Public Document

GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

DATE: **Wednesday, 13 November, 2019**
TIME: **10.00 am**
VENUE: **GMCA Boardroom, Churchgate House, 56 Oxford Street, Manchester, M1 6EU**

1. APOLOGIES

2. CHAIRS ANNOUNCEMENTS AND URGENT BUSINESS

3. MINUTES 1 - 10

To consider the approval of the minutes of the meeting held on 11 September 2019

4. IMPROVING SPECIALIST CARE PROGRAMME UPDATE 11 - 42

Report of Anthony Hassall, Accountable Officer, NHS Salford CCG and Commissioning Lead for the Improving Specialist Care Programme and Andrew Walmsley, Transport Strategy Senior Analyst, Transport for Greater Manchester (TfGM)

5. GM DELIVERY PLAN 2020-24, GREATER MANCHESTER'S IMPLEMENTATION GUIDE FOR THE PROSPECTUS (2019) AND RESPONSE TO THE NHS LONG TERM PLAN 43 - 60

Report of Warren Heppolette, Executive Lead, Strategy and System Development, Greater Manchester Health and Social Care Partnership

6. WORK PROGRAMME 2019-20 61 - 62

Report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA

7. DATES OF FUTURE MEETINGS

Wednesday 15 January 2020
Wednesday 11 March 2020

All meetings will take place between 10.00am – 12 noon in the Boardroom at GMCA Offices, Churchgate House, Oxford Street, Manchester, M1 6EU

COMMITTEE MEMBERSHIP 2019/20 (FOR REFERENCE)

Member	Substitute Member	Authority
Councillor Linda Thomas	Councillor Mudasir Dean	Bolton
Councillor Stella Smith	Vacancy	Bury
Councillor Eve Holt	Councillor Julie Reid	Manchester
Councillor Eddie Moores	Councillor Colin McLaren	Oldham
Councillor Ray Dutton	Councillor Patricia Sullivan	Rochdale
Councillor Margaret Morris	Councillor Samantha Bellamy	Salford
Councillor Keith Holloway	Councillor Wendy Wild	Stockport
Councillor Stephen Homer	Councillor Teresa Smith	Tameside
Councillor Sophie Taylor	Councillor Anne Duffield	Trafford
Councillor John O'Brien	Councillor Ron Conway	Wigan

For copies of papers and further information on this meeting please refer to the website www.greatermanchester-ca.gov.uk. Alternatively contact the following Governance and Scrutiny Officer: ✉ Lindsay Dunn, Lindsay.dunn@greatermanchester-ca.gov.uk
☎ 0161 778 7009

This agenda was issued on Tuesday 5 November 2019 on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority, Churchgate House, 56 Oxford Street, Manchester, M1 6EU

MINUTES OF THE MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY MEETING HELD ON WEDNESDAY, 11 SEPTEMBER, 2019 AT BOARDROOM, GMCA OFFICES, CHURCHGATE HOUSE, OXFORD STREET, MANCHESTER M1 6EU

PRESENT:

Councillor John O'Brien (in the Chair)	Wigan Council
Councillor Keith Holloway	Stockport MBC
Councillor Eve Holt	Manchester City Council
Councillor Eddie Moores	Oldham Council
Councillor Margaret Morris	Salford City Council

OFFICERS IN ATTENDANCE:

Lindsay Dunn	GMCA
Lisa Fathers	Director of Teaching School & Partnerships, Bright Futures Educational Trust (BFET) Executive Team
Michael Forrest	Deputy Chief Executive, North West Ambulance Service (NWAS)
Warren Heppolette	Executive Lead, Strategy and System Development, Greater Manchester Health and Social Care Partnership (GMHSCP)
Joanne Heron	GMCA
Dr Sandeep Ranote	Medical Director, Northwest Boroughs Healthcare NHSFT & Children & Young People MH Lead, GMHSCP
Lee Teasdale	GMCA

APOLOGIES: Councillor Stella Smith (Bury Council)

JHSC/25/19 DECLARATIONS OF INTEREST

Councillor Holloway declared that his daughter was an employee of the Oldham Clinical Commissioning Group.

JHSC/26/19 MINUTES OF THE MEETING HELD ON 10 JULY 2019

Members were asked to consider the approval of the minutes of the last meeting held on 10 July 2019.

Resolved/-

That the minutes of the last meeting held on 10 July 2019 be approved as a correct record.

JHSC/27/19 GREATER MANCHESTER MENTAL HEALTH IN EDUCATION (MHIE) PROGRAMME

The Committee considered a report from Warren Heppolette (Executive Lead, Strategy & System Development, GMHSCP); Dr Sandeep Ranote (Medical Director, Northwest Boroughs Healthcare NHSFT & Children & Young People Mental Health Lead, GMHSCP) and Lisa Fathers (Director of Teaching School & Partnerships, BFET Executive Team), which provided an overview of the Mental Health in Education programme (MHiE) being delivered across Greater Manchester and provided details on each of the initiatives. The report also explored the scope of the future ambitions for the MHiE programme both locally and nationally and the governance structure by which the programme would be managed.

Warren Heppolette advised Members that in December 2017 the government had published the green paper 'Transforming Children and Young People's Mental Health Provision'. The paper had set out the ambition to go further in ensuring that children and young people showing early signs of distress were always able to access the right help in the right setting, when they needed it. As part of the next steps in the reforms the government had agreed to support the following three key elements:

- Mental Health Support Teams
- Four-week waiting times for access to specialist NHS children and young people's mental health services
- Designated senior leads for mental health

In addition to these, Greater Manchester (GM) had been working to deliver local projects designed to test the potential implementation model for the priorities within the green paper. These GM initiatives included:

- GM Mentally Healthy Schools and Colleges Pilot
- GM Mental Health in FE Colleges Project
- GM Universities MH Service Pilot
- GM Mental Health in Education Setting Standards

Dr Sandeep Ranote advised Members that the green paper had been informed in part by the 2015 paper 'Future in Mind'. This paper had brought together children and educational mental health experts from across the country to consider child psychiatric care and set an ambitious agenda for protecting and improving children and young people's mental health and wellbeing. It was emphasised that the programme was not just about putting money into services but also about ensuring parity in the support offer across all of GM and removing the stigma that was sometimes involved in seeking mental health support. Dr Ranote stated that the level of passion from all partners to make the programme a success was hugely positive – with the programme having allowed for joint working and collaboration on a level that had not been available previously.

Information around the development of mental health support teams was provided. Education Mental Health Practitioners (EMHPs) were linked to groups of schools and colleges, and would offer individual and group help to young people with mild to moderate mental health issues including anxiety; low moods and behavioural difficulties. The support teams would work with the school or college designated mental health lead to provide a link with more specialist mental health services. This would mean schools and colleges finding it much

easier to contact and work with mental health services. These teams would provide the link between the NHS and schools, and would work alongside others providing mental health support such as school nurses; educational psychologists; school counsellors; voluntary & community organisations and social workers.

It was emphasised that the support teams would be newly trained and would not take away from the existing specialist Child and Adolescent Mental Health Services (CAMHS) provision as this was about delivering a programme that supported and added to, rather than taking away from the existing structure.

Lisa Fathers spoke to the Committee from the perspective of Bright Futures Educational Trust (BFET). She advised that a positive side effect of the programme had been that it had also so far proved to have improve the wellbeing of the teachers involved as well as the students. Schools were being helped in a strategic way on how best to embed the ethos behind the programme. An example of this good practice had been in Gorton, where children knew exactly where they needed to turn to access first aid support and mental health support. 42nd Street as the Voluntary, Community and Social Enterprise (VCSE) lead had been very helpful, working hard to increase the number of mental health practitioners. Overall there was a strong package in place, with each individual school working in tandem with others across the piece. Young Mental Health Ambassadors had also been a great help in spreading knowledge around the work being done.

Dr Ranote advised that the Mentally Healthy Schools and Colleges Project was now about to move into Phase 4. At the conclusion of the project, it would have reached 125 schools and colleges, this equated to 10% of the 1200 schools and colleges across GM – whilst it was agreed that on paper this may not seem an impressive figure, in actuality it was considerably above the national average in its level of reach. The unfortunate reality was that there was not the funding or level of resource in place to directly reach all 1200 locations. The Project had helped the partners involved to develop a set of education setting standards that would act as the framework for schools and colleges across GM going forward.

It was noted that good work was taking place at local authority level as well, with Salford developing a strong programme for example. However, there was cognisance of the need to avoid 'postcode lotteries' and that all schools within GM should receive the same high level of support.

Committee Member Comments and Questions

Members expressed concerns about the number of children having to go straight from CAMHS into Adults mental health services – with many being 'failed by the system and falling through the gaps'. With this in mind, what level of work was taking place with mental health practitioners within schools and colleges?

It was advised that it was recommended to all schools and colleges that they sent their Special Education Needs Co-ordinators (SENCOs) on the training programme. Close work was also taking place with secondary education colleges as these often included cohorts that had behavioural and educational issues in their youth and had a differing set of needs from the mainstream with many having previously already had CAMHS support for mental health issues.

Members noted their concerns around only 125 of GM's 1200 schools and colleges being directly involved in the Mentally Health Schools and Colleges Project. How could local councillors help in getting the messages about the good work being done over to the remaining 90% of schools and colleges within GM? Members also asked about the process by which the 125 locations had been selected.

It was advised that following the conclusion of phase 3 of the project, officers were in a stronger position to review the governance aspects. A dedicated programme board needed to be formed to look at this, and it was suggested that a member of the Joint Health Scrutiny Committee could form part of the membership of this programme board. Further details about the programme board including the terms of reference would be provided to Members for further consideration. Any Members wishing to be nominated were asked to contact GMCA officers.

Regarding the 125 locations chosen - Phase 1 had involved a rapid 10 day turnaround with the initial cohort of schools being chosen very quickly but with an appropriate geographical spread across all localities in GM. Phase 2 saw closer working with the locality leads to identify schools that were most in need of assistance at present. Constant re-evaluation work had been taking place, and lessons were being learnt. It was also noted that the selection process had been overseen and agreed at the highest level.

Members expressed concern about parents who were unwilling to engage with the process – what was being done to communicate the work to them?

It was explained that a key part of the work involved in the pilot was seeking to reduce the taboos and stigmas around mental health, if these common concerns could be broached and dealt with, then parents would be less likely to refuse help for their child. There however remained many challenging situations to broach – and it was therefore important that the work continued beyond the school setting, with the whole system carrying these important messages – through parent champions, parent teacher associations, school governors etc. The messages often had more power when delivered by fellow parents instead of health professionals, and helped in developing an organic increase in understanding and empathy.

Members welcomed this approach and asked that they be informed of the schools within their localities involved in the programme – so that they could be involved in meetings helping to spread the importance of the work being undertaken.

It was also advised that schools themselves could choose to prioritise the importance of the issue, by paying to send more staff on training and arm them with the skills needed to approach mental health issues. National and international learning collaborations were also being formed – for example, GM was sharing intelligence with schools in Staten Island, New York – which had a similar makeup of demographics and wealth disparities to those seen in GM.

The Chair re-emphasised the importance of local links, stating that each of GM's local health scrutiny panels should also be looking to feed this information down through their own committees and receiving presentations on the good work being done.

It was commented that mental health issues often stopped many children from achieving at the level they should at school, and that if children could be made more resilient at the right age, then they would likely be more resilient as adults.

Officers agreed, stating the importance of pathway succession. The programme was one of a number of transformation programmes taking place in children's mental health and none of them worked in isolation, with 'the dots being joined' across schools; youth services; GPs; youth centres and other relevant partners. It was not expected at the present time that this work would lead to reductions in referrals to CAHMS, but instead it should see an increase in children being referred at the right time in the right setting. It was hoped that eventually, with good embedded working across the piece, that reductions in referrals would be seen, but this would inevitably take time.

Members sought more information on addressing the stigmas around mental health. Was fear and a lack of understanding at the root of the concerns? Was this lack of understanding being addressed in order to remove the element of fear?

Officers emphasised the importance of embedding the appropriate language and making services fully accessible. There was a need to influence the harder to reach parents who might not interact with the schools, like attending parent's evenings for example – there was often a need to go out to them. Sometimes these parents had been through bad educational experiences in their youth and could be distrusting initially – with trust having to be carefully built up over time.

Dr Ranote felt that the NHS needed to use its media partners in a more positive proactive way. It was found that often communications from the NHS were only being used to address negatives – and there was a need to look at a more proactive strategy, where the media could be used to help spread positive messages.

The Chair noted that the Greater Manchester Mental Health Network was due to hold a Greater Manchester Mental Health Strategy Review at the British Muslim Heritage Centre on 30 September and asked that all the relevant details be forwarded on to the Committee Members.

Lisa Fathers advised that she could arrange a mental health workshop for members and that this could be arranged outside of the meeting.

Resolved/-

- That the progress made to date across a number of key education settings be noted by the Committee.
- That the proposals put forward be endorsed by the Committee.
- That details of the 125 schools and colleges involved in the GM Mentally Healthy Schools and Colleges Project be fed back to Committee Members.
- That details on the arrangements for the Greater Manchester Mental Health Strategy Review due to take place on 30 September 2019 be fed back to Committee Members.
- That officers be asked to confer further with Bright Futures Educational Trust around arrangements for a mental health workshop.
- That further details on the proposed dedicated governance board, including any terms of reference be fed back to Committee Members for consideration.

JHSC/28/19 NORTH WEST AMBULANCE SERVICE (NWAS) PERFORMANCE ACROSS GREATER MANCHESTER (GM)

The Committee considered a presentation from Michael Forrest on the performance of NWAS across Greater Manchester.

It was advised that following the development and implementation of a North West wide Performance Improvement Plan (PIP) in May 2018, the Trust had made significant improvements in performance throughout the 2018/19 operational year. Response performance had stabilised, leading to considerable improvements in patient safety and there was a commitment to achieving continued improvements – with 2019/20 having seen the devising of a Service Delivery Improvement Plan (SDIP) with the purpose of achieving and maintaining certain standards.

Across GM, the Trust had achieved some notable successes. During 2018/19 the Trust had conveyed over 15,500 fewer patients to emergency departments by both doubling its telephone triage capability, and increasing the number of patients managed on scene. This made a significant difference and allowed ambulances more freedom to deal with the most acute calls.

Timely access to response pathways of care was crucial to managing patients without the need for conveyance to emergency department. The NWAS referral pathway into the Wigan Community Response Team (CRT) had been developed in August 2018, with the main objective being to reduce conveyance to hospital for frail/elderly patients who could be supported within a community setting with additional support to best meet their individual need. The CRT was an existing service, however it was felt that if NWAS could access and utilise the multidisciplinary team and the wider range of services, then patient care would benefit. The Wigan CRT provided a strong example of how NWAS could work with providers across the wider health system, and it was intended that similar models of care would be pursued to ensure that patients avoided unnecessary conveyance when clinically appropriate to do so.

The level of demand for services was detailed to the Committee. Over 270,000 calls had been received but many of these were duplicate calls. For example, a significant traffic accident may result in 10+ calls to 999, and sometimes calls were made multiple times to check on the progress of an ambulance en-route. 10% of calls were now dealt with over the telephone, but this was only where appropriate and always with mindfulness of managed risk. 25% were now able to be dealt with on the scene. Good mechanisms were also in place which meant further growth could be absorbed without overburdening the department – the activity levels were continuing to increase so these appropriate mechanisms were increasingly important.

The Trust had developed a number of key strategies over the previous twelve months in order to support its ambition to be in the top three ambulance services by 2021, and to be the best in England by 2023. Urgent and Emergency Care and Quality Strategies would ensure that the right care was delivered at the right time, in the right place, every time. These were complimented by a number of key enabling strategies such as digital, workforce, fleet and estates.

It was also noted that the 111 Service contract was due for renewal in the next year. There was still some lack of understanding around what the 111 Service could do for people and this had helped to foster an undeserved poor reputation.

Warren Heppolette was invited to comment. He stated that systems working together to ensure the best level of integrated care was absolutely key. In the past the work of the NWAS would have been heard about in isolation, but that was not the case anymore, with services no longer being considered as a silo'd independent system, and instead being considered and understood within the context of the bigger picture of care models.

Committee Member Comments and Questions

Members agreed about the increasing importance and value of partnership working. When people did not have to face the trauma of entering a hospital setting and instead had an issue that could be managed on scene – it often added to the quality of life for that person.

Members asked, given the stressful and demanding nature of the job, how NWAS was coping when it came to levels of recruitment and retention.

It was advised that until recently paramedics had been on the staff shortage list, with a 14% gap. However, following a rigorous recruitment exercise – there was now a full establishment of paramedics in place. It was of course a job with challenges, it being noted that around 1300 assaults on NWAS staff were reported each year which was unacceptable – and it was found that the job had a higher than average turnover of staff. The staff could also often suffer burnout when working in the inner cities as there tended to be no breaks between call-outs. With that in mind, a transfer system had been implemented where paramedics could elect to spend some time working in a more town based/rural setting for a period, as taking care of the wellbeing of staff was vital

Reference was made to the installation of defibrillators in public spaces/businesses. It was important that these were registered so a record could be kept of their locations. The Chair recommended that members go back to their councils and work with other councillors/officers to establish the locations of defibrillators and help to build up a picture of all the locations.

Members suggested that a breakdown of the NWAS figures by district would be welcome to help them be in a position to ask the best related questions. It was advised that this information would be sourced for Members. It was advised that NWAS also made use of the 'Tableau' software system which could be signed up to for access to the catalogue of NWAS statistics.

Members expressed concern around the reliability of patient transport services, particularly in areas of low car ownership. It was advised that after being outsourced for some time, the transport patient service had now been brought back in-house, talks were taking place on how best to commission the service.

Members sought to see some of the NWAS sites on context, asking if a meeting could be held at the Parkway Centre on Princess Parkway, to look at the dispatch process in action, and also to pay a site visit to the new Wigan Fire and Ambulance Service hub. It was agreed that this

could be arranged and officers would take up the arrangement of suitable dates outside of the meeting.

The Chair drew the item towards a close – stating that three years previously he had been involved in a meeting where he had expressed serious reservations around repeated incidents of ambulance stacking, and was pleased to see that this service had been changing radically since then. He stated that statistics and data meant little to the patient at ground level – and all that mattered to them was their personal experience of being cared for appropriately and seeing a doctor or paramedic as soon as possible to assuage their fears. It was clear that NWAS had worked hard to achieve this, and examples of dealing with patients on site where appropriate so that they did not have to face the trauma of entering a hospital setting was a good example of this. The report was very welcome, and the results achieved were deserving of congratulation.

Michael Forrest thanked the Chair and the Members for their comments, stating that it was important that NWAS continued to receive an equal measure of support and challenge. He also advised that as part of looking to provide the best possible service to patients – 3000+ staff had now been trained in dementia awareness as NWAS sought a rollout of a dementia friendly ambulance service.

Resolved/-

- That the performance figures of North West Ambulance Service in GM and the opportunities to improve the service provided to Greater Manchester patients be noted by the Committee.
- That a breakdown of North West Ambulance Service figures by district be fed back to Committee Members.
- That arrangements be made for a site visit to, and meeting to be held, at the Parkway Centre.
- That arrangements be made for a site visit to the Wigan Fire and Ambulance Service Hub.

JHSC/29/19 WORK PROGRAMME

Consideration was given to the report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA.

The planned programme of work up to the March 2020 meeting was detailed to the Committee – the Statutory Scrutiny Officer asked that Members contact her if they would like to make any additions to the programme.

Resolved/-

That the work programme items be approved.

JHSC/30/19 DATES OF FUTURE MEETINGS

All meetings will take place between 10.00am – 12 noon in the Boardroom at GMCA Offices, Churchgate House, Oxford Street, Manchester, M1 6EU on the following dates:

- Wednesday 13 November 2019
- Wednesday 15 January 2020
- Wednesday 11 March 2020

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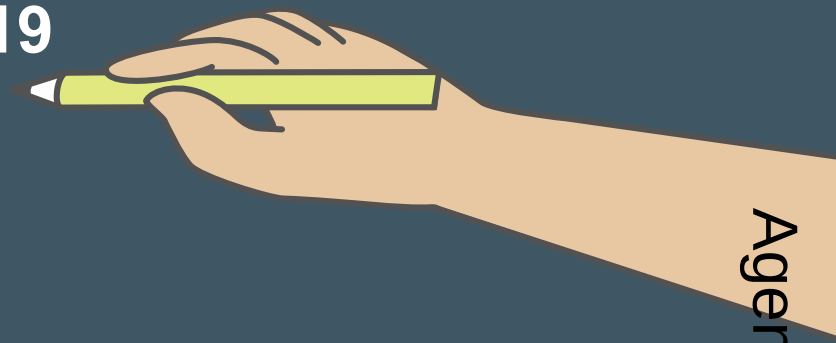
Greater Manchester Health and Social Care Partnership

IMPROVING SPECIALIST CARE PROGRAMME

UPDATE

GM JOINT HEALTH SCRUTINY COMMITTEE

13 NOVEMBER 2019



GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Anthony Hassall

ISC Commissioning Lead
Accountable Officer Salford CCG

Improving Specialist Care

PROPOSED SITE-SPECIFIC OPTIONS FOR DETAILED EVALUATION

Total of combined Options:	1	2	3	4
Breast 4 options	**South:** Wythenshawe **West:** RAE **East:** NMGH	**South:** Wythenshawe **West:** RAE **East:** TGH	**South:** Wythenshawe **West:** Bolton **East:** NMGH	**South:** Wythenshawe **West:** Bolton **East:** TGH
Benign Urology 1 option	**Hubs:** MRI, Bolton, Oldham, Salford, Stepping Hill **Spokes:** Altringham, Fairfield, TGH, Wythenshawe, Leigh Infirmary, NMGH, Rochdale, RAE, Wrightington, The Christie, Trafford, Withington			
Paediatric Surgery 1 option	**Tertiary:** Royal Manchester Children's Hospital **High acuity:** Oldham, Stepping Hill, Bolton **Low acuity:** RAE, Tameside, Fairfield, NMGH, Salford, Wythenshawe			
MSK and Orthopaedics 2 options	**For Review**			
Cardiology 1 option	**For Review**			
Respiratory	*Status quo activity flows will be modelled as predominantly outpatient specialty*			
Vascular 1 option	**Arterial hub:** MRI **Spoke module 2/3:** Oldham, Salford, Stepping Hill, Wythenshawe **Spoke module 1:** Fairfield, NMGH, Rochdale (outpatients only), Bolton, Tameside, Trafford (outpatients only)			
Neuro-rehab 1 option	**Hot site:** Salford **Warm site:** Trafford **Cold sites:** Rochdale, Stepping Hill			

RATIONALE AND LEGAL CONSIDERATIONS ON THE ISC BOARD RECOMMENDATIONS FOR *BREAST SERVICES*

- At the JCB, 17 July 2019, the ISC Programme Board set out recommendations for the site configuration of a limited number of hospital-based specialist services and in particular a specific option for Breast Services – Option 4
- At the JCB's direction, further evaluation of the supporting information relating to the site options 4 for Breast services, has been undertaken
- In August 2019, the ISC Programme Board initially recommended Options 3 and 4 for Breast Services

ISC PROGRAMME BOARD RECOMMENDATIONS TO JCB – 17 SEPTEMBER 2019

1. Consider the recommendation of the ISC Programme Board for the site configurations of a limited number of hospital-based specialist services, namely:

a) **Respiratory** – as modelled, all existing sites and consistent with the Model of Care – to progress to PCBC

b) **Vascular** – as modelled to be sited as a Hub and Spoke configuration and consistent with the Model of Care – to progress to PCBC

c) **Benign Urology** - as modelled to be sited as a Hub and Spoke configuration and consistent with the Model of Care – to progress to PCBC

d) **Paediatric Surgery** – as modelled to be sited as a tiered configuration and consistent with the Model of Care – to progress to PCBC

e) **Breast** – as three equitable Hub sites and consistent with the Model of Care – to progress to PCBC (Options Appraisal) covering options 1-4

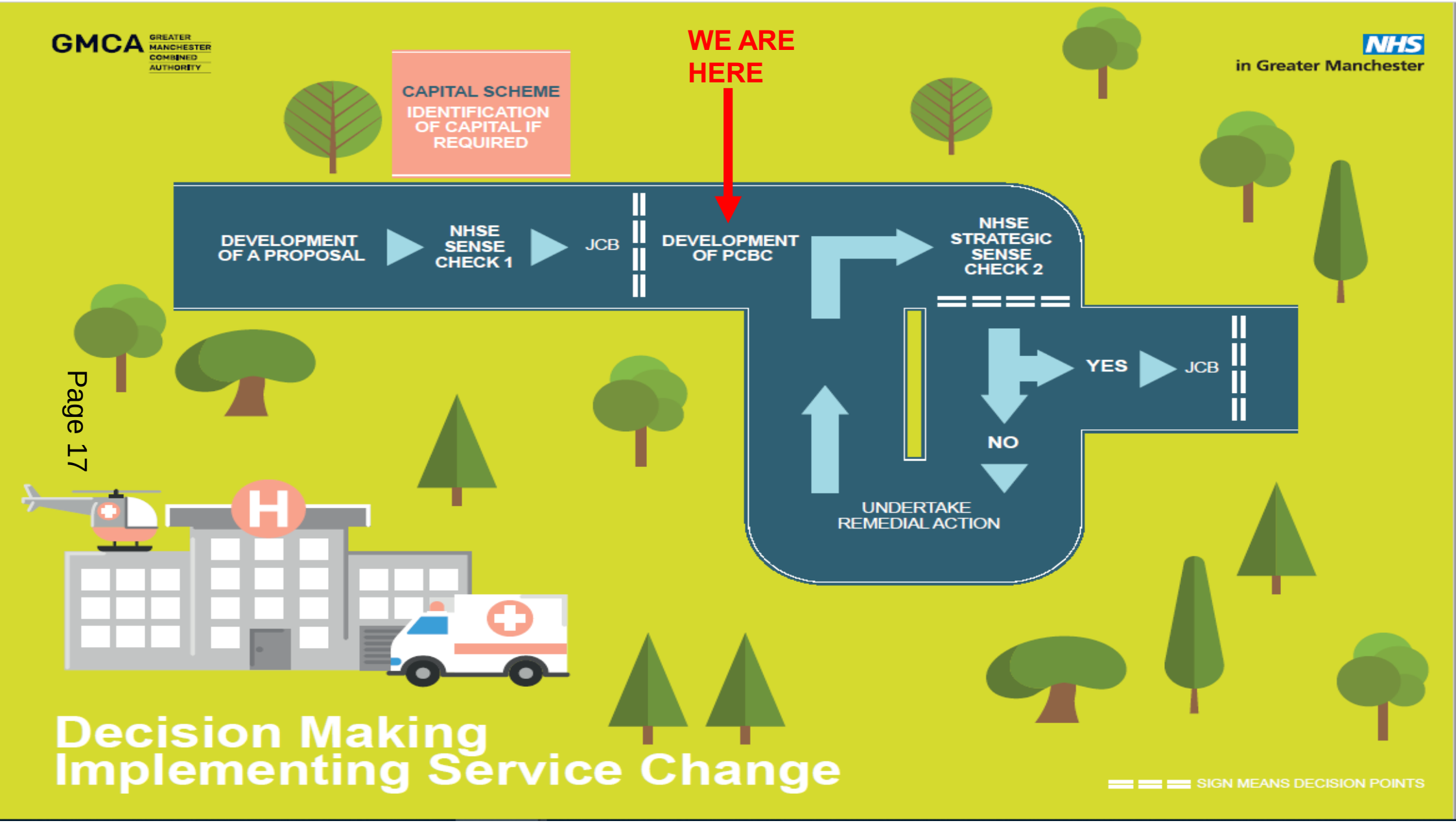
ALL RECOMMENDATIONS WERE APPROVED BY THE JCB

ISC PROGRAMME BOARD RECOMMENDATIONS TO JCB – 17 SEPTEMBER 2019

2. Consider the recommendations of the ISC Programme Board in order to progress to:

- NHS England's Strategic Sense Check 1, where evidence for the case for change will be submitted and presented
- GM Joint Health Scrutiny Committee to review of the proposed changes
- The development of a Pre-Consultation Business Case (Options Appraisal) for each Model of Care

ALL RECOMMENDATIONS WERE APPROVED BY THE JCB


GMCA
GREATER MANCHESTER COMBINED AUTHORITY
NHS
in Greater Manchester
CAPITAL SCHEME
IDENTIFICATION OF CAPITAL IF REQUIRED
WE ARE HERE
DEVELOPMENT OF A PROPOSAL
NHSE SENSE CHECK 1
JCB
DEVELOPMENT OF PCBC
NHSE STRATEGIC SENSE CHECK 2
YES
JCB
NO
UNDERTAKE REMEDIAL ACTION
Decision Making
Implementing Service Change
SIGN MEANS DECISION POINTS

NEXT STEPS

- Pre-Consultation Business Case (PCBC) work to commence in October 2019
- Engage formally with NHS England/Improvement in October 2019
- Due to their fragility Breast, Benign Urology and Vascular will be prioritised; followed by Paediatric Surgery, Respiratory, Cardiology, MSK/Orthopaedics
- Additional resource to prepare the Business Cases using the ‘5 case model’ is being commissioned by the Programme
- Key role for Provider leads, Clinical leads, Reference groups, Commissioners, PFB (Directs of Strategy, Chief Operating Officers etc),

NEXT STEPS

- PCBCs will be presented to JCB for consideration
- Proposals will be presented to GM Joint Health Overview Scrutiny Committee for discussion regarding consultation requirements and public scrutiny
- Intermediate arrangements ensuring close oversight for Breast Services across GM and East Cheshire will be put in place until a more permanent solution is agreed and implemented
- Continuing programme of Communications and Engagement activity

NEXT STEPS - MSK/ORTHOPAEDICS

- Revised Model of Care will go to ECAP, 7th October 2019
- Revised Model of Care will go to Clinical Reference Group, 22nd October 2019
- Revised Model of Care will then progress through ISC Governance framework October/November 2019

NEXT STEPS - CARDIOLOGY

- Clinical Reference Group (CRG) have received and were generally positive about revised Model of Care
- Patient Engagement concluded 30th September and evidence is being reviewed.
- Revisions to Cardiology workforce data to be modelled and reviewed by CRG in October 2019.
- Revised Model of Care will then progress through ISC Governance framework October/November

NEXT STEPS - PAEDIATRIC MEDICINE

- The Transformation Unit was awarded the contract to design the new Model of Care
- Workstream will link in with work being undertaken by the Strategic Clinical Networks
- Design and Oversight Forums will take place in November 2019 and February 2020
- A Communications and Engagement Strategy has been drafted – Links with young people's groups in Greater Manchester has commenced

INDICATIVE TIMELINES FOR SCRUTINY CONSIDERATION

As detailed in July 2019 GM Joint Health Scrutiny minutes "*any decision to progress to a business case or consultation for any site and speciality be delegated to the GM Joint Health Scrutiny Committee*"

ISC WORKSTREAM	NHS ENGLAND STRATEGIC SENSE CHECK 2	PRESENTATION TO GM JOINT HEALTH SCRUTINY
Breast	April 2020	June/July 2020
Vascular	April 2020	June/July 2020
Urology	April 2020	June/July 2020
Paediatric Surgery	August 2020	September 2020
Respiratory	August 2020	September 2020
MSK/Orthopaedics	September 2020	October 2020
Cardiology	September 2020	October 2020
Paediatric Medicine	TBC	TBC

QUESTIONS?

Contact us
If you have any queries about these guidelines, contact the GMHSC communications team:
gm.hsccomms@nhs.net

www.gmhsc.org.uk
@GM_HSC

Transport for Greater Manchester

Improving specialist care - GM HSCP

Update on transport analysis

November 2019

Transport for Greater Manchester

Purpose of presentation

- To explain TfGM role
- To outline transport analysis methodology (McKinsey)
- To present initial findings, and
- To set out next steps

Transport for Greater Manchester

Summary of ISC approach to transport analysis

- Any approach that looks to refine and focus activities to fewer sites to help deliver better health outcomes necessarily implies, on average, longer distances and journey times for service users
- ISC Board recognised that transport access will be an important consideration, and commissioned McKinsey to undertaken some travel analysis to help inform process
- TfGM asked by Board to provide assurance on McKinsey travel analysis methodology and to re-present its findings
- This initial work has been undertaken, specifically looking at transport implications for Breast Care Service reconfiguration
- TfGM also provided some wider transport context, in terms of scale of flows, inclusion of neighbouring GM areas and identifying areas of multiple deprivation.

Summary of TfGM analysis approach

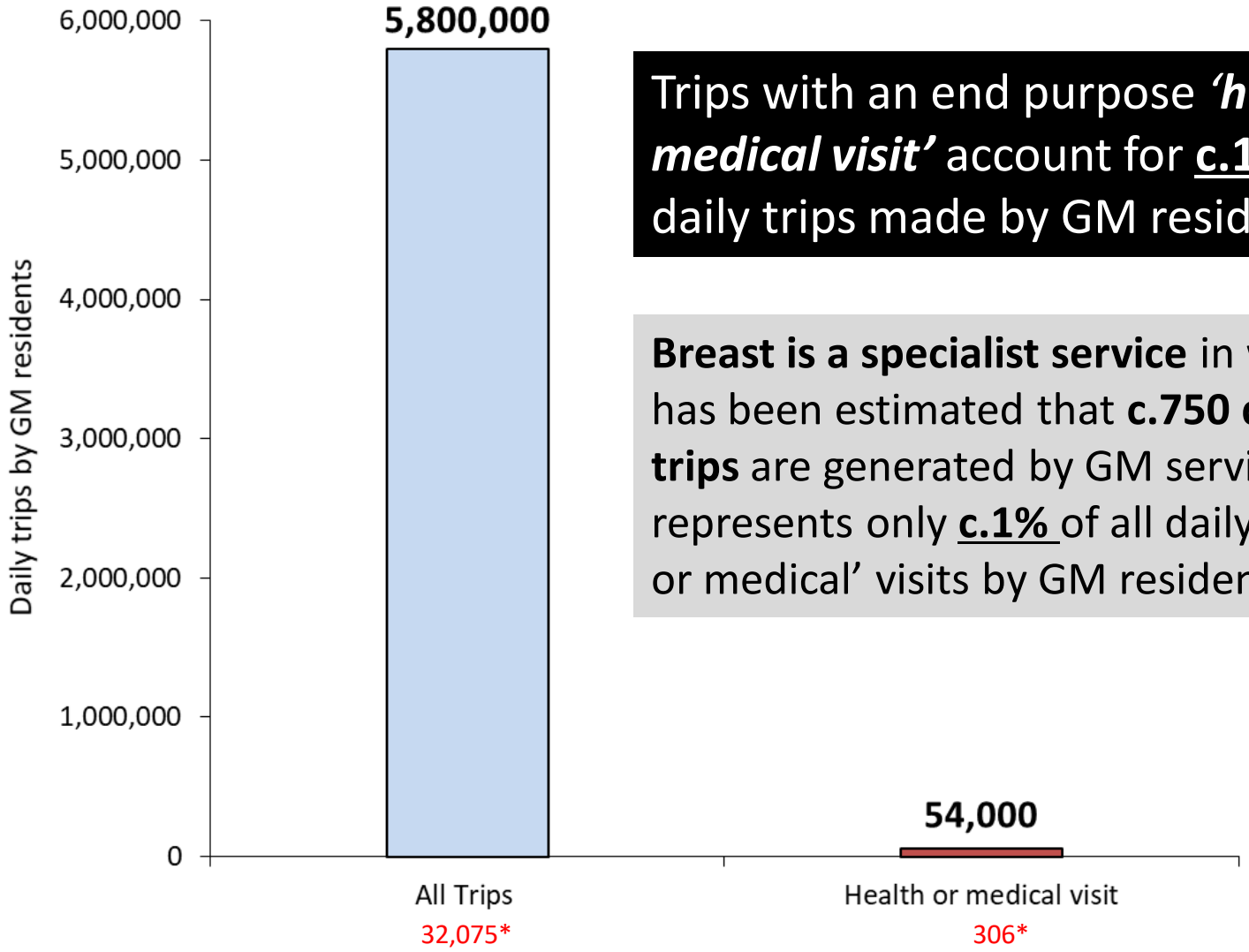
- Information from GM Travel Diary Surveys (TRADS) is used to place 'health / medical' trips in the context of overall travel by GM residents.
- Analysis of options uses change in travel time data provided by McKinsey.
- Travel time comparisons for both Public Transport and Car during the interpeak period for each option against the counterfactual.
- Acorn data (sourced from CACI) is used to provide detailed profiling information about the residential population of the geographic areas impacted by proposed service changes - distributional impact analysis

Transport for Greater Manchester

Using GM Travel Diary Surveys (TRADS) for context

Transport for Greater Manchester

Daily Trips by GM Residents



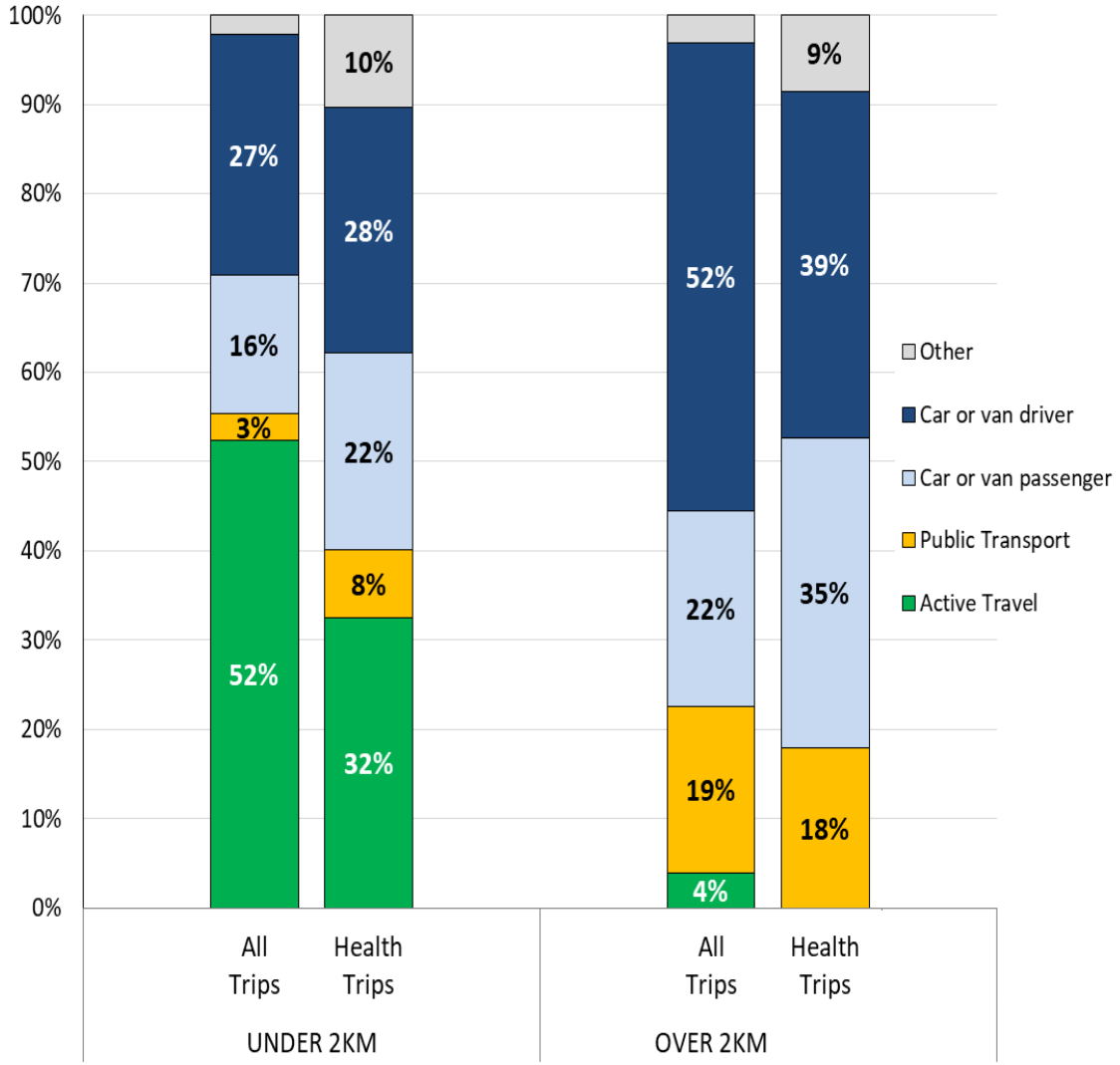
Trips with an end purpose ***'health or medical visit'*** account for **c.1%** of all daily trips made by GM residents.

Breast is a specialist service in which it has been estimated that **c.750 daily trips** are generated by GM services. This represents only **c.1%** of all daily 'health or medical' visits by GM residents.

*Number of TRADS records.

Transport for Greater Manchester

Daily Trips by GM Residents: Trip Length by Main Mode



c.75% of health trips over 2km are made by the private car.

Taxi plays an important role for health trips which is represented in 'Other' at c.10%

Less than 20% of health trips over 2km are made by public transport.

Transport for Greater Manchester

Breast Services: Options 1-4 Travel Time Summary

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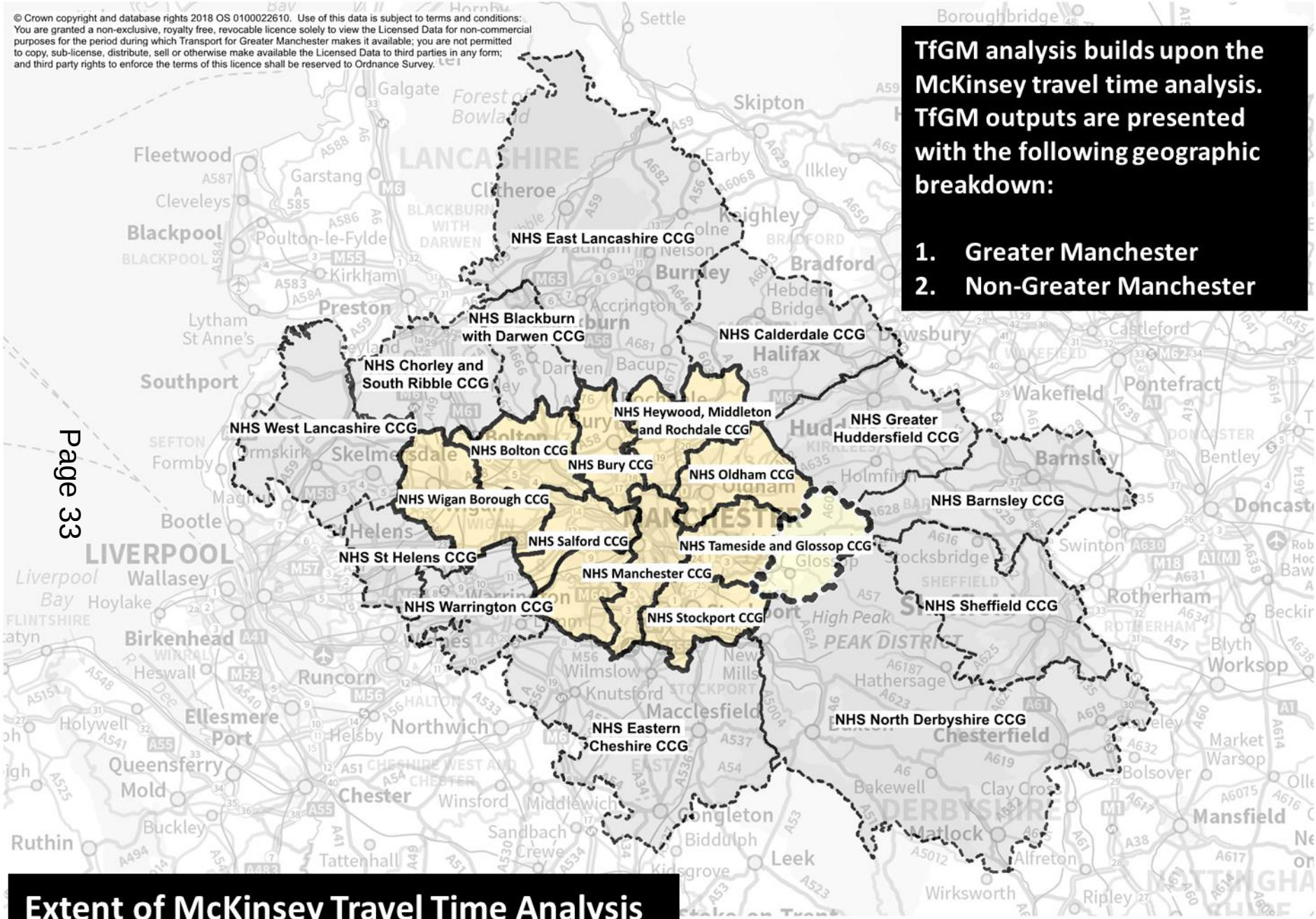


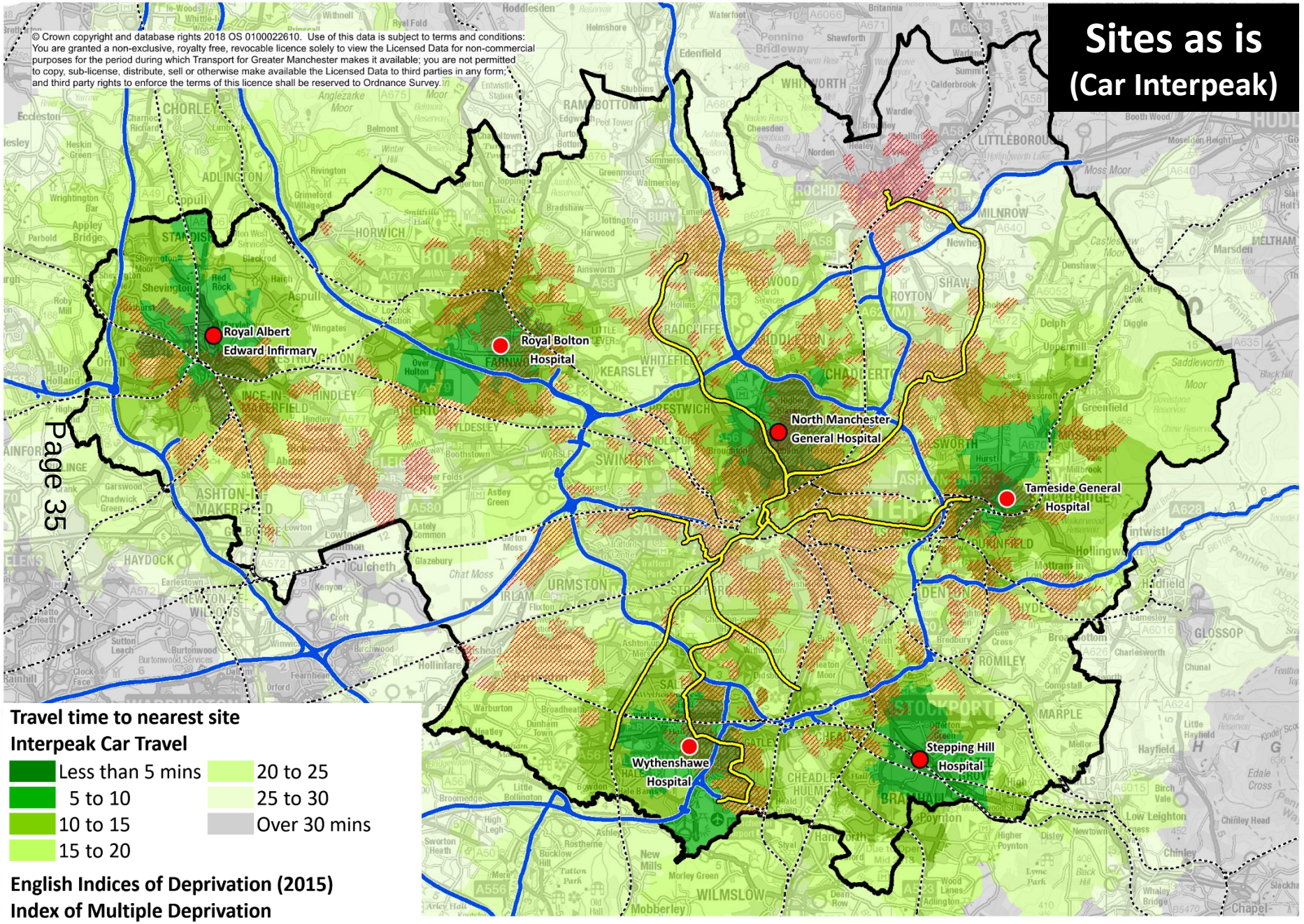
TfGM analysis builds upon the McKinsey travel time analysis. TfGM outputs are presented with the following geographic breakdown:

1. **Greater Manchester**
2. **Non-Greater Manchester**

Extent of McKinsey Travel Time Analysis

Transport for Greater Manchester

Car- Interpeak


Sites as is
(Car Interpeak)
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Royal Albert Edward Infirmary
Royal Bolton Hospital
North Manchester General Hospital
Tameside General Hospital
Wythenshawe Hospital
Stepping Hill Hospital
Travel time to nearest site
Interpeak Car Travel
Less than 5 mins
5 to 10
10 to 15
15 to 20
20 to 25
25 to 30
Over 30 mins
English Indices of Deprivation (2015)
Index of Multiple Deprivation
20% most deprived areas within England
N.B. IMD analysis is shown for GM only

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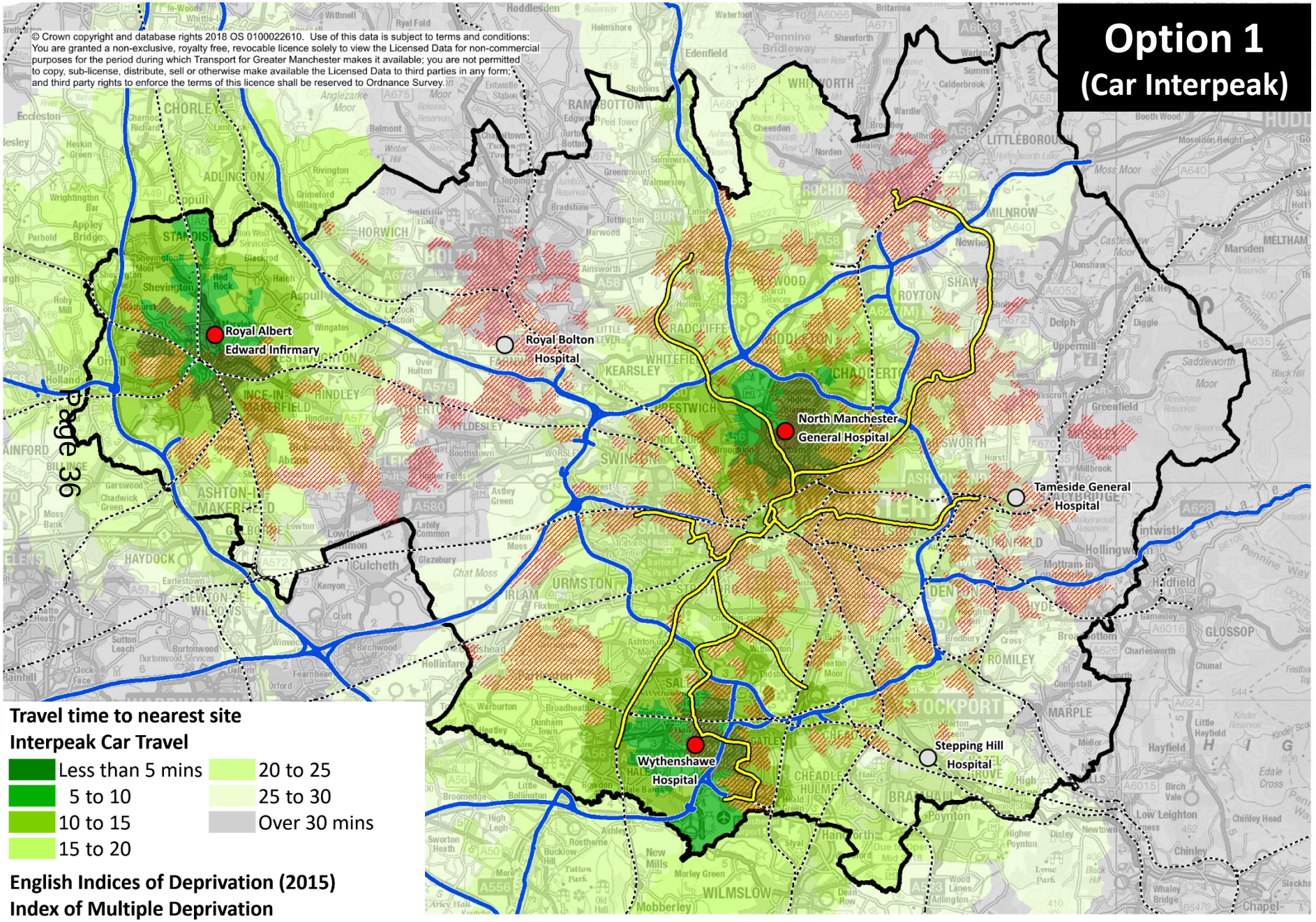
Option 1
(Car Interpeak)



Travel time to nearest site
Interpeak Car Travel

- Less than 5 mins
- 5 to 10
- 10 to 15
- 15 to 20
- 20 to 25
- 25 to 30
- Over 30 mins

English Indices of Deprivation (2015)
Index of Multiple Deprivation

- 20% most deprived areas within England

N.B. IMD analysis is shown for GM only

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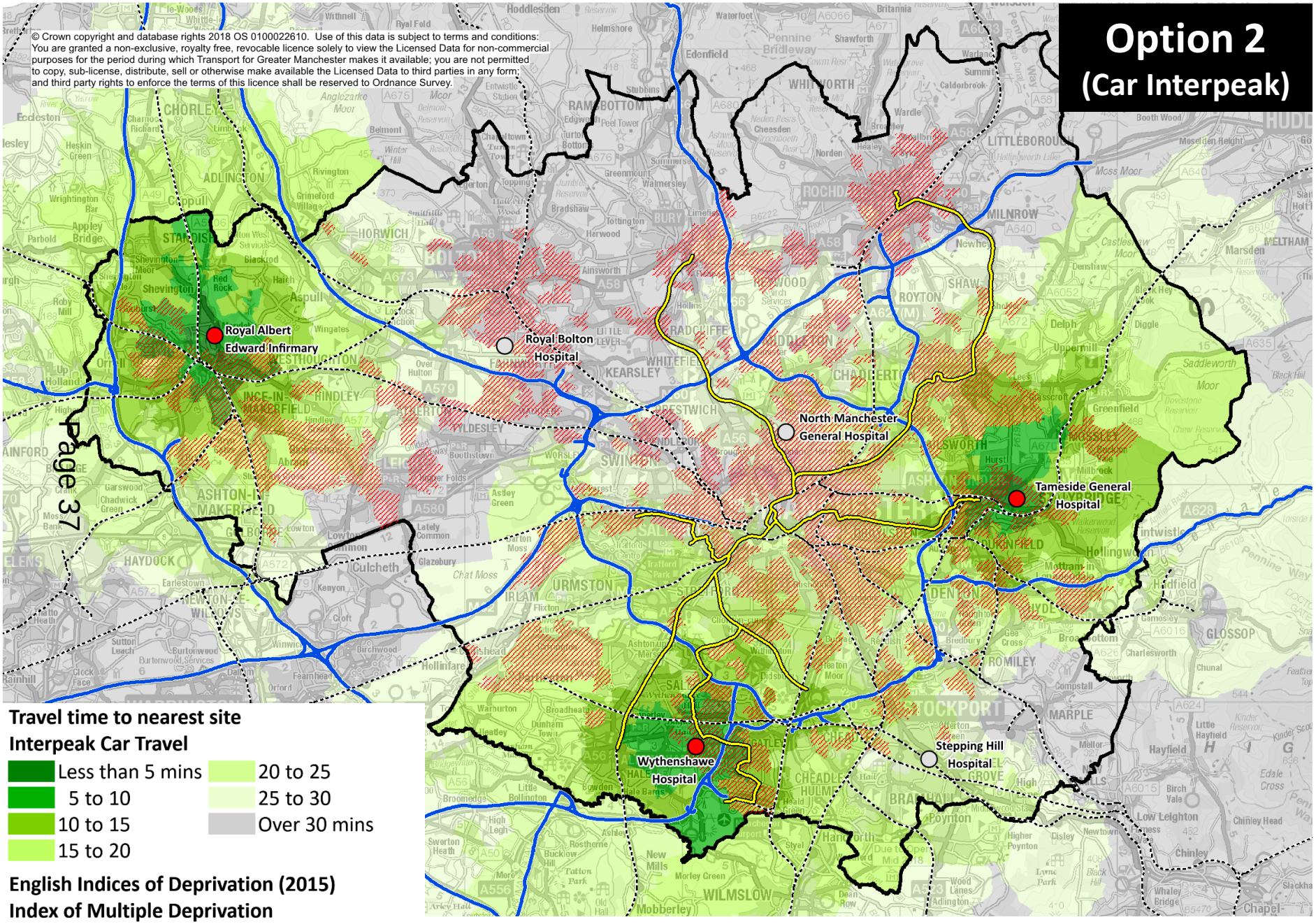
Option 2 (Car Interpeak)



Travel time to nearest site
Interpeak Car Travel

- Less than 5 mins
- 5 to 10
- 10 to 15
- 15 to 20
- 20 to 25
- 25 to 30
- Over 30 mins

English Indices of Deprivation (2015)
Index of Multiple Deprivation

- 20% most deprived areas within England

N.B. IMD analysis is shown for GM only

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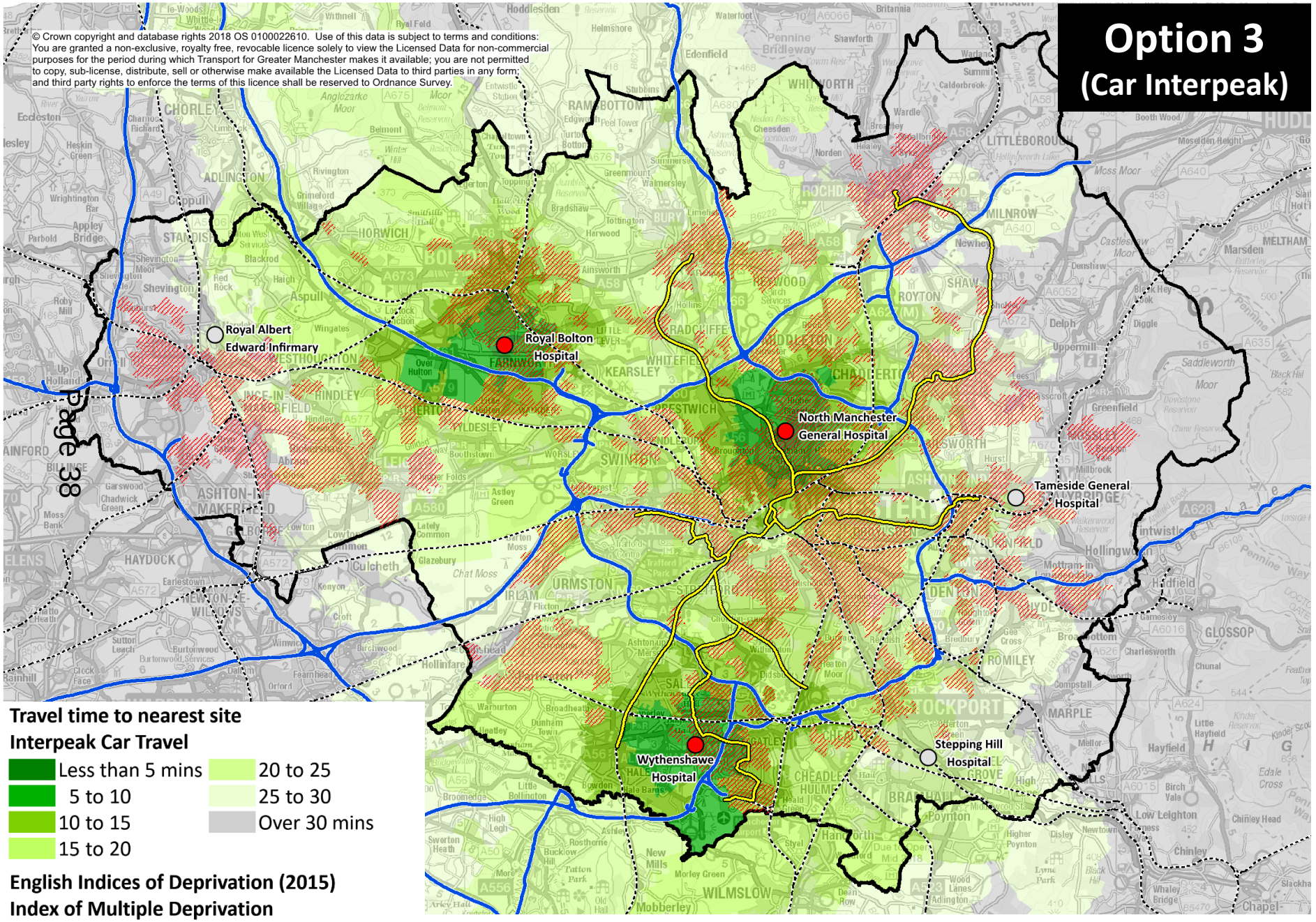
Option 3 (Car Interpeak)



Travel time to nearest site
Interpeak Car Travel

- Less than 5 mins
- 5 to 10
- 10 to 15
- 15 to 20
- 20 to 25
- 25 to 30
- Over 30 mins

English Indices of Deprivation (2015)
Index of Multiple Deprivation

- 20% most deprived areas within England

N.B. IMD analysis is shown for GM only

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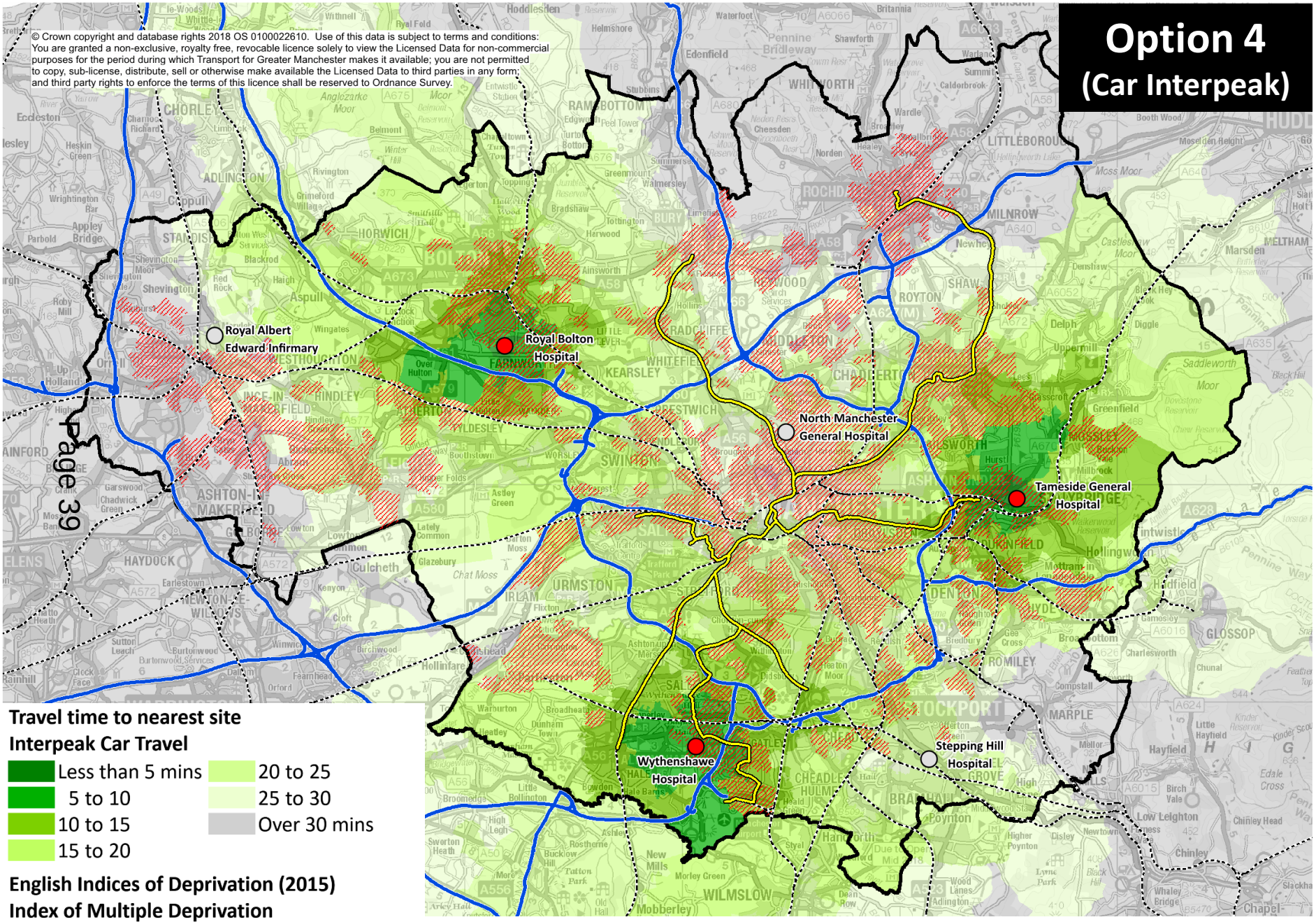
Option 4
(Car Interpeak)



Travel time to nearest site
Interpeak Car Travel

- Less than 5 mins
- 5 to 10
- 10 to 15
- 15 to 20
- 20 to 25
- 25 to 30
- Over 30 mins

English Indices of Deprivation (2015)
Index of Multiple Deprivation

- 20% most deprived areas within England

N.B. IMD analysis is shown for GM only

Transport for Greater Manchester

Counterfactual vs. Options 1-4 (Interpeak Car vs. PT)

GM residents

Breast service configuration	Within 30 mins by car	Within 60 mins by PT
Counterfactual	**97% (c. 2.70m)**	**52% (c. 1.44m)**
Option 1	87% (c. 2.41m)	29% (c. 0.80m)
Option 2	79% (c. 2.19m)	21% (c. 0.59m)
Option 3	89% (c. 2.46m)	33% (c. 0.92m)
Option 4	87% (c. 2.43m)	26% (c. 0.73m)

Non-GM residents

Breast service configuration	Within 30 mins by car	Within 60 mins by PT
Counterfactual	**20% (c. 0.58m)**	**1% (c. 0.02m)**
Option 1	16% (c. 0.46m)	1% (c. 0.02m)
Option 2	16% (c. 0.46m)	1% (c. 0.02m)
Option 3	10% (c. 0.31m)	0%
Option 4	10% (c. 0.31m)	0%

Transport for Greater Manchester

Next steps

- ISC Board have commissioned further work to explore configuration of Breast Care services in greater detail, including transport analysis
- TfGM will assist and advise, as required
- Key issue also to be fully considered is how to mitigate any negative access effects of any reconfiguration

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GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 13 November 2019

Subject: GM Delivery Plan 2020 – 24, Greater Manchester's implementation guide for *The Prospectus* (2019) and response to the NHS Long Term Plan.

Report of: Warren Heppolette, Executive Lead, Strategy and System Development, Greater Manchester Health and Social Care Partnership (GMHSCP)

PURPOSE OF REPORT:

The purpose of the report is to provide the GM Joint Health Scrutiny committee with an update on the 'GM Delivery Plan 2020-24' – Greater Manchester's implementation guide for The Prospectus (2019) and the NHS Long Term Plan. It provides a narrative of the process taken during the production of the document, and includes the Executive Summary as featured in the most recent Delivery Plan draft.

RECOMMENDATIONS:

The Greater Manchester Joint Health Scrutiny Committee is asked to note the update provided, comment on the process taken to draft the plan and offer feedback on the summary of emerging priorities contained within the report.

CONTACT OFFICERS:

- Warren Heppolette, Executive Lead, Strategy & System Development, GMHSCP warrenheppolette@nhs.net
- Conor Dowling, Strategy and System Development, GMHSCP conor.dowling@nhs.net

1.0 INTRODUCTION

1.1. The GM Delivery Plan 2020-24 will set out how we will implement the Health and Social Care Prospectus[1] and the NHS Long Term Plan in Greater Manchester.

1.2. It does so in the context of the development of key Greater Manchester strategies including the Greater Manchester Unified Model of Public Services and the Local Industrial Strategy – underpinned by the Greater Manchester Independent Prosperity Review.

1.3. Our Delivery Plan is expected to be finalised early in 2020 at the conclusion of the national 5 year planning process. The GM Delivery Plan will describe how we will go beyond the Long Term Plan to realise the ambition we set out in the Prospectus: to create a comprehensive Population Health system in GM that spans all mechanisms of action from transport planning to housing policies, welfare design to educational curricula, and all actors – public, private and voluntary sectors, and crucially citizens themselves.

1.4. Running in parallel to this, each locality is also refreshing its Locality Plan setting out their strategies for how health and care services can join up with wider public services at neighbourhood level. These plans are due for submission to the Partnership on 29th November to inform the final Plan and ensure alignment between our shared objectives across Greater Manchester and implementation in each locality.

1.5. The emerging priorities prompted by both the GM Health and Social Care Prospectus and the NHS Long Term Plan are summarised in the appendix to this paper.

2.0 DEVELOPING THE PLAN

2.1. The NHS Long Term Plan was published on 7th January 2019 and its detailed implementation framework in June this year.

2.2. On 8th March 2019 an update and proposed approach to setting our Greater Manchester's Health & Care priorities for the next five years was provided to Greater Manchester Health & Care Board outlining the development of Greater Manchester's response to that document and the continuation of our collective

[1] The GM Health & Social Care Partnership published Taking Charge: Our Prospectus for the next 5 Years in April 2019. http://www.gmhsc.org.uk/wp-content/uploads/2019/03/GMHSC-Partnership-Prospectus-The-next-5-years-pdf.pdf

journey to integrated care supported through devolution and the implementation of Taking Charge.

2.3. The focus for the Delivery Plan therefore is to build on the start we have made over the past three and a half years and incorporate the additional impetus the Long Term Plan provides. The broader scope of our vision leads us to the ambition to create a comprehensive population health system in GM – that goes beyond the aim of Integrated Care Systems (ICS) set out in the Long Term Plan.

2.4 This does not mean that we will shy away from the immediate challenges that we face – in particular securing a return to the reliable delivery of NHS Constitutional Standards in all parts of GM.

2.5 As was the case in the development and implementation of Taking Charge, our ambition our approach will need to confirm clarity on three things:

- Those things we elect to do once across GM;
- Those things we elect to do consistently across the ten localities; and
- The implementation and innovation which is happening in the ten districts now and that which is planned in each locality during the coming period.

2.6 This is relevant across each of the three main ambitions of Taking Charge – The Next Five Years and will inform the structure and key themes of the Delivery Plan:

- **building a population health system** – drawing on the health potential of the unified model for place based working and community connectedness in each district as well as the opportunity to develop as a Marmot City Region and the GMCA commitment to a 'health in every policy' approach;
- **creating a sustainable health and care system** – utilising the unified model to support integrated neighbourhood care and support and the LCO model, progressing place based commissioning to commission for health as well as health services, and working together to drive improvement and quality at scale and to implement the objectives of Improving Specialist Services; and
- **unlocking economic potential** - the unified model supporting health and work as well as the building on our strengths around health innovation.

2.7 Developing the Delivery Plan, especially in the context of the development of place based working in the ten districts, will reflect the mobilisation of leadership across Greater Manchester: political, clinical and managerial – and going beyond health and social care into the wider public service, the VCSE and civic society. The principle of subsidiarity is an important part of this. We will need to recognise that the implementation of the Prospectus starts with the citizen in each part of Greater

Manchester; builds to the neighbourhood (30,000 to 50,000 population) and then to the locality.

2.8 At the same time, and through the same process GM will be expected to offer that part of this detailed delivery plan which serves as a formal response to the NHS Long Term Plan. This will be important to ensure a coordinated and proactive approach to making the case for transformation resources associated with implementation.

3.0 REFRESH OF LOCALITY PLANS

3.1 Updated plans at locality level are therefore critical to the coherence and alignment of the Delivery Plan. The original set of 10 locality plans were constructed in 2015 and need to be updated to reflect the breadth of transformation in localities since then. A number of localities have reported that the original locality plans have been overtaken by their implementation and better described and better evidenced reality can now be presented.

3.2 Clearly, the shape and content of the 10 Locality Plans will need to be driven by stakeholders in localities themselves but will each provide:

- a reaffirmation of the outcomes they were seeking to influence
- a description of progress against those outcomes since 2016
- a description their plans for the pillars of the local system: the approach to place based, integrated delivery and the neighbourhood model, and the approach to place based commissioning.

3.3 In the context of the long term plan it will be evident that, as Greater Manchester made more progress in implementing the NHS 5 Year Forward View, there will be long term plan objectives which we have already delivered; others for which we are implementation ready; and those for which we need to prepare more fully to be ready to implement. These aspects will need to be drawn out in detail to help us make sense of phasing and the resourcing sought.

4.0 THE GM DELIVERY PLAN & THE LONG TERM PLAN

4.1 The updated locality plans, and the detail supporting them, will inform the Delivery Plan covering the period to the end of 2023/4 – and including how GM will deliver on its requirements as part of the NHS Long Term Plan.

4.2 The Implementation Plan for the Prospectus will both describe how GM will deliver on our ambition to create a population health system and how we will implement the totality of the Long Term Plan over the next five years.

4.3 In describing implementation of the Long Term Plan, we will reflect the progress we have made in GM and the unique system architecture we are building: where programmes in the Long Term Plan are already embedded in the care model in GM, we will say so; where there are new requirements, we will seek to phase these in and ensure they align with and complement the system architecture in GM. In doing so, we will provide a clear plan for consistent delivery of NHS constitutional standards in GM.

4.4 The Delivery Plan for the Prospectus will also need to serve as the basis for decisions for the allocation of transformation funding to GM as part of the implementation framework for the LT Plan.

4.5 The GM Delivery Plan and the Locality Plans will need to be connected by aligned and detailed finance, activity and workforce plans covering the period to 2023/4. This will both enable GM to meet the planning requirements for the NHS Long Term Plan and provide the basis for any future investment decisions for transformation funding in GM.

4.6 Formal engagement and submission of draft documents to NHS England is the focus of work through the autumn. The feedback from that engagement and the locality plans will inform the final plan which will be submitted to the GM Health and Care Board on 31st January 2020.

5.0 RECOMMENDATION

The Greater Manchester Joint Health Scrutiny Committee is asked to:

- Note the update provided.
- Offer feedback on the process taken when drafting the GM Delivery Plan.
- Offer feedback on the structure and content of this iteration of the GM Delivery Plan Executive Summary.

CONTACT OFFICERS:

Warren Heppolette, Executive Lead, Strategy and System Development, GMHSCP
warrenheppolette@nhs.net

Conor Dowling, Strategy and System Development, GMHSCP
conor.dowling@nhs.net

APPENDIX

GM DELIVERY PLAN: STRUCTURE, THEMES AND PRIORITIES

INTRODUCTION

Since 2016 devolution has enabled Greater Manchester to take charge of its health and care spending and decisions. Over the past three years we have progressed the implementation of our strategy to meet the ambition outlined in *Taking Charge Together* (2015): to deliver the greatest and fastest possible improvement to the health and well-being of the people of Greater Manchester.

The Health and Social Care Prospectus, published in 2019, took stock of the first three years of the Health and Social Care Partnership. It presented what we learnt and achieved; and set out where we want to go next as a Partnership.

This Delivery Plan 2020-24 represents the GM system's implementation strategy for the Prospectus and incorporates our response to the responsibilities set out in the NHS Long Term Plan. As with the Prospectus, this plan is set within the context of the development of key Greater Manchester policies such as the GM Unified Model of Public Services (2019), the GM Transport Strategy 2040 and the Local Industrial Strategy (2019) – which is underpinned by findings from the GM Independent Prosperity Review (2019).

The Greater Manchester Unified Model of Public Services

As a devolved city region, we want to push beyond the boundaries of an Integrated Care System (ICS) to create a comprehensive Population Health system in GM that spans all mechanisms of action from transport planning to housing policies, welfare design to educational curricula, and all actors – public, private and voluntary sectors, and crucially citizens themselves.

To create a population health system, health and social care will need to integrate with wider public services in Greater Manchester. The GM Unified Model of Public Services is based on the fundamental principle that change is done with, and not to people and that we build on what individuals, families and our communities can achieve rather than focusing on what they lack. The White Paper clearly states that the neighbourhood of 30,000 to 50,000 population is the geographical unit through which our reform endeavour across all public services, including our model of care and support, will focus.

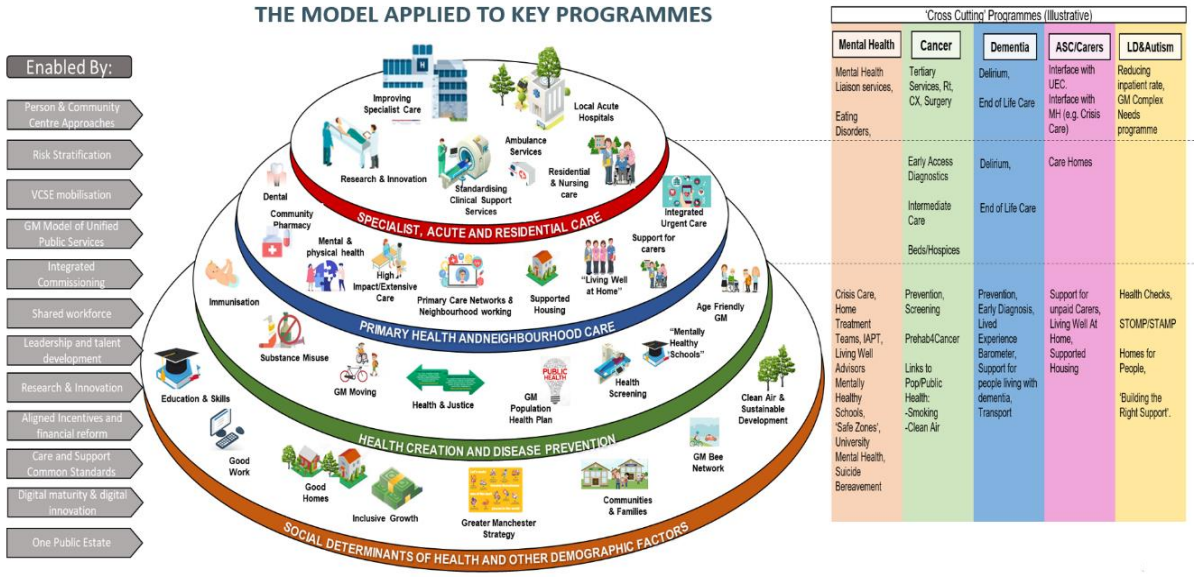
A Model of Care and Support for the 21st Century

The resetting of the health and care landscape in Greater Manchester stems from the recognition in *Taking Charge* that our system was characterised by a stark imbalance: 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.

Through Local Care Organisations (LCOs) in our 10 localities, we are already beginning to see the potential of what coordinated, anticipatory, integrated neighbourhood and community-based care can provide to local populations. The development of integrated models of care across Greater Manchester is the focal point of our Delivery Plan. We describe our approach to the delivery of GM-wide programmes and our responsibilities under the Long-Term Plan through this care model.

These new models of neighbourhood care are enabled by joined up commissioning between CCGs and local authorities that allow us to focus on the full public service spend in a place to improve health and well-being.

Through our model of care and support, we will enable hospitals in Greater Manchester to focus on what they do best: providing more specialist care to those who are most ill. We will help hospitals to share expertise, experience and efficiencies across clinical services so everyone can benefit equally from the same standards of specialist care. Through our model of care and support, we will enable hospitals in Greater Manchester to focus on what they do best: providing more specialist care to those who are most ill. The model of care emerging through our integrated work with Localities and beyond provides a platform for the delivery of GM and NHS Long Term Plan Ambitions and is displayed diagrammatically in the figure below. The columns on the right-hand side show illustrative examples of how individual and



cross cutting programmes can be staged and delivered within a regional Population Health system approach:

All of this will be supported by Greater Manchester system architecture where it makes sense to do so. This includes workforce, digital and estates for example.

SYSTEM PRIORITIES IN THE FIRST TWO YEARS

For the first two years of the delivery of this plan, we have confirmed the following collective priorities in Greater Manchester – all of which build on progress we have made since Devolution. These are:

A MODEL OF CARE AND SUPPORT FOR THE 21ST CENTURY

Local Care Organisations

- **New neighbourhood delivery models** will be fully in place in every part of Greater Manchester based on 30-50,000 populations with **Primary Care Networks** (PCNs) at their heart. These neighbourhoods will form Local Care Organisations (LCOs) in every GM locality and will be the focal point for the health and care contribution to the **GM Model of Unified Public Service**.

- Each LCO will have a defined leadership structure and will offer a mature provider platform that can manage new contractual arrangement that can deliver on activity shifts from the acute sector to the community and improve population health. They will be **whole population models** with neighbourhood teams embracing a broad range of partners – including the VCSE. Whilst the ambition is the same across our city region – the precise organisational form of each LCO will be for each locality to determine.

- We will see **risk stratification** models in place in all neighbourhoods identifying the most vulnerable cohorts of our population so that we can provide **systematic anticipatory care**. Increasingly, these models will go beyond health data to bring together but bringing together data sets from wider public sector partners: for example, on school readiness. We will also put in place an agreed set of **GM neighbourhood metrics** that receive the same level of system attention as acute sector metrics do currently. We will deliver major transformation programmes through these care models – including on cardiovascular, stroke, respiratory, diabetes and community frailty pathways.

- Our neighbourhood models will operate on the principle of **putting people and communities genuinely in control of their health and wellbeing**. This requires an integrated response that focusses on preventative approaches and a shift away from the medical model of illness towards a model of care which considers **the expertise and resources of people and their communities**. **The VCSE** has a significant role to play in this.

Primary Care

- We will bridge the gap between primary and secondary care **by supporting high risk patients through intensive proactive care to avoid hospital admissions.** This will build on the intermediate or extensivist models that are being developed in localities across

GM where seamless support can be provided during periods of crisis and the transition to and from hospital-based care.

- We will continue the **alignment of our 67 Primary Care Networks to our integrated neighbourhoods based on GP-registered lists**. In GM we will deliver the national ask of PCNs as a minimum. However, our neighbourhoods will deliver a much wider vision in order to tackle the social determinants of health. Community pharmacy, general dentistry and optometry, are all critical to this.

- Primary Care is integral to our neighbourhood models. We will deliver the **refreshed GM Primary Care Strategy** (2019-24). As part of this, we will facilitate the roll out of group consultations as a routine model for **supporting people with long-term conditions**; provide full population coverage of **online consultations** by April 2020 and video consultations by April 2021; ensure every person who needs a **same day intervention** can receive one; deliver seamless provision of **routine and urgent and emergency primary care**; routinely offer **general practice appointments during evenings and weekends**; roll out the **GP Excellence programme** and expand GP Excellence to all primary care providers by 2021; implement the GM Primary Care Workforce Strategy.

Adult Social Care

- We will continue to make significant **improvements in the quality of Greater Manchester's social care provision** – building on the strong Care Quality Commission ratings for both care homes and domiciliary care.

- We will **implement our Living Well at Home programme** - a new model of independent living supporting people to stay well in their own homes and communities of **choice**.

- We will **develop new 'blended' neighbourhood-based care roles** which will support and **enable** care staff to undertake some healthcare tasks – providing better career opportunities and job enrichment for the workforce, as well as better support for the individual

- We will put in place an agreed set of **local metrics to measure the quality of life, care** and system partnerships for care homes and living well at home. All localities will also have an **electronic real time care home bed state tracker**. This will be linked to our Tableau business intelligence to facilitate enhanced capacity and demand management.

- We will play our part in **improving the supported housing offer** for people in GM. We will see an increase and improvement in the supported housing offer working with planning and housing colleagues to achieve our ambition of **providing a further 15,000 supported housing units** in Greater Manchester by 2035.

- We will continue the delivery of our **co-designed strategies on learning disability and autism.** We will support people with learning disabilities or autism or both to live in the community and move safely out of inpatient settings.

- We will continue to explore new solutions to transform social care and are keen to work with Government on these. We believe that our experience of operating a devolved health and care system can be helpful in **developing future social care policy.** We would want to see any future funding model for social care based on the risk being shared across the whole population, in a similar way to the NHS.

Improving Mental Health Care & Wellbeing

- We will continue to implement the agreed deliverables in our Mental Health Strategy and work to ensure **parity of esteem with physical health**.

- We will deliver the 12 standards in the **Mental Health Five Year Forward View** by March 2021 and maintain delivery of core constitutional standards affecting access and recovery.

- We will go above and beyond the Long-Term Plan, including: continuing to grow the **GM Mentally Healthy Schools** approach (a forerunner of the National Schools Trailblazer) and establishing a **GM Universities Service Pilot**.

- We have identified further actions to **improve the IAPT (Improving Access to Psychological Therapies) access rate** in order to achieve the target increase of up to 25% by 2020/21. These include GM procurement of **digital therapies**, a GM joint recruitment process for new and replacement therapists and development of a GM IAPT workforce modelling tool.

- We will develop **new and integrated models of primary and community mental health care and crisis support** for adults and older adults with severe mental illnesses including complex mental health difficulties associated with a diagnosis of 'personality disorder'

- We will **increase the number of children and young people who have access to mental health support**. We are currently ahead of national targets on this – but we recognise that there is a lot more to do. We will put new services in place for children and young people including Rapid Response Teams and Safe Zones and we are planning to test the transition model with both ADHD & Eating Disorders.

- Our ambition is that **all acute hospitals in Greater Manchester will have mental health liaison services** that can meet the specific needs of adults and older adults. Our plan is that all large acute hospitals in GM will have liaison/core 24 services in place by March 2021.

Improving Hospital Care

- We will develop **a thriving network of hospitals that are part of** integrated **local models of care**, are networked in terms of single services and mutual support whilst retaining distinct identities based on a mix of both core District General Hospital functions and areas of specialism.

- We will pursue this transformation in **a safe and sustainable way** – without compromising on our commitment to the highest levels of service quality. We will tackle the challenges faced by hospitals across Greater Manchester – including shortages in key areas of workforce and out-of-date estate.

- Our transformation work must enable us to secure a return to the **consistent delivery of NHS Constitution Standards**.

- We will continue the **delivery of our Improving Specialist Care programme** – including the successful implementation of Healthier Together. We are aiming to develop pre-consultation business cases for all the models of care by the summer of 2020.

- We will deliver on the **Greater Manchester Elective Reform Programme**. This will reduce demand for elective care; standardise our approach to referral; and make more efficient use of available capacity including the potential for resource to be shared across the system.

- We will significantly **reduce demand for face to face outpatient appointments** by supporting more individuals to self-care; identifying alternative mechanisms and services that can help manage symptoms/conditions (including digital solutions); as well as supporting healthier lifestyle choices.

Reform of the Urgent and Emergency Care System

- We will deliver on our agreed **Urgent and Emergency Care Improvement and** Transformation **Programm**e.

- Partners in GM have co-designed a **fully integrated urgent care service model** that brings together a single GM Clinical Assessment Service (CAS) and a community-based MDT urgent care response within each locality. We will commission a single GM CAS from April 2020 onwards.

- We will undertake a full evaluation of locality integrated urgent care models to support the wider adoption and scaling of innovation across all localities to deliver a **consistent community-based MDT urgent care response** in all localities by Autumn 2020. This will include the implementation of an agreed Urgent Treatment Centre model as part of a

fully integrated service. The community-based MDT urgent care response will have the ability to respond within two hours to urgent requests and will have the ability to provide a wide range of assessment, treatment, care and support.

- We will co-design GM standards for **Same Day Emergency Care (SDEC)** that include; streaming, acute medical and surgical specialities and acute frailty. These standards will be embedded by the end of March 2020. As part of the SDEC development, we will introduce a GM 'refer to ED' streaming model that is consistent with the GM CAS assessment and streaming process. We will increase the proportion of acute admissions discharged on the day of attendance from 20% to 33% through delivery of effective SDEC operating a minimum of 12 hours a day, 7 days per week.

- GM will continue to test and roll out the **GM Discharge and Recovery standards** during the remainder of 2019/20 and focus on achieving our ambitions to reduce the number of patients with a length of stay of 21 days or more. In addition to this, we will work across health and care to reduce our DTOC (Delayed Transfers of Care) to 2.5% or less during the next two years.

- Year on year, we will **reduce attendances to Emergency Departments** and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through improved primary, community and social care services working together. This will be underpinned by a philosophy of 'home first' wherever safe and appropriate.

OUR POPULATION'S HEALTH

Creating a Population Health System

- We will fully implement our **GM Population Health Plan** and evidence the impact of this approach.

- We will shift towards a whole system approach to Population Health which will see health as a primary consideration across all GM policy with a focus on **reducing health inequalities**. This will include: transport, housing quality and availability, spatial planning, town centre and neighbourhood developments and green space provision, jobs and the economy, sustainable development and early childhood development, education and skills.

- Given our devolved status, GM is also in a strong position to move faster on the **application of social value** in our city region. As the Health and Social Care Partnership we have an important role to play in our city region's approach to inclusive growth and we will accelerate our progress on the contribution of health and care organisations as **anchor organisations** in GM.

- We aim to **close the Life Expectancy and Healthy Life Expectancy gap** to the Northwest average by 2021 and the England average by 2026. Our plan for GM to become **the first 'Marmot City Region' in England** will help to drive this work.

- Building on the success of **Making Smoking History**, we aim to reduce smoking prevalence in GM to 13% by 2021 and the prevalence of smoking in pregnancy to 6% by in the same period.

- We will also work to ensure that children in GM have the best possible start in life. By 2021, 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** with 100% of our early years settings rated 'good' or 'outstanding'.

- Through our **GM Moving Strategy**, our goal is to increase the physical activity rate in GM to 75% by 2026.

GM's Cancer Plan

- We will increase the pace of delivery of the GM Cancer Plan. A **comprehensive integrated cancer system is in place in Greater Manchester** and is led by committed patients affected by cancer, clinicians, managers, VCSE organisations and others.

- We will strive to meet the national aim of **55,000 more people surviving cancer** for five years or more each year by 2028. This equates to approximately, 2,750 people each year surviving cancer for longer in Greater Manchester.

- We are committed to ensure more **consistent delivery of cancer waiting time** standards **across Greater Manchester**. We will work with all localities in GM to support delivery of the **28-day Faster Diagnosis Standard** (FDS) from April 2020. GM Cancer will support providers in the delivery of the 28-day standard in identified disease groups, especially in high volume cancers including lung, colorectal and prostate. We will implement the recommendations from the clinically-led review of providers' processes and performance in respect of the 62-day standard. In respect of emergency cancer presentation, we have set an expectation that less than 18% of cancers will be diagnosed as a result of an emergency presentation; the current GM position on this is 19.8%.

- Approximately **2,000 people in GM will benefit from participating in the Prehab 4Cancer** programme over the next two years: the first prehab programme to be delivered at scale nationally. Our aim is that 100% of patients are offered appropriate prehab for Cancer before all treatment modalities.

- We will **refresh our health inequalities strategy to ensure that we focus on the areas of lowest uptake and coverage across cancer screening programmes**. We will explore funding possibilities to pilot innovative changes such as cervical screening home testing, delivery of cervical screening and breast screening in co-located venues and working with the Primary Care Networks on extended hours access to cervical screening appointments.

BUILDING A SUSTAINABLE SYSTEM

Continued Reform of the Commissioning System

- We will continue to implement the recommendations from the Greater Manchester Commissioning Review (2017). Principally, these are: **local authorities and Clinical Commissioning Groups to come together to form Strategic Commissioning Functions**, (SCFs); and the Joint Commissioning Board, supported by a GM Commissioning Team, to discharge commissioning functions on behalf of CCGs, Local Authorities and NHS England.
- All 10 localities will continue to develop their Strategic Commissioning Function and embed this as a core element of implementing the GM model for Public Service Reform. This particularly relates to the commitment to bring together commissioning and an understanding of the full public spend in a place.
- We will continue to drive the benefits that come from the SCFs. These include: **pooled budgets across the Local Authority and CCG**; opportunities for further pooling of targeted investment in local communities and neighbourhoods; alignment of investment to ensure it is directed towards reform in its widest sense; integration of teams to facilitate the delivery of efficiencies; and radical reform of payment methods to incentivise outcomes to secure improved health, early intervention and prevention and long term sustainability.
- Our **Joint Commissioning Board will continue to mature and provide a vehicle for system wide commissioning leadership and activity**. It will draw on its founding principle that political, clinical and managerial leaders meeting in public to make decisions on the future shape of public services in GM is a necessary and very powerful representation of our integrated, devolved system in operation.

Delivering our Workforce Strategy

- In 2017 we produced the Greater Manchester Workforce Strategy, which was built from the 10 locality plans and identified 4 priority areas. Since then, the **Greater Manchester Workforce Collaborative** have together been delivering the Greater Manchester workforce programme. The GM Workforce Collaborative structure will provide the vehicle to enable further workforce transformation and address the requirements set out in the Health and Social Care Prospectus, the GM Unified Model of Public Services and the NHS Long Term Plan and Interim People Plan

- We continue to implement programmes to **address areas of greatest workforce shortage**. This includes working together across system partners to support workforce transformation in: primary care, social care, mental health services, acute services as well as development and innovation in hard to fill professions such as nursing, medical and AHP (Allied Health Professional) workforce. These will be supported by overarching workstreams that support: **talent management, leadership development, apprenticeships and education transformation**.

- The Strategic Planning Tool submissions highlight for trusts and primary care a small projected growth of the workforce over the next five years (3.4%). Consequently, to support workforce development and transformation required to achieve our vision, **optimising new ways of working, new roles and innovation will be crucial.**

- **Realistic and integrated workforce planning** will be essential to enable continued understanding of the workforce over time. We are developing tools to support workforce planning across the health and social care system at organisational, locality and GM levels. Use and embedding of these tools will be supported by facilitated networks of peer support that will share and spread best practice in workforce planning. Building up the picture of current and planned future workforce locally and across GM will **ensure locality and GM plans meet demand and are informed and underpinned by real intelligence.**

- The **Guaranteed Employment Scheme** for nurses who complete their studies in Greater Manchester was recently announced with the practicalities for implementation of the scheme currently being finalised with organisations. Additionally, across GM the number of nurses finishing training **will increase over the next three financial years**. Adult Nursing in 2019/20 - 584 nurses are due to qualify rising by 34% to 784 in 2021/22. Mental Health Nurses increase from 135 to 173 in the same period.

- Local Education establishments are working in partnership with trusts to **increase the numbers of Physicians Associates** as a key part of future proofing GM's workforce. In line with the Interim NHS People Plan commitment to grow Physician Associate (PA) to over 2,800 by the end of 2020, GM trusts have committed to increase PAs by 107%; the largest increase for any area in the North. In addition, we will put in place two physician associate preceptorship programmes in primary care, using NHSE funding that we successfully bid for.

- We will put in place a **collective approach to leadership and talent across public services** that supports system and place-based working, through providing consistent underpinning principles for GM and locality leadership programmes and targeted talent initiatives

- In 2018 all public sector employers in Greater Manchester made the historic commitment to **working together to tackle race inequality in the workplace**. Our commitment will be

measured against three key outcomes: BME applicants will be just as likely to be appointed from shortlisting as white applicants within three years; to close the gap in the disproportionate rate of disciplinary action between BME and white staff, such that there will be no difference in the likelihood of BME and white staff entering the formal disciplinary process within 3 years; that we will see a 10% minimum (15% stretch) shift in BME representation into more senior grades in organisations – taking into account an organisation's starting position.

- We will **continue the development of our 'Employment Offer'**: our unique selling point, which sets the region apart. This approach seeks to promote Greater Manchester as an attractive place to work in order to recruit and retain our workforce.

- We are launching a new, **integrated health and care careers hub.** The new service will build on the current NHS careers hub to include social care and primary care in its offers and will be hosted by Manchester University NHS Foundation Trust. The service will include engagement sessions with schools, colleges and other target groups supported by a network of ambassadors, as well as launching a new health and care careers website for Greater Manchester.

Sustainable Development

- We recognise that climate change and wider environmental degradation are unprecedented threats to the health and wellbeing of our population. Health and social care organisations **have a crucial role to play in sustainable development** across Greater Manchester.

- By embedding sustainable development principles in every aspect of our services and programmes, we can also **secure the public health gains** that come from benefits such as cleaner air, cleaner water, more active people, healthier eating, reduced inequalities and resilient economies.

- On **Carbon Reduction, we will seek annual reductions** of approximately 10% per year within our Partnership. **On Air Quality, we will cut our air pollutant emissions** from business mileage and fleet by 20%. We will also set out proposals to incentivise health and care staff to use public transport and improve opportunities to walk and cycle for patients and staff at NHS sites in Greater Manchester.

UNLOCKING ECONOMIC POTENTIAL

Innovation (including Digitally-Enabled Care)

- Greater Manchester will discover, develop and deploy new solutions that will lead to transformed service models and improved outcomes. **Health Innovation Manchester** is positioned at the heart of this with a role to strengthen and confirm Greater Manchester as the place to conduct world-leading research, foster partnerships and deliver innovation for the benefit of our citizens.

- Working with Health Innovation Manchester, we will establish a set of performance indicators that deliver value for city-region partners and citizens. This will include **developing up to 10 key innovations that are ready for deployment at scale across all 10 localities**. The pipeline will pull innovations through from discovery to develop up to 20 value propositions to feed the pipeline in subsequent years.

- We will continue to build a **close partnership with industry – ranging from global life sciences and technology companies, through to SMEs**. This work will be underpinned by GM's strategic agreement with the Association of the British Pharmaceutical Industry (ABPI) and Association of British HealthTech Industries (ABHI).

- The Health and Social Care Partnership, working closely with Health Innovation Manchester, will play a significant role in the **implementation of the GM Local Industrial Strategy** (LIS). This includes an '**Innovation Partnership' on healthy ageing**

- We will continue to use our devolved health and social care arrangements, excellence in **health research and thriving life sciences and digital industries** to act as a test-bed for large scale clinical and medical technology trials and accelerate the pace of application of new technologies to manage and treat diseases – including through our work on genomics.

- The Health and Social Care Partnership is playing a full role in **digital transformation in Greater Manchester** by upgrading our offer of an integrated digital care record system and supporting with the development of digital strategies across the 10 localities. Our plans will be drawn together in an updated Digital Strategy.

- We will **build on our participation in the Local Health and Care Records Exemplar programme** (LHCRE) to integrate digital care record system across GM using the Graphnet platform. All localities are already committed to this platform and integration is underway with every secondary care provider.

- **Graphnet should be available integrated into all organisational (Electronic Patient Records) EPRs with single sign on by end of 2019/20**. The LCHRE programme will be implemented in four localities for Dementia and Frailty use cases by September 2020.

- In support of the GM Elective Care programme, we will work with referral management providers to **deliver electronic referral mechanisms** from primary dental and primary optical services which will integrate with the NHS e-referral arrangements. As part of this, discharge letters will be electronically provided by to referring dental providers.

- All GM localities have **committed to the roll out of online consultations** by March 2020. The localities will be procuring and implementing their solution during the remainder of 2019/20.

WORK PROGRAMME
FOR GREATER MANCHESTER JOINT HEALTH SCRUTINY

The table below sets out the Greater Manchester Joint Health Scrutiny's work programme for the full meeting for Members to develop, review, and agree. This is a 'live' document and will be reviewed and, if necessary, updated at each meeting to ensure that the Committee's work programme remains current.

For information items taken previously to Greater Manchester Joint Health Scrutiny in 2018/19 are listed over the page:

MEETING DATE	TOPIC	CONTACT OFFICER	REASON FOR SUBMISSION TO SCRUTINY COMMITTEE
13th November 2019	Implementation of NHS Long Term Plan in the context of the GM approach to public service reform	Warren Heppolette	To Provide an update on the 'GM Delivery Plan 2020-24' – GM's implementation guide for the Prospectus (2019) and the NHS Long Term Plan.
	Improving Specialist Care Programme	Jackie Bene and Anthony Hassall	To provide feedback to the Committee on recommendations from the GM Joint Commissioning Board (JCB) on pre consultation site configuration business case options.
15th January 2020	Investment in Homeless Healthcare and 'A Bed Every Night'	Rob Bellingham/Helen Simpson/ Ruth Bromley	
	Primary Care Update	Tracey Vell	
11th March 2020	Digital Transformation Update	Stephen Dobson	
10th July 2019	Improving Specialist Care Programme	Jackie Bene Anthony Hassall, ISCP Team	To provide an overview of the Improving Specialist Care Programme
11th September 2019	GM Mental Health in Education (MHiE) Programme	Warren Heppolette (GMHSCP)	To provide an overview of the mental health in education (MHiE) programme that is currently being delivered across Greater Manchester, including providing details of each of the initiatives.
	NWAS Performance across GM	Daren Mochrie/ Michael Forrest (NWAS)	To update the committee on the performance of North West Ambulance Service (NWAS) across Greater Manchester (GM).

Items considered in 2018-19 by the Committee

13.03.19	• Digital Strategy • GM Drug and Alcohol Strategy
16.01.19	• Working with the VCSE • Primary Care Reform Update
14.11.18	• Standardising Acute and Specialised Care – Neuro Rehabilitation Services • Lord Carter's Review into Unwarranted Variation In NHS Ambulance Trusts
12.09.18	• Automated External Defibrillator (AED) Provision across Greater Manchester • Local Care Organisation (LCO) Development across Greater Manchester
11.07.18	• Greater Manchester Health and Social Care Partnership Delivery Plans For In 2017-18 and Plans For 2018-19