulances and hospital A&Es should not exceed 30 minutes.
GM NWAS are currently in the process of producing an improvement plan with NHSI and E. Performance trajectories will be agreed as part of this. Plan due to be finalised and signed off by mid-March 18.

3. Continue to work towards the 2020/21 deliverable of all acute hospitals having mental health crisis and liaison services that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals, subject to hospitals being able to successfully recruit. In GM Mental health is currently not covered by the UEC Programme. However, this is being delivered through the GM Mental Health Programme.

4. Access to enhanced NHS 111 services to 100% of the population, with more than half of callers to NHS 111 receiving clinical input during their call. Every part of the country should be covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 and GP out of hours service provision. This will include direct booking from NHS 111 to other urgent care services. Testing of 111 direct booking in 4 GM areas is starting during March 18.

5. By March 2019, CCGs should ensure technology is enabled and then ensure that direct booking from IUC CAS into local GP systems is delivered wherever technology allows. This is a national initiative and is tracked by each CCG- at present the stats available from NHS England are not functioning correctly to give accurate figures on this. Localities are aware and report on this quarterly.

6. Designate remaining UTCs in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care. GM is working with all localities to understand their trajectories to implement UTCs, and aiming for the delivery of national requirements by the national target of December 2019. A pipeline for rollout will be developed during 18/19, some of which will also be mobilised within this timeframe. Implement a proprietary appointment booking system at particular GP practices, 50% of integrated urgent care services and 50% of UTCs by May 2018, supported by improved technology and clear appointment booking standards issued by December 2018. This will be delivered alongside point 7 above.
<table>
<thead>
<tr>
<th>Patient Flow</th>
<th>NATIONAL PLANNING GUIDANCE PRIORITY AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development of GM initiatives and standards focused on improving patient flow and improving four hour performance including:</td>
</tr>
<tr>
<td></td>
<td>Implementation of &quot;Improving Patient Flow&quot; guidance</td>
</tr>
<tr>
<td></td>
<td>Adoption of a zero tolerance approach to ambulance handover delays</td>
</tr>
<tr>
<td></td>
<td>Introduction ED Safety Checklist</td>
</tr>
<tr>
<td></td>
<td>Introduction a full capacity protocol</td>
</tr>
<tr>
<td></td>
<td>Adoption maximum length of stay of 72 hours and bed occupancy of no more than 90% for Acute Medical Units</td>
</tr>
<tr>
<td></td>
<td>Full implementation of the SAFER patient flow bundle and red/green days methodology on all wards</td>
</tr>
<tr>
<td></td>
<td>Ensure that there is specialty and surgical in-reach in to ED and AMU</td>
</tr>
<tr>
<td></td>
<td>Development of GM standards for patient flow</td>
</tr>
<tr>
<td></td>
<td>Development of local urgent care control rooms/hubs</td>
</tr>
<tr>
<td></td>
<td>GM UEC Operational Hub</td>
</tr>
<tr>
<td></td>
<td>Development of the extensivist model</td>
</tr>
<tr>
<td></td>
<td>Targeted system based improvement initiatives</td>
</tr>
<tr>
<td></td>
<td>Best Practice Site Management Standards</td>
</tr>
</tbody>
</table>

This contributes to the national requirements:

1. To ensure that aggregate performance against the four-hour A&E standard is at or above 90% in September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019. Also Trusts are expected to improve on their performance each quarter compared to their performance in the same quarter the prior year in order to qualify for STF payments.

7. Also to continue to improve patient flow inside hospitals through implementing the “Improving Patient Flow” guidance. Focus specifically on reducing inappropriate length of stay for admissions, including specific attention on ‘stranded’ and ‘super stranded’ patients who have been in hospital for over 7 days and over 21 days respectively. GM patient flow standards and Improvement trajectories for stranded and super stranded will be defined by April 2018.
<table>
<thead>
<tr>
<th>Discharge and Recovery</th>
<th>NATIONAL PLANNING GUIDANCE PRIORITY AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development of GM initiatives and standards focused on improving discharge and recovery including:</td>
</tr>
<tr>
<td></td>
<td>- Delivery of three agreed protocols e.g. Discharge to Assess, Trusted Assessment and Patient Choice at a local level.</td>
</tr>
<tr>
<td></td>
<td>- Introduction of a standard GM trusted assessor mode for care homes, social care and restarts of packages of care</td>
</tr>
<tr>
<td></td>
<td>- Delivery of standardised approach to Integrated Discharge Teams, to support the delivery of early discharge planning</td>
</tr>
<tr>
<td></td>
<td>- Full implementation of the 8 high impact changes</td>
</tr>
<tr>
<td></td>
<td>- Effective transport planning</td>
</tr>
<tr>
<td></td>
<td>- Development of the extensivist model</td>
</tr>
<tr>
<td></td>
<td>2. This contributes to the national requirement to ensure that fewer than 15% of NHS continuing healthcare full assessments take place in an acute setting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Overarching work to support the aims of the UEC Reform and Improvement programme including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- GM communications</td>
</tr>
<tr>
<td></td>
<td>- Enhanced technology</td>
</tr>
<tr>
<td></td>
<td>- Estates</td>
</tr>
<tr>
<td></td>
<td>- Delivery of a 24/7 Operational Hub providing a single shared data picture for UEC/intelligent divert/ pro-active demand management.</td>
</tr>
</tbody>
</table>
## Unify Trajectories List
(New additional lines are highlighted in Blue)

<table>
<thead>
<tr>
<th>National 18/19 Ambition</th>
<th>Planning Trajectory</th>
<th>Regularity of Plans</th>
<th>Extent of refresh of previously submitted 2018/19 plan expected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RTT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total numbers of patients on an incomplete pathway at month end (This line together with the line below will allow the calculation of RTT performance)</td>
<td>The WL should be sustained at March 2018 levels in March 2019</td>
<td>Yes</td>
<td>Monthly</td>
</tr>
<tr>
<td>Total numbers on an incomplete pathway waiting less than 18 weeks at month end</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
</tbody>
</table>

**NEW: RTT 52 Week Wait**

<table>
<thead>
<tr>
<th>Diagnostics</th>
<th>1%</th>
<th>Yes</th>
<th>Monthly</th>
<th>Alterations permitted as required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cancer two week wait</td>
<td>93%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>Two week wait for breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from ‘date of decision to treat’)</td>
<td>96%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>31-day standard for subsequent cancer treatments-surgery</td>
<td>94%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>31-day standard for subsequent cancer treatments - anti cancer drug regimens</td>
<td>98%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>31-day standard for subsequent cancer treatments - radiotherapy</td>
<td>94%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer</td>
<td>85%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service</td>
<td>90%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status</td>
<td>n/a</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
</tbody>
</table>
### Appendix 2 : GM Taking Charge Business Plan 2018/2019

#### Constitutional Standards

<table>
<thead>
<tr>
<th>Unify Trajectories List (New additional lines are highlighted in Blue)</th>
<th>National 18/19 Ambition</th>
<th>Planning Trajectory</th>
<th>Regularity of Plans</th>
<th>Extent of refresh of previously submitted 2018/19 plan expected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A&amp;E</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E waiting times – total time in the A&amp;E department (4 hour waits). Note this measure is collected as: Numerator - numbers of patients seen in 4 hours, and Denominator - total number of A&amp;E attendances.)</td>
<td>Achieve above 90% in September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elective Activity (National Growth shown below is the annualised growth)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Referrals (General and Acute)</strong></td>
<td>2.2% Growth</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td><strong>Total GP Referrals (General and Acute)</strong></td>
<td>0.8% Growth</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td><strong>Total Other Referrals (General and Acute)</strong></td>
<td>4.6% Growth</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td><strong>Consultant led1st Outpatient attendances (Specific Acute)</strong></td>
<td>6.4% Growth</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td><strong>Consultant led Follow up outpatient attendances (Specific Acute)</strong></td>
<td>4.1% Growth</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
<tr>
<td><strong>Total elective admissions (spells) (ordinary admissions and day cases) (specific Acute)</strong></td>
<td>3.6% Growth</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh required</td>
</tr>
</tbody>
</table>

**NEW:** Total Elective Admissions - Day Cases

**NEW:** Total Elective Admissions – Ordinary

| **Number of completed RTT admitted pathways** | N/A | Yes | Monthly | Refresh required |
| **Number of completed RTT non-admitted pathways** | N/A | Yes | Monthly | Refresh required |
| **Number of New RTT pathways (clock starts)** | N/A | Yes | Monthly | Refresh required |

**Non Elective Activity**

| **Total number of A&E Attendances excluding Planned Follow Ups** | 1.1% Growth | Yes | Monthly | Refresh required |
| **Total non-electic admissions (Specific Acute)** | 2.3% Growth | Yes | Monthly | Refresh required |

**NEW:** Non elective Admissions - 0 LoS

**NEW:** Non elective Admissions - +1 LoS

<table>
<thead>
<tr>
<th><strong>NEW:</strong></th>
<th>** Extent of refresh of previously submitted 2018/19 plan expected**</th>
</tr>
</thead>
</table>

**NEW Measure**
## Appendices 2: GM Taking Charge Business Plan 2018/2019
### Constitutional Standards

<table>
<thead>
<tr>
<th>Unify Trajectories List (New additional lines are highlighted in Blue)</th>
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<th>Extent of refresh of previously submitted 2018/19 plan expected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IAPT Roll-Out</td>
<td>19% by Q4</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Q1-Q3 profiling can be amended. Q4 position can only be amended in exceptional circumstances</td>
</tr>
<tr>
<td>Estimated diagnosis rate for people with dementia</td>
<td>66.70%</td>
<td>Yes</td>
<td>Monthly</td>
<td>Previously submitted trajectories can only be amended in exceptional circumstances</td>
</tr>
<tr>
<td>IAPT Recovery Rate</td>
<td>50%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Q1-Q3 profiling can be amended. Q4 position can only be amended in exceptional circumstances</td>
</tr>
<tr>
<td>IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.</td>
<td>75%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Q1-Q3 profiling can be amended. Q4 position can only be amended in exceptional circumstances</td>
</tr>
<tr>
<td>IAPT Waiting Times - The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.</td>
<td>95%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Q1-Q3 profiling can be amended. Q4 position can only be amended in exceptional circumstances</td>
</tr>
<tr>
<td>Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral</td>
<td>53%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Q1-Q3 profiling can be amended. Q4 position can only be amended in exceptional circumstances</td>
</tr>
<tr>
<td>Improve access rate to CYPMH</td>
<td>32%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Trajectories to be reprofiled by exception only. Data quality issues should not be viewed as acceptable grounds for</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for eating disorders within four weeks from a routine referral</td>
<td>Further progress towards 95%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Trajectories to be reprofiled by exception only. Data quality issues should not be viewed as acceptable grounds for</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for eating disorders within one week from an urgent referral</td>
<td>Further progress towards 95%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Trajectories to be reprofiled by exception only. Data quality issues should not be viewed as acceptable grounds for</td>
</tr>
<tr>
<td><strong>NEW: Out of area placements</strong></td>
<td>33% Reduction</td>
<td>Yes</td>
<td>Quarterly</td>
<td>New Measure</td>
</tr>
</tbody>
</table>
## Appendix 2: GM Taking Charge Business Plan 2018/2019
### Constitutional Standards

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</thead>
<tbody>
<tr>
<td><strong>Transforming care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliance on inpatient care for people with a learning disability and/or autism (CCG Funded)</td>
<td>By March 2019 no area should need more inpatient capacity than is necessary at any one time to cater to: • 10-15 inpatient in CCG-commissioned beds (such as those in assessment and treatment units) per million population • 20-25 inpatients in NHS England-commissioned beds (such as those in low, medium or high-secure units or CAMHS Tier 4 units) per million population</td>
<td>Yes</td>
<td>Quarterly</td>
<td>End points should remain unchanged. Where there are significant concerns about data integrity, the programme team should be contacted for advice</td>
</tr>
<tr>
<td>Reliance on inpatient care for people with a learning disability and/or autism (NHS England Funded)</td>
<td></td>
<td>Yes</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong>: Reliance on inpatient care for people with a learning disability and/or autism with a length of stay of over 5 years (CCG Funded)</td>
<td></td>
<td>Yes</td>
<td>Quarterly</td>
<td>New Measure</td>
</tr>
<tr>
<td><strong>NEW</strong>: Reliance on inpatient care for people with a learning disability and/or autism with a length of stay of over 5 years (NHS E Funded)</td>
<td></td>
<td>Yes</td>
<td>Quarterly</td>
<td>New Measure</td>
</tr>
<tr>
<td><strong>NEW</strong>: Annual Health Checks delivered by GPs</td>
<td>64% Increase in number of Annual Health Checks delivered by GPs compared with 2016/17</td>
<td>Yes</td>
<td>Quarterly</td>
<td>New Measure</td>
</tr>
<tr>
<td><strong>Primary care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended access (evening and weekends) at GP services</td>
<td>100% Coverage by 1st October 2018</td>
<td>Yes</td>
<td>Monthly</td>
<td>Refresh Required</td>
</tr>
<tr>
<td><strong>Personal health budgets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Health Budgets (PHBs)/integrated personalised commissioning (IPC)</td>
<td>0.10%</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Updates by exception only</td>
</tr>
<tr>
<td><strong>Wheelchair access</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of children waiting less than 18 weeks for a wheelchair</td>
<td>100% by Q4 2018/19</td>
<td>Yes</td>
<td>Quarterly</td>
<td>Updates by exception only</td>
</tr>
<tr>
<td><strong>E-referrals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS e-Referral Service (e-RS) Utilisation Coverage</td>
<td>100% by Q2 2018/19</td>
<td>Yes</td>
<td>Monthly</td>
<td>Updates by exception only</td>
</tr>
</tbody>
</table>
Greater Manchester
Quality Improvement Framework

Taking charge
in Greater Manchester

Greater Manchester Health and Social Care Partnership
Contents

1. Introduction ...................................................... 3
2. Background ...................................................... 4
3. What is quality? ................................................... 6
4. QI Model ........................................................ 8
5. Communities of Practice (Clinical Networks) ......................... 10
6. Service user participation .......................................... 11
7. Quality Board role and terms of reference .............................. 12
8. Maturity of current systems ........................................ 13
9. Working with other agencies. ...................................... 13
10. Culture and Leadership .......................................... 14
11. Measuring and monitoring the quality of care ...................... 14
12. Refining (financial) incentives to improve quality .................. 15
13. Research and Innovation ....................................... 15
14. Next steps .................................................... 15

Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-21
1. Introduction

Improving the quality of care and support service users experience in Greater Manchester (GM) is at the heart of all our objectives and plans. It drives the transformation of existing services, the development of new services and the collaborative working of partnerships. In plans we need to make sure we measure and monitor quality of care, ensuring we maintain the current quality of care as we implement actions that will improve it.

This paper introduces an innovative and unique GM framework for quality improvement that guides a consistent approach to quality improvement in GM, locality, organisation, and service plans. This is the first time that a Quality Improvement Framework has been produced that incorporates both health and social care in this way. This report pulls together historical perspectives into a logical framework for quality improvement founded on leading international practice.

Whilst there is no single best approach to quality improvement there are similar attributes that are common to all:

- Leadership and clear direction
- Engagement of service teams
- Participation of service users
- Access to quality improvement resources
- Quality improvement skills development
- Use of an improvement process
- Continual efforts to improve
- Measure and evaluate the impact of a change

The participation of patients, service users, carers and the public in quality improvement is essential and therefore when the phrase ‘service user’ is used, it encompasses them all.
2. Background

Quality improvement is prominent in the GM plan. A guiding principle of Taking Charge is to deliver the best quality, outcome based services within the resource available whilst reducing variation of outcomes and service standards within and between organisations. The will to improve quality (and reduce variation) using evidence to inform standardisation has been reflected in the strategies and plans approved by the Strategic Partnership Board.

Numerous quality improvement policies and practices have been introduced in health and social care over the past twenty years. Many of these have been the result of a national response to serious adverse events. This has been reflected in a variety of approaches taken by national organisations leading quality improvement. As teams have addressed service priorities and responded to the numerous national quality initiatives, competing beliefs have emerged about how to improve quality of care. These beliefs are often firmly held based on long experience in each setting. We need to build on these foundations to develop an enduring GM approach to quality improvement that has both consistency of purpose and a compelling theoretical and evidential base.

Recently the National Quality Board (NQB) was re-established with a new clinical and professional focused leadership and membership. The NQB comprises the Care Quality Commission (CQC), NHS England, NHS Improvement, Public Health England, National Institute for Health and Care Excellence (NICE) and Health Education England in a partnership model. The new NQB has far greater congruence with developments in GM as it is incorporating a wider set of organisations and considering all of health and social care. The NQB published its model, Shared Commitment to Quality, in December 2016. The CQC has been leading the development of and consulting on an aligned national Adult Social Care Quality Strategy and this is due for publication imminently.

The NQB’s Shared Commitment to Quality and its forthcoming Adult Social Care Quality Strategy are valuable foundations for quality improvement activity in GM.

![Figure 1: NQB’s single, shared view of quality model](image-url)
The NQB model of multi-agency partnership to guide quality improvement is similar to the approach established in GM in 2016. The Greater Manchester Quality Board is somewhat broader in membership as it also reflects commissioners and providers across the whole health and social care system.

The NQB broadens the scope of the CQC model (caring, safe, responsive, effective, and well-led) emphasising the importance of patient-centred care provided using resources responsibly and efficiently, with fair access to all, according to need (Figure 1).

The NQB’s Shared Commitment to Quality describes seven steps to improve quality (Figure 2). These are already reflected in existing GM arrangements.

- Set a clear direction and priorities
- Bring clarity to quality
- Measure and publish quality
- Recognise and reward quality
- Maintain and safeguard quality
- Build capability, improving leadership and culture
- Stay ahead by developing research and innovation

**Figure 2: NQB’s seven steps to improving quality**
### 3. What is quality?

There is no single accepted definition of quality in health and social care but there is acknowledgement that it has different dimensions:

<table>
<thead>
<tr>
<th>Safe</th>
<th>Safe: Avoiding harm from care that is intended to help people.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td><strong>Examples:</strong></td>
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<tr>
<td></td>
<td>● Good infection control minimises care acquired infections like MRSA and CDiff</td>
</tr>
<tr>
<td></td>
<td>● Systems are in place to identify and report safeguarding concerns</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Timely</th>
<th>Timely: Reducing waits and sometimes harmful delays.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Examples:</strong></td>
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<tr>
<td></td>
<td>● Action is taken quickly where early intervention improves the outcome (e.g. lung cancer and stroke)</td>
</tr>
<tr>
<td></td>
<td>● Support is delivered reliably where it is linked to other events (e.g. helping service users get ready for school)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective</th>
<th>Effective: Providing services based on evidence and which produce a clear benefit.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Examples:</strong></td>
</tr>
<tr>
<td></td>
<td>● Young people are immunised against HPV, Meningitis, and other infectious diseases</td>
</tr>
<tr>
<td></td>
<td>● Regular checks are made to promote the wellbeing of groups at higher risk such as looked after children and people with a learning disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficient</th>
<th>Efficient: Avoiding waste.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Examples:</strong></td>
</tr>
<tr>
<td></td>
<td>● Medicines are personalised so patients get the benefit without side effects</td>
</tr>
<tr>
<td></td>
<td>● Community services work collaboratively to share care plans and reduce multiple visits</td>
</tr>
</tbody>
</table>
**Person-centred**

Person-centred: Establishing a partnership between practitioners and service users to ensure care respects service users needs and preferences.

Examples:
- Providers seek and act on feedback from service users
- Service users are supported to make decisions about their own care and support

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**Equitable**

Equitable: Providing care that does not vary in quality because of a service users’ characteristics.

Examples:
- Service users have a consistent offer of service and support in all localities
- Dementia diagnosis rates and support are the same in all communities

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Quality improvement is the continual actions to improve outcomes for service users and to develop the workforce that supports them using systematic methods. The two key elements are ‘continual’ and ‘systematic’.

There are many accepted care improvement methods, such as Lean, PDSA (Plan, Do, Study, Act), and Six Sigma. The choice of a preferred method for an improvement activity is less important than choosing one that takes a systematic approach.

In some services quality assurance has been founded on an assurance process that combines checks of contractual commitments and levers with periodic audit. This assurance process is most effective where there is a learning culture and continual improvement. The promotion of learning and improving quality of care is at the heart of GM’s transformation plans (e.g. the learning hubs included in the Primary Care Reform plan and the workforce development activity included in the Adult Social Care Transformation Programme).
4. QI Model

“healthcare is a system-of-systems. Perturbing one element of the system without considering its impact on the other elements of the system may result in a breakdown.”

Pronovost PJ et al
World Innovation Summit for Health; 2015

Although there are many views on the best quality improvement approaches, there is a broad consensus on the benefits of a systems approach. This is especially important in learning from adverse events where it is important that the immediate factors that led to the event are addressed but also the underlying factors that will prevent further occurrences.

The QI approach for GM must offer a unifying framework that builds a coherent picture that increasingly draws together the excellent work that has been done to date and that will be done in the future. This must foster a learning culture in all care settings.

Organisations have had to respond to the regular national adjustments to priority and policy and, in doing so, similarities in approaches have emerged. These local similarities lend themselves to a GM model derived from leading international practice and research. A quality improvement model can be adopted that is founded on these similar organisational approaches.

Structures of self-similar patterns – fractals – are common. The whole object has the same shape as its parts.

A fractal model has been adopted successfully to align quality improvement activities in renowned systems, such as Baltimore (John Hopkins) and Michigan. The fractal model offers a hierarchical, organisational structure for quality and safety. Its foundation is based on the integration of smaller units that are similar in structure (people), process (use of similar tools), and approach (using a common framework to address issues).

In a GM fractal Quality Improvement (QI) Framework there is accountability at each level of the system and organisation to improve quality and encourage innovation but sufficient flexibility within the self-similar approach to allow the best cultural fit within services and to encourage local ownership of the preferred improvement methodology.

1. Define a unifying purpose
2. Establish a fractal organisational structure
3. Develop a common framework for understanding quality and safety
4. Develop tools for communication and reporting
5. Create a system of shared leadership responsibility

Figure 3: Elements of a QI framework (Mathews et al 2016)
There are five key characteristics of a fractal QI Framework (Figure 3).

- The unifying purpose is defined in the improvement/business plans of teams and organisations
- The existing arrangements provide the basis of a fractal QI infrastructure – further work is needed to encourage structured quality improvement where this is less well developed.
- The Quality Board has a pivotal role in building a shared understanding of similar approaches within a fractal framework.
- The GM performance dashboard provides the foundation for reporting measures of quality of care – further work will be required to ensure there is agreement on clear and transparent measures.
- Shared leadership responsibility has become an important characteristic of health and social care – further work is needed to strengthen this mutual accountability for quality improvement where this is less well developed.

Taking a fractal view has several advantages:

- it helps resolve the tension between different improvement methodologies;
- it enables each part of the system to define its own unique size and shape and include any element that can influence the quality of care experienced by its service users from processes and technology to leadership behaviour and culture; and
- it highlights new areas for development that may have received less attention up to now.
5. Communities of Practice (Clinical Networks)

Important enablers of the fractal QI model are communities of practice to harness the skills, professionalism and enthusiasm of front line workers. Interventions that feel imposed are often resisted and not sustained. Improvement happens when they own it. Communities rely (primarily) on the volition of their members.

These communities transcend organisational, disciplinary and professional boundaries and ensure inclusion of all relevant stakeholders. A community has a vertical core of leadership responsible for leading, organising and mobilising activities and horizontal relationships linking members that make the community an effective enabler of quality improvement.

- Formed of interdependent groups and individuals
- Cross service and organisational boundaries
- United by a common purpose
- Consist of members responsible for achieving the aims
- Combine vertical leadership and horizontal relationship structures
- Use primarily informal mechanisms to achieve change

Two key principles guide these communities of practice:
- Clear and transparent data: They must be informed by agreed clear and transparent reporting of data that is as rigorous for quality as it is for operational and financial performance.
- Leadership accountability: They must have mutually supportive leaders whom hold each other to account to provide time and resources (for quality improvement).

These two principles are established characteristics of our governance arrangements in GM. Furthermore, we have many existing communities of practice. These range from single issue communities within a single provider (e.g. hospital infection control committee), to single issue communities drawn from many providers (e.g. pressure ulcer care), to broader issues communities including the GM Clinical Networks, Operational Delivery Networks and Alliances.
6. Service user participation

When the phrase ‘service user’ is used within this Framework it encompasses patients, service users, carers and the public.

“First, put the patient at the centre – at the absolute centre of your system of care.”

Don Berwick
NHS 60th birthday speech, 2008

Service users are at the heart of quality improvement.

“Patients and their carers should be present, powerful and involved at all levels.”

Don Berwick
Improving the Safety of patients in England, 2013

By listening to people who use and care about our services, we understand their diverse health needs better and focus on and respond to what matters to them. By prioritising the needs of those who experience the poorest health outcomes, we have more power to improve access to services, reduce health inequalities in our communities and make better use of our resources.

GM is committed to listening to and learning from the experiences of service users and ensuring their full participation in design, redesign, assessment and governance. Representatives of service users are members of many leadership groups, including the elected representatives in GM and the Quality Board for health and social care.

Participation in quality improvement is not limited to attendance at meetings and involvement in project teams. There are many mechanisms to involve service users. They are engaged through feedback, compliments and comments, through social media, voluntary organisations, elected representatives, consultations, meetings and through Healthwatch which is represented on the Quality Board. Successful quality improvement is founded on actively listening to service users and promptly and effectively acting in response.
7. Quality Board role and terms of reference

The Quality Board leads a consistent approach to quality improvement in GM. Substantial changes have already been made to the membership, the preparation of reports, the purpose and the style of the Quality Board.

The Terms of Reference for the Quality Board has been evolving to reflect new arrangements. A forward plan has been prepared to consider in detail key aspects of health and care (Figure 5).

<table>
<thead>
<tr>
<th>Quality Board</th>
<th>Key issues for review</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017</td>
<td>Neonatal mortality</td>
</tr>
<tr>
<td>November 2017</td>
<td>Tissue viability</td>
</tr>
<tr>
<td>Issues to monitor led by other Boards</td>
<td>Health of children and young people</td>
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<td></td>
<td>Mental health</td>
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<td></td>
<td>Workforce development</td>
</tr>
<tr>
<td></td>
<td>Reducing medication errors</td>
</tr>
</tbody>
</table>

Figure 5: Developing forward plan for GM Quality Board
8. Maturity of current systems

Although the assortment of quality improvement approaches cascaded through large NHS organisations over the past two decades has resulted in variation in approaches there are also many similarities (that are accommodated in a unifying fractal model). These influences have been far weaker in both smaller organisations providing NHS services (such as dental and GP practices) and in social care. GM plans are already in place to develop a quality improvement approach consistent with the fractal framework in primary care and social care.

The report on Social Care Transformation Programme noted considerable variation in quality in the sector and a very broad range of local and national approaches to supporting quality improvement. The report found GM would be in the bottom quartile nationally for the quality of its residential and nursing care and in the bottom quartile for quality of domiciliary care (as measured by CQC ratings). The report suggested actions to improve care at home included supporting the definition of care at home development contracts and co-producing an agreed model of care and specification. In addition, one of the immediate priorities for the residential and nursing care work stream is to build on good practice and improve quality.

The first part of the GM Primary Care Strategy was published in February 2017 representing the GM approach to the delivery of the national GP Forward View (GPFV). This began to set the direction of travel for primary care transformation and described a sustainable foundation on which to develop new models of care and Local Care Organisations. The report identified variation and contrasting characteristics in GP practices rated outstanding with the characteristics of others that required improvement. At the centre of the reform plans there is a GM excellence programme which adopts a proactive approach to identifying improvements and using quality improvement methodologies to sustain change whilst developing capability.

9. Working with other agencies

Services in GM must respond effectively to national organisations that establish standards, guidance and regulations for health and social care.

The CQC and NICE both provide guidance to support improvement in all parts of the health and social care system. They are directly represented by members of the Quality Board but the influence of CQC and NICE pervades the system through their guidance and standards.

The quality of care service users experience is inextricably linked to the capability and values of the caring workforce. Standards for the health and care workforce are established by agencies concerned with development (such as Skills for Care and Health Education England) and others concerned with professional standards (such as the Health and Care Professionals Council and the Nursing and Midwifery Council).

NHS Improvement is helping build the capacity and capability for improvement across the NHS.
10. Culture and Leadership

In GM quality of care and the safety of patients are highly valued. Leaders and communities of practice recognise the importance of system connectivity and relationships and work together to engage our workforce and our service users to design services and bring about improvements in care. Leaders set the example by promoting a culture of improvement, learning and support. This can be achieved by understanding staff experiences and their motivations.

Education, incorporating insights from continuous reflective learning, leads to informed decision-making and system resilience. The science and practice of quality improvement is part of continuing education for the GM health and social care workforce.

11. Measuring and monitoring the quality of care

Measures are valuable indicators of quality and one critical source of intelligence. There needs to be agreement on measures which are clear and transparent and their value is enhanced when they are combined with soft intelligence from service users, the workforce and other colleagues.

Providers are responsible for delivering care that meets the quality expectations of service users. Commissioners are responsible for monitoring this. The Greater Manchester Health and Social Care Partnership is focused on quality assurance through confirming and supporting the effectiveness of local quality governance systems, monitoring and developing a balanced portfolio of quality metrics, and reviewing quality of care performance in the periodic assurance reviews with localities.

The health and social care workforce are mutually accountable for working together to identify opportunities to improve care and collaborating to make those improvements. Learning and improvement are professional expectations.

Quality metrics already form one of the main sections of the performance dashboard/report. It is likely there will be some refinement of metrics over coming months. The feasibility of a synthesised summary measure of variation is being explored to bring together the six dimensions of quality (safe, timely, effective, efficient, person-centred and equitable).

In relation to the measurement and monitoring of safety indicators, guiding principles are described below.

| Safety measurement and monitoring must be customised to local settings. |
| Clarity of purpose is needed when developing safety measures. |
| Collaboration between regulators and the regulated is critical. |
| A more holistic approach to measuring, monitoring and implementation interventions for all potential types of harm is needed. |
| More anticipation and proactive approaches to safety in addition to the reactive measures is needed. |

Figure 6: The Measurement and Monitoring of Safety, Professor Vincent, 2013

It is important measures of quality are both visible and easy to understand. However, the simplicity of aggregated data can disguise variations, particularly within large organisations and across localities. The metrics used to monitor quality of care must be supplemented by intelligent, fine-grained analysis by leaders across the system.
12. Refining (financial) incentives to improve quality

Actions to improve the quality of care often reduce costs, not least from targeting resources efficiently to maximise outcomes and minimise adverse effects. Nevertheless, an important consideration must be direct financial incentives to deliver improvements to care (and associated financial disincentives where improvements are not implemented).

There are incentives in the existing commissioning arrangements across all health and social care. In health care, for example, these include the NHS ‘Quality Premium’ and ‘Best Practice Tariffs’ (BPTs are national tariffs that have been specifically structured and priced to incentivise and adequately reimburse care that is of high-quality and cost effective with the aim of reducing unexplained variation in clinical quality and universalise best practice). Recently the NHS has also introduced a variant of BPTs to directly incentivise innovation and technology.

Quality improvement is as important a consideration in the Theme 4 ‘Incentivising Reform’ work stream of the Transformation Plan as it is with all other GM Plan work streams.

13. Research and Innovation

Research and innovation are the mechanisms by which the quality of care can be transformed. This is particularly the case for two of the six dimensions of quality, safe and effective, but also true of other dimensions, including timely and efficient. Research evidence informs leading practice and informs guidance (notably from NICE).

Fostering research and innovation is an integral part of excellence in quality improvement. This has been acknowledged in recently approved plans. For example, a specific section on research was included in the GM Cancer Strategy, promoting research is a highlight of the Memorandum of Understanding with the pharma industry, and, following the approval of its outline business plan, Health Innovation Manchester is set to become an important facilitator of quality improvement in the future. These developments build on existing work, including the research led by quality improvement support providers in GM.

Research and innovation is already recognised as one of GM’s strengths and actions are underway to further strengthen this. However, there is more that can be done to optimise our research and innovation capability as partners within GM and as a coherent system beyond GM.

14. Next steps

Assess the maturity of Quality Improvement in all sectors and plans.

Produce an Implementation Plan for quality improvement for the next 18 months, which will include, amongst other things, establishing clear and transparent measures of quality (safe, timely, effective, efficient, person-centred and equitable) which will be co-designed with service users.

Explore the feasibility and benefits of a GM Care Quality Improvement learning institute.

Support the review and action of the national Adult Social Care Quality Strategy once published.
Get involved
You can visit our website at www.gmhsc.org.uk or get in touch with us directly:

Email: gm.hscinfo@nhs.net
Tweet: @GM_HSC
Call: 0161 625 7791 (during office hours)
Address: 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN
Defining the GM Transformation Portfolio: Progress so far and plans for 18/19

1.0 The approach

Through the last quarter of 17/18, a significant amount of time has been dedicated to an alignment piece of the Greater Manchester Portfolio to:

- Ensure we are maximising opportunity to deliver the quickest improvements in health and wellbeing for the benefit of the population of Manchester, whilst ensuring clinical and financial sustainability of the Health and Social Care system by 2021
- Ensure there is clarity on the implementation status of all projects / programmes within the Portfolio, to inform a review of benefits realisation assumptions
- To inform the short-term business planning approach for 18/19, and to ensure that commissioners have built in funding and implementation resource for GM programmes, which are aligned to locality programmes of delivery for 18/19

The cube below outlines the connectivity between programmes in the portfolio:

### Aligning our themes and programmes

The exercise has categorised all of the projects within the programmes outlined above in the Portfolio as either:

1. Already embedded within implementation: Those projects which have been approved through governance, which localities and GM programmes are actively getting on with now, and are understood across the system, as a result of the project maturity
Appendix 4: GM Taking Charge Business Plan 2018/2019

assessment process. The final list was released to the system on the 2\textsuperscript{nd} March and is included within appendix A.

2. Being considered for acceleration: Those projects that have been identified as priorities to move forwards with a GM standard (if affordable) to ensure a consistency of offer across the patch. With the exception of cancer (where this exercise is ongoing already) and population health (which already has funds aligned), we will be working a task and finish group with representatives nominated by JCB and PFB, to understand the current position with regard to the funding and implementation of these projects at a local level, to enable prioritisation and sequencing to be determined.

3. For consideration in 19/20: These are projects which require implementation to support the realisation of the Taking Charge benefits, but are not yet fully designed and costed, therefore are unlikely to be ready for implementation before 19/20. Given the current allocation of the Transformation Funding, these commitments are also likely to require realignment of existing resources.

The diagram below highlights the key dates for completion

![Diagram]

The allocation of remaining transformation monies will be aligned with the proposals above via the TFOG process.

This approach has:

- Ensured commissioners have built in funding and implementation resource for GM programmes for 18/19
Appendix 4: GM Taking Charge Business Plan 2018/2019

- Assessed the current implementation status of all projects / programmes to inform a review of benefits realisation assumptions
- Informed the business planning approach for 18/19
- Confirmed that we are not missing the delivery of any key ‘must do’s’ from the 17/19 operating plan with regard to the transformational delivery areas of:
  - STP trajectories
  - Finance: demand reduction and provider efficiency measures
  - Primary Care
  - Urgent and Emergency Care
  - Referral to treatment times and elective care
  - Cancer
  - Mental health
  - People with Learning Disabilities

2.0 The process

Throughout December, the PMO team undertook a stage assessment for each project within the GM Portfolio, in line with the model below.

Projects were assessed by the GM programme SRO’s and the PMO before sharing with localities to verify the status.
Appendix 4: GM Taking Charge Business Plan 2018/2019

Based on consistency checks with localities (more than 70% agreement across the 10 localities) and follow up discussions with GM programme SRO’s, the projects were then subsequently classified into these implementation categories:

- 18/19 implementation (those already at stages 4,5 excluding HINM projects as a separate process is in design)
- Consideration for acceleration 18/19: priority 1 (national must do projects to address system pressures which require little work up)
- Consideration for acceleration 18/19: priority 2 (national must do projects to address system pressures but require detailed work up)
- Implementation into 19/20 (those projects classified at stage 1,2 or 3 where they don’t fall into the acceleration category)

Appendix A includes a list of those projects which are already in implementation, or have been approved through governance. This was approved by TPB and SPBE in March.

The table below contains the proposals for acceleration: phase 1

<table>
<thead>
<tr>
<th>Programme</th>
<th>Proposals</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute service transformation: Neurorehabilitation</strong></td>
<td>Standardisation of the out of hospital offer to support acute reconfiguration</td>
<td>To accelerate T3 workstream given the progress of the community offer described at P&amp;D in February 2018</td>
</tr>
</tbody>
</table>
| **Dementia**                                   | Living well:  
- Development of the Lived Experience Barometer to measure the lived exp of people living with a diagnosis of dementia and their carers  
- Enabling people with dementia to have the same access to community health and care services as others with complex support needs.  
- People with dementia will receive an assessment for evidence based assistive technology and/or necessary personal ‘reasonable adjustments’ shortly after diagnosis and on request by carers at other times | Perception that the implementation of this project is on the same timeline as other dementia projects in the currently being implemented list |
## Appendix 4: GM Taking Charge Business Plan 2018/2019

### Population Health

- Eradication of HIV
- Health and employment
- Drugs and alcohol
- Physical activity
- Lifestyle and wellness
- Health checks
- Common health outcomes framework

Approval for implementation been supported by population health board with funding identified

### Elective demand

Priorities agreed within the elective care strategy approved by SPBE in February 2018 and at the workshop in March

To support recovery of the elective constitutional standards

### Cancer

To be confirmed following the refresh of the cancer strategy within the context of affordability

To support national and GM priorities relating to outcomes and access

The following are the proposals for consideration for acceleration: phase 2

- Adult Social Care: Care 2020 (selected localities), care homes and carers
- Children’s and young people – LTC management (outputs from the 28th) plus any additional priorities from the HWBB strategy
- Suicide prevention
- Maternity
- Urgent and emergency care – to be defined following the workshop on the 20th
- Medicines management

A workshop is being arranged to align urgent and emergency care, frailty, LCO standards, EOL, person and community centred approaches, population health (falls), theme 3 medicine and primary care to start to formulate the basis of a consistent offer across all LCO’s within Greater Manchester.
The combination of the projects already in train, plus those to be accelerated will ensure that Greater Manchester deliver the national mandatory improvements outlined in Annex A of the national planning guidance and the NHSE mandate.

A prioritisation criterion (see below) and a methodology has been developed, to assess programmes of work proposed for acceleration in 18/19, and to determine the priorities for 19/20.

All localities have now received transformation fund allocations. The GM programmes were asked to submit Transformation funding proposals in September 2017. All programmes that submitted a funding proposal have been asked to populate a short business case template to identify the need and risks of not supporting funding based on prioritisation criteria headings. Any remaining Transformation Fund will be aligned with programmes identified for acceleration.

The proposal is to establish a 3 month time limited task and finish group supporting JCB, PFB, TFOG and PBE to:

- Oversee the development of business cases (where required) for acceleration in 18/19
- Oversee the prioritisation process for 19/20
- Review the detail of individual proposals for the remaining Transformation Fund to support the TFOG decision making process
Appendix 4: GM Taking Charge Business Plan 2018/2019

It is proposed that this group is established of Directors from different disciplines across Health and Social organisations, to ensure recommendations are fully owned by the system given the short timescales involved.

A prioritisation criterion and methodology has been developed, which will be considered by a task and finish group with membership identified by the Joint Commissioning Board and the Provider Federation Board to determine the priorities for 19/20.

Importance Criteria

<table>
<thead>
<tr>
<th>Area of importance</th>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Direction</td>
<td>Does it deliver a national priority, a GM priority (set out in the Mayor’s Manifesto), or a GM HSC priority (including population health outcomes)?</td>
<td>1: National and GM and GM HSC</td>
<td>2: National and GM or GM HSC</td>
<td>3: National or GM or GM HSC or none</td>
</tr>
<tr>
<td>Operational Imperative</td>
<td>Is this initiative driven by any known / anticipated changes which might impact service demand or provision in this area? (e.g. structural changes, workforce changes, political changes, regulatory changes, policy drivers, new providers/market entrants, etc)?</td>
<td>1: Significant, imminent changes known to be driving shifts</td>
<td>2: Changes are coming which would require change to be implemented within medium term</td>
<td>3: No known changes that might impact service demand or provision existing</td>
</tr>
<tr>
<td>Cost benefits</td>
<td>How much will be saved per year once it is fully operational? This includes savings (i.e. the actual amount that budgets can be reduced by).</td>
<td>1: Greater than £1 million</td>
<td>2: Between £500,000 and £1 million</td>
<td>3: Under £500,000</td>
</tr>
<tr>
<td>Return on investment (excluding non-financial benefits)</td>
<td>Timeframe important in delivering a return recognising the GM imperative</td>
<td>1: Yes, return on investment has been fully described</td>
<td>2: Return on investment is likely, but has not yet been developed</td>
<td>3: No return on investment</td>
</tr>
<tr>
<td>Dependencies</td>
<td>Is the work a dependency for other programmes?</td>
<td>1: Yes</td>
<td>2: Yes</td>
<td>3: No</td>
</tr>
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</table>

Feasibility Criteria

<table>
<thead>
<tr>
<th>Area of feasibility</th>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well evidenced</td>
<td>The proposal must have supporting evidence that it can deliver change</td>
<td>1: Project has evidence base and has been successfully implemented elsewhere</td>
<td>2: Project has evidence base and has been implemented successfully</td>
<td>3: Project does not have an evidence base and has not been implemented successfully</td>
</tr>
<tr>
<td>Workforce</td>
<td>To what extent could an existing workforce be utilised vs. there being a need for a new workforce to be recruited and trained / an existing workforce be re-trained?</td>
<td>1: No workforce would need to be recruited and trained, existing workforce could be re-trained and utilised</td>
<td>2: New workforce will need to be recruited and trained, existing workforce is not sufficient</td>
<td>3: New workforce would need to be recruited and trained, existing workforce is not sufficient</td>
</tr>
<tr>
<td>Availability of resources</td>
<td>All resources required have been identified (including funding), approved in principle and are available within short timeframe (up to 4 weeks)</td>
<td>1: All resources required have been identified (including funding), approved in principle and are available within short timeframe (up to 4 weeks)</td>
<td>2: Project has some resources identified, approved in principle and available within short timeframe (1 to 6 months)</td>
<td>3: Project does not have resources identified, approved, and available within specified timeframe</td>
</tr>
<tr>
<td>Implementable</td>
<td>Proposals need a plausible rationale that they can be delivered</td>
<td>1: Proposal has a plausible rationale that it can be delivered within 18/19</td>
<td>2: Proposal has a plausible rationale that it can be delivered within 20/21 timeframe</td>
<td>3: Proposal does not have a plausible rationale that it can be delivered within 20/21 timeframe</td>
</tr>
<tr>
<td>Stakeholder engagement</td>
<td>Providers, commissioners, public &amp; broader stakeholders</td>
<td>1: Project developed with 3 to 4 of the groups described</td>
<td>2: Project developed with 1 to 2 of the groups described</td>
<td>3: Project developed with no engagement with any of the groups described</td>
</tr>
</tbody>
</table>

The intention is that the programme teams will provide responses on a single page, under each prioritisation criteria for their projects, which would be assessed by the task and finish group. Projects prioritised for next stage development would then have an outline business case developed to be considered by the task and finish group before presentation to TFOG.
Appendix 4: GM Taking Charge Business Plan 2018/2019

3.0 Measuring the delivery of the Portfolio

As part of the Portfolio definition piece, work has been underway to establish a process to measure progress and effectiveness of delivery at locality and GM programme level for 2018/19

For the Quarter 2 locality assurance meetings, there was a clear focus on transformation, which will continue for future assurance meetings. However, there is now a need to take a much more rigorous approach to assuring transformational delivery, given scrutiny now being placed on the outcomes of Transformation Fund investment.

To enable the GMHSP to demonstrate the impact of investments during 2017/18, localities were asked during February and March to:

- Complete an audit declaration that TF monies have been invested in line with the initial intended spending plan
- Confirm that material conditions have been met
- Confirm that initial milestones outlined in the investment agreement have been met, and if not, that remedial plans in place
- Explain any differences in actual activity vs the plan in the Investment agreement
- Highlight areas of good practice in demand management that can be shared with other localities.

The new highlight report template to be introduced from April 18 will assure at sub programme level as well as programme level to ensure that specific interventions which will impact on benefits are on track, and to capture the above assurance on a bi-monthly basis.

The quarterly maturity status of the Portfolio will be reviewed on a monthly basis.

3.1 Balanced scorecard to assure delivery

The Greater Manchester dashboard has been developed to include a series of indicators relating to:

- Population health
- Process inputs
- Process outputs
- User/ staff satisfaction

There are approximately 70 metrics, which have been selected, as they as available to capture and indicate direction of travel of the benefits intended to be realised. As programmes mature, we will look to capture metrics which are more meaningful to our population. The majority of the outcomes relating to population health are only collated on a quarterly or annual basis. These metrics will be presented to Performance and Delivery (P&D) as they become available, to support measurement of the impact of transformation.

The monthly metrics reviewed by the Performance and Delivery Board currently include CCG IAF and constitutional standards, and indicative measures of transformation including:
Appendix 4: GM Taking Charge Business Plan 2018/2019

- Activity vs investment agreement plan for OP, EL, DC, A&E and NEL at locality level
- Bed days per 1000 population
- LOS data

It is recognised that these indicators are not a true representation of transformation, however will be included as a proxy for transformation, whilst the 12-15 key benefits metrics are developed. These metrics will be identified from information collected at a GM level through the programme scorecards, which when aggregated together at locality level will give an indicator of the pace and impact of transformation.

We are currently undertaking a piece of work to ensure alignment with the quantitative evaluation, currently being undertaken by the University of Manchester. We will continue to ensure that these pieces of work align, alongside the qualitative evaluation which will be undertaken. We are also working with other STP areas to learn from summary benefits metrics developed elsewhere.

The process for assuring system level and transformation metrics is outlined below: 

**System Management Assurance processes**
Appendix 4: GM Taking Charge Business Plan 2018/2019

Measuring the impact of transformation across the system

3.2 Assurance escalation process

In order to ensure that as we move into 18/19, the whole system is clear of how delivery against Investment Agreements will monitored, a formal assurance escalation process has been approved by SPBE, which is outlined overleaf.

This is required to ensure that all programmes who have received transformation monies have a consistent and formal process of escalation, should a programme fall off track in meeting the requirements of the investment agreement which includes:

- How has the money has been spent (timeliness, in the right areas)?
- Have / will the milestones be achieved (timeliness, completion)?
- Have the material conditions been met?
- Has activity (including IA metrics) moved in line with plans?

The escalation process describes the incremental steps to be undertaken, where one or more of these factors are not in line with the investment agreement. It should be noted that halting funding would be a final stage process which we would not wish to instigate.
This will be implemented with effect from April 2018, to assure the GM HSCP Chief Officer accountabilities relating to assurance can be effectively discharged.

### 4.0 Aligning operational plans and investment agreement intent

Alongside this approach to ensure that GM programmes have a route to implementation, there is a requirement to ensure that for the start of 2018/19, the Partnership is in a position to effectively regulate all programmes of change at locality level as well as GM level. The Transformation Portfolio Board recommended that:

- Operating plans should be fully aligned with investment agreements and contracts.
- An agreed method of capturing new models of care needs to be put in place, with a particular focus on ambulatory care.

Gearing up for the planning round, each locality was asked to consider the alignment between operating plans for 18/19 and Investment Agreements, and to consider if any ambitions within existing plans need review, in order to enable the agreement of a single locality plan as we go into the new financial year and beyond. GM guidance has been given that the locality investment agreements (IAs) must be the primary focus and driver of the operational plans and associated contracts.
GM is a strong position with regard to contracts successfully negotiated by the 23rd March. The Partnership Team has stated that it will not be in a position to sign off any operational plans on 30th April, unless there is universal agreement that they are aligned with existing investment agreements and signed contracts, or that any variation is clearly understood.

To support the operational plan sign off process, the Partnership Team has now met with all ten localities to discuss the operating plan submissions, and the alignment with the Investment Agreement. This process has identified a number of areas where there is misalignment for 2018/19 for a variety of reasons e.g. coding, implementation delays, data sources, etc. The Partnership Team is working closely with localities to strengthen and consolidate the information gathered from each of the technical pre-meets, which will then be used as the basis for the executive to executive meetings which will take place during April.

GM is planning to be more ambitious than the North, and particularly England with respect to lower levels of non-elective activity, and the level of growth anticipated by the planning guidance. Further complicating this, there is a gap between what the first cut of the plans are proposing, and the agreed metrics in the investment agreement. These areas have been the focus of discussions within locality meetings to ensure that ambition remains, but that appropriate levels of activity are commissioned taking into account current demand patterns.

A locality level risk assessment has been undertaken to determine the level of focus and support needed in the first quarter of 18/19 to support the delivery of our 5 year ambition.

Due to variability in the number of benefit metrics included within locality Investment Agreements, we are looking to standardise the measurement of transformation into a 12-15 key indicator set. Over the next 3 months, we will be asking localities to participate in the development and baselining of the key indicators to be regulated through the Performance and Delivery Board.

Based on the reassessment of ambition of locality plans given currently the current delivery phase and impact, a dedicated TFOG meeting will be convened in July to understand the consequential impact of the realignment exercise.

It was agreed via the Directors of Operations a methodology of capture new models of ambulatory care, however we are still awaiting some data from providers to complete this piece of work. The outputs from this work will provide a greater level of insight into transformed pathways of care.

5.0 Key strategic risks

The risk management approach has been further refined through 17/18. The GM HSCP risk register is now built from the GMHSCP team risk register (including all the GM transformation programme risks), and the 10 locality risk registers. Risks associated with delegated functions were previously been escalated to NHSE, and transformation risks escalated to SPBE, which did not allow SPBE to view the whole picture of risk for the partnership. The partnership agreed to a combined function to ensure that both NHSE and SPBE have the full view of all GM system wide risks in line with the approach below.
Each of the sub-governance groups are considering the risks in the register that relate to their remit. Challenges are managed by ensuring that the consideration of the issues by SPBE is by exception and are escalated by the sub-governance groups.

5.1 The Board assurance framework (BAF)

Risks are profiled on a quarterly basis, with an assessment being undertaken by the lead Executive / Director within the Partnership Team to populate the overall Board Assurance Framework for a quarterly view by SMT / SPBE. The GM HSCP Executive / Director leads have been assigned as owners to each category in the first instance, with all risks in the register being aligned to the 12 categories below:

- System design / new models of care (16 risks).
- Political (2 risks).
- Stakeholder relations (7 risks).
- Governance and accountability (9 risks).
- Public engagement (2 risks).
- Workforce (18 risks).
- Technology (6 risks).
- Environmental and Estates (3 risks).
- Quality and safety (21 risks).
- Finance (16 risks).
Appendix 4: GM Taking Charge Business Plan 2018/2019

- Operational performance (15 risks).
- Catastrophic events -force majeure (1 risk).

The risk categories reflect the key strategic risks for the partnership, and are the strategic areas that if managed correctly, will support the achievement of our strategic objectives set out in Taking Charge. These categories were supported by SPBE in October 2017.

The most recent BAF identifies the 4 top risk categories highlighted above, these are:

- Quality and Safety – 21 risks
- Workforce – 18 risks
- New Models of Care / System Re-design – 16 risks
- Finance – 16 risks

The key strategic risks facing the transformation programme include:

- Locality plans do not deliver activity shifts and financial shifts as intended. The process for aligning activity plans and investment agreement ambition has already been described.

- GM programmes do not deliver quickly enough to release intended benefits: Clear descriptions of projects already in implementation for 18/19 have been provided to the system. A dedicated focus will continue on determining the possibility of implementation for those projects to be considered for acceleration into 18/19, though it should be recognised that the programmes being considered for acceleration will not deliver significant financial savings. Cancer projects form a significant part of this cohort, along with elective care and urgent and emergency care, which will support system resilience.

- There is a need for an urgent conversation with regard to the prioritisation of GM standards, to support the consistency of LCO offers, taking into account current outcomes and financial positions within each locality.

- GM and locality programmes do not connect effectively to deliver collective benefits relating to quality, experience and outcomes: Alongside the alignment of activity plans, work will be completed to describe the contribution of GM and locality programmes to deliver constitutional and outcome targets.

- How we rapidly progress programmes that have had a strategy agreed, but do not have a fully funded route to implementation identified. The creation of the proposed task and finish group will ensure that the outcomes of this exercise are fully owned by the system, and there is agreement with regard to how GM programmes / standards will be funded.

- Ensuring robust measurement systems are in place to assure transformation
Appendix 4: GM Taking Charge Business Plan 2018/2019

delivery. Whilst the Portfolio definition piece is being completed, work will also continue to manage interdependencies and strengthen methods of assurance to measure delivery in line with Taking Charge ambitions.

Kath Wynne-Jones
Portfolio Director
11th April 2018
<table>
<thead>
<tr>
<th>GM CCG</th>
<th>FOT 17/18</th>
<th>Op Plan 18/19</th>
<th>Growth for 18/19</th>
<th>National Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GM Total</strong></td>
<td>FOT 17/18</td>
<td>Op Plan 18/19</td>
<td>Growth for 18/19</td>
<td>National Assumptions</td>
</tr>
<tr>
<td>Total Admissions (General and Acute)</td>
<td>1,149,694</td>
<td>1,161,745</td>
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<td>2.3%</td>
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<tr>
<td>Total Admissions (General and Acute)</td>
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<tr>
<td>Total Other Admissions (General and Acute)</td>
<td>472,090</td>
<td>477,752</td>
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<tr>
<td>Consultant Led First Outpatient Attendances</td>
<td>906,412</td>
<td>1,011,031</td>
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<td>Consultant Led Follow-Up Outpatient Attendances</td>
<td>1,998,809</td>
<td>1,305,166</td>
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<td>4.3%</td>
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<td>Total Elective Admissions</td>
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<td>399,619</td>
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<td>3.6%</td>
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<tr>
<td>Total Elective Admissions - Day Cases</td>
<td>335,321</td>
<td>342,042</td>
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<tr>
<td>Total Elective Admissions - Ordinary</td>
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<td>57,577</td>
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<tr>
<td>Total Non-Elective Admissions - 0 LoS</td>
<td>352,970</td>
<td>356,974</td>
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<td>Total Non-Elective Admissions - 1 LoS</td>
<td>123,531</td>
<td>127,298</td>
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<td>Total Non-Elective Admissions - &gt; 1 LoS</td>
<td>229,439</td>
<td>229,676</td>
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<tr>
<td>Total A&amp;E Attendances excluding Planned Follow Ups</td>
<td>1,201,745</td>
<td>1,204,621</td>
<td>0.2%</td>
<td>1.3%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Bolton CCG</th>
<th>FOT 17/18</th>
<th>Op Plan 18/19</th>
<th>Growth for 18/19</th>
<th>National Assumptions</th>
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</thead>
<tbody>
<tr>
<td>Total Referrals (General and Acute)</td>
<td>110,426</td>
<td>110,378</td>
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<tr>
<td>Total GP Referrals (General and Acute)</td>
<td>67,499</td>
<td>67,746</td>
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<tr>
<td>Total Other Referrals (General and Acute)</td>
<td>42,927</td>
<td>42,632</td>
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<tr>
<td>Consultant Led First Outpatient Attendances</td>
<td>127,257</td>
<td>177,802</td>
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</tr>
<tr>
<td>Consultant Led Follow-Up Outpatient Attendances</td>
<td>37,573</td>
<td>37,573</td>
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</tr>
<tr>
<td>Total Elective Admissions</td>
<td>6,947</td>
<td>6,047</td>
<td>0.0%</td>
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<tr>
<td>Total Elective Admissions - Day Cases</td>
<td>6,947</td>
<td>6,047</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions - Ordinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 0 LoS</td>
<td>31,661</td>
<td>32,051</td>
<td>1.1%</td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 1 LoS</td>
<td>9,802</td>
<td>8,995</td>
<td>1.1%</td>
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</tr>
<tr>
<td>Total Non-Elective Admissions - &gt; 1 LoS</td>
<td>109,839</td>
<td>111,202</td>
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<tr>
<td>Total A&amp;E Attendances excluding Planned Follow Ups</td>
<td>76,255</td>
<td>96,508</td>
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<table>
<thead>
<tr>
<th>Bury CCG</th>
<th>FOT 17/18</th>
<th>Op Plan 18/19</th>
<th>Growth for 18/19</th>
<th>National Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Referrals (General and Acute)</td>
<td>83,824</td>
<td>87,017</td>
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<tr>
<td>Total GP Referrals (General and Acute)</td>
<td>50,774</td>
<td>52,129</td>
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<tr>
<td>Total Other Referrals (General and Acute)</td>
<td>31,050</td>
<td>34,858</td>
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</tr>
<tr>
<td>Consultant Led First Outpatient Attendances</td>
<td>62,354</td>
<td>63,873</td>
<td>2.4%</td>
<td></td>
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<tr>
<td>Consultant Led Follow-Up Outpatient Attendances</td>
<td>100,108</td>
<td>100,641</td>
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</tr>
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<td>Total Elective Admissions</td>
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<td>28,913</td>
<td>2.1%</td>
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</tr>
<tr>
<td>Total Elective Admissions - Day Cases</td>
<td>23,755</td>
<td>28,913</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions - Ordinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 0 LoS</td>
<td>7,920</td>
<td>8,217</td>
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<tr>
<td>Total Non-Elective Admissions - 1 LoS</td>
<td>13,791</td>
<td>13,853</td>
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<td>25,775</td>
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<td>Total A&amp;E Attendances excluding Planned Follow Ups</td>
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<td>72,336</td>
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<table>
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<tr>
<th>HMR CCG</th>
<th>FOT 17/18</th>
<th>Op Plan 18/19</th>
<th>Growth for 18/19</th>
<th>National Assumptions</th>
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</thead>
<tbody>
<tr>
<td>Total Referrals (General and Acute)</td>
<td>95,921</td>
<td>97,074</td>
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<td>Total GP Referrals (General and Acute)</td>
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<td>55,741</td>
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<tr>
<td>Total Other Referrals (General and Acute)</td>
<td>40,623</td>
<td>41,313</td>
<td>1.7%</td>
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<tr>
<td>Consultant Led First Outpatient Attendances</td>
<td>101,208</td>
<td>104,110</td>
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<td>Consultant Led Follow-Up Outpatient Attendances</td>
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<td>21,162</td>
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<td>8,217</td>
<td>4.0%</td>
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</tr>
<tr>
<td>Total Elective Admissions - Ordinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 0 LoS</td>
<td>10,466</td>
<td>10,382</td>
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<td>Total Non-Elective Admissions - 1 LoS</td>
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<td>19,636</td>
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<td>Total Non-Elective Admissions - &gt; 1 LoS</td>
<td>30,375</td>
<td>30,518</td>
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<td>Total A&amp;E Attendances excluding Planned Follow Ups</td>
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<td>102,314</td>
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<table>
<thead>
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<th>Manchester CCG</th>
<th>FOT 17/18</th>
<th>Op Plan 18/19</th>
<th>Growth for 18/19</th>
<th>National Assumptions</th>
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</thead>
<tbody>
<tr>
<td>Total Referrals (General and Acute)</td>
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<td>218,221</td>
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<tr>
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<td>Consultant Led First Outpatient Attendances</td>
<td>258,015</td>
<td>170,732</td>
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<td>Consultant Led Follow-Up Outpatient Attendances</td>
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<td>399,540</td>
<td>-1.6%</td>
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</tr>
<tr>
<td>Total Elective Admissions</td>
<td>55,166</td>
<td>61,129</td>
<td>4.9%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions - Day Cases</td>
<td>55,166</td>
<td>61,129</td>
<td>4.9%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions - Ordinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 0 LoS</td>
<td>10,407</td>
<td>10,937</td>
<td>5.0%</td>
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<td>70,104</td>
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<td>28,026</td>
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<td>42,138</td>
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<table>
<thead>
<tr>
<th>Oldham CCG</th>
<th>FOT 17/18</th>
<th>Op Plan 18/19</th>
<th>Growth for 18/19</th>
<th>National Assumptions</th>
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<tbody>
<tr>
<td>Total Referrals (General and Acute)</td>
<td>19,212</td>
<td>20,931</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Total GP Referrals (General and Acute)</td>
<td>48,933</td>
<td>49,192</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Total Other Referrals (General and Acute)</td>
<td>44,839</td>
<td>44,109</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>Consultant Led First Outpatient Attendances</td>
<td>106,823</td>
<td>114,580</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>Consultant Led Follow-Up Outpatient Attendances</td>
<td>271,870</td>
<td>180,398</td>
<td>-3.5%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions</td>
<td>28,550</td>
<td>27,788</td>
<td>-4.3%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions - Day Cases</td>
<td>21,833</td>
<td>24,842</td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>Total Elective Admissions - Ordinary</td>
<td>4,717</td>
<td>4,015</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 0 LoS</td>
<td>32,096</td>
<td>31,979</td>
<td>2.8%</td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - 1 LoS</td>
<td>11,410</td>
<td>11,909</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Total Non-Elective Admissions - &gt; 1 LoS</td>
<td>20,686</td>
<td>21,070</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>Total A&amp;E Attendances excluding Planned Follow Ups</td>
<td>100,050</td>
<td>102,308</td>
<td>2.2%</td>
<td></td>
</tr>
</tbody>
</table>
Connecting assurance and benefits realisation
As the GM HSCP moves through planning to implementation of Taking Charge, there are a range of additional areas (the green bubbles) that we are working with the system and seeking assurance / alignment on, that are not fully connected to the locality assurance process, meaning we are having multiple discussions with localities.
Purpose of a single assessment process

Functionality:

• Demonstrate progress at the place (GM and locality) level on the delivery of key plans, milestones and benefits through the lenses of Quality, Finance, Systems Performance, Population outcomes and health inequalities, transformational change and leadership.
• Align national assurance requirements of NHS England, NHS Improvement and potentially CQC.
• Enable and facilitate learning through the sharing of good practice and lessons learnt and identify opportunities for system wide mandated roll-out
• Identify key system challenges, issues and risks for resolution
• Align intelligence held across the GMHSCP team (inc. NHSI) and enable the Partnership to see / visualise the operation and performance (or health) of our system in one place.
• Define the GM HSC P response to key system issues / challenges and risks, as well as good practice.
• Convert our locality and system level data into system level intelligence to support our decision-making.
• Align all the processes that we are currently doing or are emerging relating to assurance, such as programme deep dives, LCO maturity framework, TF monitoring, locality roll ups, the implementation of the commissioning review. The Benefits Realisation Group
• Determine GM HSCP team approach and content of locality quality assurance meetings
• Accompanied by a self-assessment process within localities.
• To be implemented for Q2 assurance meetings
A proposal for aligning GM assurance and the benefits realisation processes

- Coordinated by the Assurance and Delivery team through the GM HSCP team Benefits Realisation Group (yet to be established)
- Matrix to be populated ¼ for each locality using key sources of data across the range of partnership functionalities and assurance lenses (to include NHS I) using pre-agreed sources of data.
- Localities could (if they choose) undertake a self-assessment in the same timescales
- Each locality would be placed on the matrix based on their level of progress and delivery (using Partnership team data and via a locality self-assessment) to inform a judgement on the level and type of ¼ discussion that was required.
  - All localities will need a quarterly discussion as a minimum relating to Transformation Fund, and the framework could help determine on a consistent basis the rationale for any further discussion
  - Qtrs 1 and 3: exception; qtrs 2 and 4: all have a qtrly meeting
  - The discussion may not require Exec-Exec level discussion, but could be senior leadership team representatives

The matrix would correspond to a Support Framework (aligned to the Quality Improvement Framework) that would identify the type of support if any a locality needed or could provide to others.
Utilising the Benefits Realisation Framework within the Partnership Team

Creating a dashboard which is the single version of the truth, will demonstrate the delivery of GM objectives at an aggregate and place based level.

The dashboard will be used to create a single narrative for localities, for use by the Partnership Team and localities themselves to link into existing assurance processes.

Where possible, we are trying to align internal partnership governance and requests, to ensure a joined up cohesive approach with localities

Potential teams to be formed around localities to support Executive Director leads
How the process would work in practice....

Soft intelligence

Dashboard

Benefits Realisation Group (1/12)

recommendations

Intell / asks

GM HSCP (t)

SMT (1/12)

Locality quarterly meeting schedule
Q1 and Q3:
- TF monitoring
- Exception
Q2 and Q4:
- TF monitoring
- All

Greater Manchester Health and Social Care Partnership
Benefits Realisation Group – Inputs and outputs

Transformation Portfolio Board
Performance and Delivery Board
SMT
Programme Directors Forum

Benefits Realisation Group

GM benefits dashboards
GM HSCP soft intelligence

LCO development framework
TF monitoring
Locality assurance (CCG IAF)
STP dashboard
Theme dashboards – ASC, MH, Primary Care

Greater Manchester Health and Social Care Partnership