AGENDA

1. WELCOME AND INTRODUCTIONS

2. MINUTES AND MATTERS ARISING (attached)
   To consider the approval of the minutes of the meeting held on 30th October 2015

3. HEALTH AND SOCIAL CARE - CHIEF OFFICERS UPDATE (attached)
   Report of Ian Williamson

4. STRATEGIC PLAN
   Reports of Katy Calvin-Thomas and Warren Heppolite
   a. Update (attached)
   b. Draft Strategic Plan (to follow)
   c. Communication and Engagement: Taking Charge (to follow)
5. **GOVERNANCE**  
Reports of Liz Treacy  

a. Revised Governance Arrangements (to follow)  
b. Transparency (attached)  
c. Proposed Health and Social Care Team structure (attached)  

6. **PRIMARY CARE DEVELOPMENT UPDATE**  
Reports of Rob Bellingham  

a. Delivering Effective Primary Care Engagement (attached)  
b. Delivering Primary Care at Scale (attached)  

7. **SPECIALISED SERVICES COMMISSIONING**  
(to follow)  
Report of Leila Williams  

8. **PROGRAMME OF FUTURE MEETINGS**  

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11/15 WELCOME AND INTRODUCTION

Councillor Peter Smith welcomed all present to the meeting of the Strategic Partnership Board, formerly the Health and Social Care Standing Conference.

The Board agreed that they should meet on the last Friday of the month, to ensure momentum and pace of the GM Health and Social Care Devolution plans.

RESOLVED/ –

To agree the Strategic Partnership Board should meet on the last Friday of the month at same venue as the GMCA. Dates to be circulated from now until March 2016.

12/15 MINUTES OF THE MEETING HELD 10 SEPTEMBER 2015

The minutes from the meeting held on 10 September 2015 were submitted for consideration.

RESOLVED/ –

To approve the minutes of the meeting 10 September 2015 as a correct record.

13/15 CHIEF OFFICER UPDATE

Ian Williamson, Chief Officer for the GM Health and Social Care Devolution Programme updated the Board on the progress to date. Greater Manchester makes up c5% of the UK NHS system and 98% of the services residents uses are also in Greater Manchester. The opportunity for transformation at a GM level is a unique opportunity to make big changes at scale to ensure that residents have the best health service available.

We are now seven months into the build-up year, and have been focussing on a number of early wins including seven day access to primary care, improved access to early interventions and the launch of Health Innovation Manchester.

The Board asked for assurance that transformation initiatives for Primary Care will be integrated with the wider GM Strategic Plan. They were assured that Primary Care forms an integral part of the transformation initiatives.

RESOLVED/ –

To note the update.

14/15 STRATEGIC PLAN UPDATE

The production of Strategic Plan remains a priority.
Board members requested that the Strategic Plan included measures to address changing public behaviours and expectations a focus on preventative approach through public health and promoting cultural change within organisations.

The Board were asked to ensure their organisations were working at pace to develop their Locality Plans, and were supporting the production of the Strategic Plan. The Board were also asked to, where possible, be mindful and supportive of the risk of slippage.

Board members asked that there be more opportunities for them to engage with work of the Programme. It was agreed that Strategic Partnership Board members be invited to an informal session which will offer another opportunity for a more detailed review of some of the potential key areas for the Strategic Plan.

The Board also asked for briefing materials to be made available to assist them in disseminating information across their organisation.

**RESOLVED/ –**

1. To note the report.
2. To agree that an informal session for Strategic Partnership Board members be organised.
3. To agree to that a tool-kit for Senior Leaders be developed in order to support the dissemination of information across their organisations.

**15/15 TRANSFORMATION INITIATIVES – NEXT STEPS**

Warren Heppolette, Strategic Director, Health and Social Care Reform, updated the Board on the process undertaken to receive and evaluate Expressions of Interest and the next steps to develop selected themes to Strategic Outline Cases.

The emerging transformation themes include: –

- Radical upgrade in population health prevention
- Standardising community care
- Standardising acute hospital care
- Standardising clinical support and back office services
- Enabling better care (enabler across the workstreams)

These themes now need to be reviewed against the context of the Strategic Plan resulting in a new model of care which brings together all the elements of the theme.

The next steps will include: –

- Strategic outline cases for potential transformational initiatives by early November.
- First draft Strategic Plan by 23 November.
- Presentation of strategic outline cases and draft strategic plan to Strategic Partnership Board on 27 November.
The Board highlighted further considerations for the development of the transformation initiatives including the option to complete certain projects at a cluster level or at a GM level, the categorisation of short-medium-long term projects, and the importance of aligning in the initiatives was noted.

The Board recognised that changes of such significance would need a strong change management plan to enable the vision to be shared cross-organisationally. Significant work would also be required to ensure that all levels of colleagues were engaged with the process.

Members of the Board requested that clinical representation formed part of the evaluation process for the transformation initiatives, especially for primary and secondary care.

The Board recognised ICT as a key enabler for this work. It was confirmed that there is already an ICT enabler group in place that would welcome other interested parties.

RESOLVED/ –

1. To note the report.
2. To agree the supplementary slides be circulated to members of the Strategic Partnership Board.
3. To agree the primary and secondary care representation on evaluation stakeholders be reviewed and circulate as necessary.
4. To agree that any members of the Board wishing to engage with the ICT workstream be requested to contact with the Project Management Office direct.

16/15 GOVERNANCE UPDATE

Liz Treacy updated the Board on the progress made towards establishing the governance and accountability framework.

There is a planned focus session for a smaller group of all stakeholders to look closer at the decision making framework and scheme of delegation which will report back through the Strategic Partnership Board Executive.

The Board was keen to ensure all other governance arrangements are aligned with the GM framework. Primary Care governance is being developed, including a process for engaging with all four professions through a workshop and the 5th Primary Care Summit.

The Board discussed the opportunity for political involvement throughout the governance structure, and a broader representation on the Strategic Partnership Board, confirming that there is political representation on the Strategic Partnership Board Executive and representation would be broader than the 37 GM organisations.

Conflict resolution also needs to be considered to ensure that there is a mechanism built into the governance framework should there be a breakdown in agreement between organisations.

RESOLVED/ –
1. To agree that a paper on Primary Care governance be submitted to the next meeting of the Strategic Partnership Board Executive.

2. To agree the governance working group be requested to consider the opportunities for broader representation within governance structures.

3. To agree draft Terms of Reference be submitted to the Strategic Partnership Board and Executive for sign off.

17/15 TRANSFORMING POPULATION HEALTH

Wendy Meredith, GM Director of Population Health Transformation, presented a report describing the progress to date in developing a unified public health system, and to align the work with Greater Manchester Strategy objectives of reform and growth.

The Memorandum of Understanding signed in July 2015 was a catalyst for developing capacity at a Greater Manchester level. The Prevention and Early Intervention Board will help to drive forward the agenda and ensure that Population Health is fully integrated across the wider GM Health Devolution arrangements.

The Board discussed the need for the Population Health priorities to link closely to the transformation initiatives as they will both be significant contributors to the social movement for change.

RESOLVED/ –

To note the report.

18/15 PROGRAMME OF MEETINGS

RESOLVED/ –

To agree that future meetings of the Strategic Partnership Board be arranged to meet on the same day as the GMCA in locations across GM as follows:-

- Friday 27 November – Trafford Town Hall
- Friday 18 December – Manchester Town Hall
- Friday 29 January – Dukinfield Town Hall, Tameside
- Friday 26 February – Oldham Civic Centre, Oldham
- Friday 18 March – Rochdale Council Offices, Rochdale
Greater Manchester Health and Social Care Devolution
Chief Officer Highlight Report – November 2015
Health and Social Care Devolution Chief Officer Highlight Report

Date: 20 November 2015

Subject: Health and Social Care Devolution Chief Officer Highlight Report
Report of: Ian Williamson – Chief Officer, GM Health and Social Care Devolution Programme

PURPOSE OF REPORT
The purpose of this report is to provide a high level overview of the GM Health and Social Care Devolution Programme including a summary of the key work streams, progress to date and upcoming milestones.

RECOMMENDATIONS:
The shadow GM Health and Social Care Strategic Partnership Board are invited to:
Note the update and record the progress made.

CONTACT OFFICERS:
Ian Williamson
ian.williamson3@nhs.net
The GM plan contains the following chapters:
- Strategic Plan
- Locality and Sector Plans
- GM Transformation Proposals and Financial Plan and Enablers

It is recognised that a large proportion of the other programme areas will feed into the Strategic Plan at the appropriate point, highlighted to the right.

### Programme Approach – Key Work Streams and Packages

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# Programme approach - Decision Making Timescales

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**Key**
- Internal deadlines
- Critical milestones

**Critical milestones**
- GM business case for CSU services
- End Aug: CSR submission to Treasury
- End Oct: Updated locality plans
- Mid Dec: Strategic Plan

**Further development**
- Review draft Strategic Plan
- Shadow operation of devolution arrangements
- Shadow governance Oct 15 – Mar 16

**Early Implementation Priorities**
- 7 Day Access
- Public Health MOU – 10th LD Fast
- AHSS – 2nd Track 7th
- 13th Nov: Dementia
- End Nov: Mental Health And Work

**CAMHS – to be confirmed**
- #Takingcharge
- Listening period for Strategic Plan
### Summary

- The programme is currently focused on the production of the GM Strategic Plan by mid-December. This will follow the spending review settlement.
- Locality Plans are currently going through Local Health and Wellbeing Boards for sign off.
- Work is ongoing to refine how the five key transformation initiative themes will contribute to the overarching Strategic Plan and financial models.
- A ‘focus session’ was held on the 19th November to work up a set of detailed proposals around the decision making framework and scheme of delegation for the Strategic Partnership Board (SPB), Strategic Partnership Board Executive (SPBE) and Joint Commissioning Board (GMJCB).
- A proposed structure for the health and social care team post-April 2016 has been proposed.
- #Takingcharge communications and engagement campaign to prepare ground for Strategic Plan and engage with people beyond that has commenced. This includes an open letter to public and a devolution family animation.
- Large amount of national media interest around health and social care devolution, including newspaper and television interviews and coverage, including around the dementia and learning disabilities early implementation priorities.
- Several representatives from GM have given evidence to the Department of Communities Local Government Select Committee running an inquiry into Devolution.
- A senior level launch meeting on Estates has been held, and a full work programme is underway, to be reported on shortly.
- Dr Chris Brookes and Dr Tracey Vell have been appointed as temporary as Medical Advisors to the Programme.
Workstream 1 – The Strategic Plan
Devolution Management Team Lead : Katy Calvin-Thomas
Date: 20 November 2015

Headlines

• **Strategic Plan** - The draft of the GM strategic plan narrative is built from detail within the 10 locality plans, work across and within the provider sector and work already taking place or emerging across GM. It is expected that the first draft will be available by the end of November.

• **Strategic Financial Plan** - The financial analysis underpinning the GM strategic plan and the 10 locality plans is currently underway and will be completed for inclusion in the first draft. The locality plans have identified plans to address more than 50% of their share of the financial challenge and work is underway with the localities to understand where the locality ambitions could be stretched to close the financial gap further. This will be supplemented by work with the GM work streams and transformation initiatives to understand the impact on population outcomes and the financial gap across GM.

• **Transformation Initiatives** - Following the work on the Transformation Prospectus, which involved submission of over 45 ideas from across health and social care in GM, five transformation themes (1 Radical Upgrade in Population Health Prevention; 2 Standardising Care in Localities; 3 Standardising Acute Hospital Care; 4 Standardising Clinical Support and Back Officer Services; 5 Enabling Better Care) have been agreed across the GM system to take forward on an accelerated path. Work is ongoing to refine what these areas aim to achieve, how they will do this and their contribution to the overarching Strategic Plan.

• **Locality plans** - Localities are currently taking the next iteration of their place-based plans through Local Health and Wellbeing Boards for formal sign off through November and into early December.

• Following confirmation of the outcome of the Comprehensive Spending Review in the Autumn Statement, there will be further work to align the GM strategic plan and locality plan ambition and assumptions. The final draft plan will be considered by key GM leadership meetings in December for approval.

• Following the publication of the national planning guidance, there will need to be an alignment of the locality and GM plans to the requirements of this guidance and the impact of the confirmation of planning assumptions and allocations.

• The period January-March will be used as a listening exercise to consult with the public and staff about the GM plan.

Key Milestones

| November 2015 | Late November 2015 – First draft of the GM Strategic Plan  
End of November 2015 – Final draft locality plans produced |
|--------------|--------------------------------------------------------------------------------------------------|
| December 2015 | 4 December – Final draft Strategic Plan  
16 December - consideration of the final draft Strategic Plan by Health and Social Care Devolution Programme Board  
18 December - consideration of the final draft Strategic Plan by Health and Social Care Partnership Board |
**Workstream 2 - Establishing Leadership, Governance & Accountability**

Devolution Management Team Lead: Liz Treacy Date: 20 November 2015

### Headlines

- An outline set of proposals around the decision making framework and scheme of delegation for the Strategic Partnership Board (SPB), Strategic Partnership Board Executive (SPBE) and Joint Commissioning Board (GMJC B) were discussed at a 'focus session' which included system wide representation on the 19th November. A more detailed proposal based on that discussion will now be developed and taken back through the agreed approval process including the SPB, SPBE Executive, and individual stakeholder governance structures.
- As agreed by the SPB in September GMCVO will be the VCS representative at the SPB from November. This is an interim measure and further work will be undertaken to ensure that GM is able to ensure that the VCS are appropriately engaged within the new governance structures.
- In November the SPBE agreed that patient voice representation in the GM governance structures would come via HealthWatch, who have nominated Jack Firth as their GM representative. Further work, led by HW, will now develop to ensure that the patient voice is appropriately represented.
- Monitor have established a team to work with the GM H&SC Devolution Team to progress the road map. A conversation with both legal teams has been initiated to underpin development of the more formal proposal by January 2016. Similarly there is significant consensus between GM and CQC on key issues and next steps with an agreement to develop an MoU or similar by early 2016.
- A Memorandum of Understanding with Health Education England continues to be progressed in order to develop a co-commissioning approach to education, training and commissioning of health (and ultimately) social care staff in GM. Following extensive discussion and engagement with the wider system, a final document will be available in December/January for formal consideration by the Strategic Partnership Board Executive, and subsequent ratification at the Strategic Partnership Board.
- Work continues to progress with NICE, following national commitment to enter into an MoU. GM NHS Trust Providers and Directors of Adult Social Services are to be engaged to develop a first draft of the document.
- Significant work has been undertaken with Primary Care stakeholders and a clear framework for engagement has been developed.
- GM NHS Trusts Providers continue to develop their federated governance arrangements.

### Key Milestones

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Following the locality stock take day, locality plans were submitted at the end of October as planned.

PwC modelling has commenced using the activity and financial impact of the opportunities identified in the plans. First cut of the quantification of these locality savings indicates that 57% of the target of £400m has been identified by ‘locality owned’ opportunities.

Current work includes review and verification of the data contained in plans and challenge of the range and level of ambition of the opportunities to ensure all areas identified within the Strategic Financial Framework have been considered and that further opportunities where identified and applicable are replicated over the GM area.

A further ‘follow up locality stock take’ was held with localities on the 17th and 18th November to facilitate effective and efficient feedback, review and challenge.

The GM finance team have been working with GM work streams and enablers to provide financial support where needed to ensure that these projects contain financial analysis of the level of investment/savings.

The provider group has identified 7 pan-Manchester opportunity programs, each with a lead Director of Finance. A scoping exercising is being undertaken based on initial work which will feed into the strategic plan followed by the development of a full project initiation document (PID) which will require in some cases external support.

The transformation initiatives are being worked up into a Strategic Outline Case which will then be included in the modelling to increase the level of identified opportunities.

The 5th Primary Care Summit took place on 4th November 2015 and was attended by c300 delegates from across health and care. The event provided the opportunity for delegates to consider new models of primary care including the wider primary care workforce with keynote speech delivered by Ravi Sharma, a Practice Pharmacist. Feedback from the event will inform the refresh of the Primary Care Strategy due end of January 2016.

To support delivery of our vision for Primary Care to be at the heart of an integrated out of hospital care system, we are working with commissioners, primary care providers and other providers of community based care, to identify areas wishing to run such a system in shadow mode in 2016/17. This process will potentially provide us with an opportunity to pilot aspects of the emerging national contract, thus testing many of the concepts and opportunities described in the emerging locality plans and the GM Strategic Plan.

Discussions continue at a regional and national level with NHS England and Public Health England to consider the devolution of budgets and authority for services within the scope of section 7a.

Enabling work streams including IM&T, capital and estates and contracting and procurement continue. This work is aligned where applicable to provider work and the expressions of interest received re the transformation initiatives.

The separately commissioned estates work commenced with a senior level launch meeting. Work is underway to collate estates data in one single database with analysis and a strategy on target for delivery by early December.

A cancer summit was held in November, in anticipation of GM taking responsibility for specialised commissioning.

### Key Milestones

| November 2015 | 25th November 2015 – CSR announcement |
# Workstream 4 – Partnerships, Engagement and Communications

Devolution Management Team Lead: Warren Heppolette Date: 20 November 2015

## Over the last month:

### Communications and Engagement:
- Significant National and Regional Media interest in national Learning Disabilities announcement including closure of Calderstones. GM H&SC Devolution Communications Team worked with colleagues at NHS England to manage the substantial interest including preparing a GM press release to promote new three year vision for GM. This was followed up by a conference and widespread social media.
- Partnership work between a number of GM and national agencies to announce our collective visions for improvements to GM dementia care. This was launched at the Haelo conference in Salford on 13th November.
- Filmed and launched a video to promote H&SC Devolution. Interviews with Lord Peter Smith, Ann Barnes, Dr Ranjit Gill and Ian Williamson. Much positive feedback and interest on social media, also been used to brief CCG and PPAG members.
- Briefing note to all Strategic Partnership Board members for wide dissemination to councillors, MPs and others.
- Significant presence at local, regional and national conferences includes Northern Powerhouse Summit in Manchester and Ian Williamson at Local Government and Communities Select Committee on Cities and Devolution Bill.
- Finalising development of GM Reference group with Healthwatch and the third sector to take a lead on engaging with the sector. In the process of setting up a VCS Assembly for GM; a steering group is in place.
- The February MOU partnership work was shortlisted for a HSJ award (in partnership category) announcement at event on 18th November.
- Plans approved by Programme Board and Partnership Executive for #Takingcharge communications and engagement campaign to prepare ground for Strategic Plan and engage with people beyond that. This includes an open letter to public and a devolution family animation.
- We are progressing relationships with both GM Healthwatch and GMCVO to utilise their expertise and networks as part of our public engagement approach in the new year.

### OD and Leadership Development:
- The 3rd workshop for GM system leaders was held on 22nd November; good support for the framework and further opportunity to refine the expectations of a GM leader.
- An engagement event with providers of leadership development was held on 12th November. This has further informed thinking and design of the framework.
- A specification is in early stages of development to seek expressions of interest from leadership providers.
- The GM GradFest was held on 20th November which is a festival of learning for graduate trainees following their exchange week (a GM opportunity for graduates to experience a week in a different sector of public services).

### Social movement:
- Good progress on developing social movement and New Society Hub. Exploring options for linking social movement with the dementia work.

## Key Milestones

<table>
<thead>
<tr>
<th>November 2015</th>
<th>Week beginning 23 November – CSR announcement due</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2015</td>
<td>CAMHS announcement</td>
</tr>
<tr>
<td></td>
<td>Strategic Plan ‘launch’</td>
</tr>
</tbody>
</table>
### Workstream 5 – Early Implementation Priorities

Devolution Management Team Lead: Leila Williams  
Date: 20 November 2015

**Headlines**

- **7 Day Access to Primary Care** – CCGs continue to mobilise their delivery plans for 7 day access to primary care by the end of December. Current plans suggest 43 hubs operational, including PMCF sites by the end of December with 8 further hubs operational early 16/17. CCG CFOs have been undertaking a piece of work with regard to recurrent funding requirements and performing due diligence. Continued shared learning and progress updates are being co-ordinated centrally with CCG leads.

- **Public Health England Place Based Agreement** – MoU with Public Health England and NHS England signed on 10th July at the first meeting of the GM Public Health Prevention and Early Implementation Board. Work is underway to implement the five work streams described in the MOU. Wendy Meredith has been appointed as Director of Population Health Transformation to oversee this work.

- **Healthier Together** – Committee in Common has made the decision regarding the geography of the four shared single services.

- **Academic Health Science System** – Work continues with the working groups to define the business case for Health Innovation Manchester plans. Steering committee reviews are scheduled for 26th November and 16th December.

- **Learning Disability Fast Track** – GM has launched the 3 year LD fast track plan to create high quality community based support for people with learning disabilities. This is supported by £3m of funding from NHSE through the national fast track programme.

- **Dementia** – Dementia United, a GM collaborative to improve dementia care in GM was launched at the Haelo conference on 13th November with significant amounts of positive press coverage. A first iteration of a dashboard for the five year dementia strategy has been developed. Discussions are on going to establish the governance of the 5 year programme and are on track to have this in place by March 2016. A business case is being worked up for a key worker programme which will be piloted in Salford from March 2016 before rolled out across GM.

- **Mental Health and Work** – Announcement on impacts on mental health improvement arising from the Working Well pilot and a new integrated delivery model for supporting unemployed residents with a mental health-related barrier to work are expected by the end November 2015.

- **Workforce policy alignment** – This project aims to deliver an agreement across providers to: adopt common standards for pre-employment checks; statutory and mandatory training; common rates for specific targeted locum and agency staff. This area is on track for the introduction of a workforce passport and standardised locum and agency rates for GM from April 2016.

- **CAMHS** – Work stream established and is led by Simon Barber. A CAMHS board has been established and meets monthly. Local CAMHS plans are being aligned to the wider GM work. A GM mental health and wellbeing workshop was held in early November with over 100 organisations present to discuss service transformation.

**Key Milestones**

| November – December 2015 | End November 2015 – Announcement of intended impact of Working Well pilot |
PURPOSE OF REPORT:

The paper updates the Strategic Partnership Board on all areas related to the Plan. This will be supported by a more detailed presentation on the day of the meeting.

RECOMMENDATIONS:

The Strategic Partnership Board Executive are asked to note the contents of the report.

CONTACT OFFICERS:
Katy Calvin-Thomas - katy.calvinthomas@nhs.net
Warren Heppolette - warrenheppolette@nhs.net
1. INTRODUCTION

1.1 The Strategic Plan and its underpinning Financial Plan are on course for first draft completion by 30th November 2015.

1.2 The paper updates the Strategic Partnership Board on all areas related to the Plan. This will be supported by a more detailed presentation on the day of the Board outlining the current structure and proposed contents of the plan.

1.3 The Strategic Plan update and transformation themes have been agreed by the Strategic Programme Board and Strategic Partnership Board Executive.

2. STRATEGIC PLAN REVIEW CYCLE

2.1 In order to deliver the Plan to the agreed timescale of December, the attached review cycle has been agreed with the Greater Manchester system and external stakeholders.

<table>
<thead>
<tr>
<th>Internal review / first pass</th>
<th>First draft</th>
<th>Final draft</th>
<th>Final version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed by: DMT 30/10, Update to: SPB 30.10, Programme Board 12.11</td>
<td>Reviewed by: DMT 01/12, SPB 07/12</td>
<td>Reviewed and signed off by: DMT 15/12, AGG 15/12, Programme Board 16/12, SPB 18/12, Provider Forum 18/12</td>
<td>Reviewed and signed off by: DMT, AGG, WLT, Provider Forum SPB Exec, Programme Board, SPB, organisational governance, OSCs</td>
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</tbody>
</table>

2.2 The management of the input to the plan is being held by a Programme Management Office which includes colleagues working on various elements of the plan (primary care, workforce, prevention) as well as the underpinning work from the finance team.
3. CURRENT POSITION (AS AT 20TH NOVEMBER 2015)

3.1 All actions agreed by 30th October 2015 were completed by the deadline. This included agreeing content for all of the Strategic Plan sections summarised below:

- Vision, goals, ambition
- Locality Plans x10
- Provider plans
- GM transformation themes
- Overarching GM work streams (prevention, social movement, mental health, etc)
- The enabling work streams (social estates, capital, workforce, contracting, procurement, payment systems, shared services)
- Overarching financial plan

3.2 We received written contributions from over 20 people working within the GM health and social care system drawn from across all localities and all parts of the system.

3.3 The team is on track to deliver a first draft of the Strategic Plan by the 30th November. This production the plan has been supported by the receipt of an outline Transformation Initiative business case.

3.4 The financial analysis underpinning the plan is currently underway and will be completed for inclusion in the first draft on 30th November 2015.

3.5 All Locality Plans were resubmitted by the 30th October deadline and the locality based activity and financial modelling tool was completed by all health economies. Work is now underway to ensure that these align with the GM elements of the plan, and an update on the locality plans will be provided at the Programme Board meeting.

3.6 Following the work on the Transformation Prospectus, which involved submission of over 45 ideas from across health and social care in GM, five transformation themes have been agreed with the system to take forward on an accelerated path. These are shown below:
3.7 Work is ongoing to refine how these areas will contribute to the overarching Strategic Plan, which will be fed into the Financial Plan in terms of their overall contribution to reducing the £2 billion gap. Significant process has also been made on how the system will need to change to achieve the scale of change alluded to in these themes.

4. **NEXT STEPS**

4.1 Work on the Strategic Plan will continue to deliver a first draft to the system by 30th November and remain on schedule for delivery in December 2015.

4.2 Briefings with the GM system will continue throughout this process and with all the national bodies such as NHSE, Monitor, TDA and NICE on the ambition and content of the plan.

5. **RECOMMENDATIONS**

5.1 The Strategic Partnership Board are asked to note the contents of the report.
Strategic Plan
Strategic Partnership Board Update
27th November 2015
Update on the strategic planning process
### Partnership Meetings – Strategic Plan
**November – December 2015**

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
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<tbody>
<tr>
<td>6 November</td>
<td>WLT/AGG √</td>
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<tr>
<td>9 November</td>
<td>Chief Executive Provider Discussion √</td>
</tr>
<tr>
<td>12 November</td>
<td>GM H&amp;SC Programme Board √</td>
</tr>
<tr>
<td>13 November</td>
<td>GM Strategic Partnership Executive √</td>
</tr>
<tr>
<td>17 November</td>
<td>WLT and AGG √</td>
</tr>
<tr>
<td>20 November</td>
<td>Provider Federation Chief Executives √</td>
</tr>
<tr>
<td>20 November</td>
<td>Strategic Plan Leadership Group √</td>
</tr>
<tr>
<td>23 November</td>
<td>Provider Federation Chairs √</td>
</tr>
<tr>
<td>25 November</td>
<td>CSR ANNOUNCEMENT √</td>
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<tr>
<td>27 November</td>
<td>GM Strategic Partnership Board</td>
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<tr>
<td>7 December</td>
<td>GM Strategic Partnership Executive</td>
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<tr>
<td>16 December</td>
<td>GM H&amp;SC Programme Board</td>
</tr>
<tr>
<td>18 December</td>
<td>GM Strategic Partnership Board</td>
</tr>
</tbody>
</table>
Comprehensive Spending Review
Key messages

(To be provided verbally)
The Strategic Plan will reflect the boldness of our leadership and the scale of our collaboration

The Greater Manchester (GM) ambition is to be a financially self-sustaining city region, sitting at the heart of the Northern Powerhouse, with the size, assets, skilled population and political and economic influence to rival any global city. The integration of health and social care provision across Greater Manchester is a fundamental component of that growth and reform strategy. Reform is not only essential to ensure that the Greater Manchester health and social care system can support Greater Manchester’s priority of reducing unemployment, supporting people back into employment and providing growth through innovation. It is a pre-requisite to addressing the fundamental challenge of ensuring that the health and social care system becomes financially sustainable over time.

Vision

Case for change

- Poor health outcomes and significant inequalities
- £2bn funding gap estimated by 2020/21
- Complex landscape of commissioners, providers, local authorities, third sector and voluntary organisations

Transformation

It is widely accepted that Greater Manchester will not meet the challenges it faces over the next five years through incremental change. Therefore Greater Manchester partners have agreed a need to take a more radical, transformational approach based on exploiting the opportunities arising from devolution.

Engagement with the system, alongside best practice from national and international experts has identified five key areas for transformational change, as indicated in the diagram on the next page. These are consistent with 5YFV and Lord Carter work.
It will describe the application of a radical new landscape of commissioning and provision towards a common purpose to maximise health benefit.
It will apply radical principles for Greater Manchester that will deliver on a set of outcomes

The transformational initiatives outlined in these four areas are not necessarily radical in and of themselves. However, the care model as envisaged does have three radical principles as described below. It is the scale of this standardisation and level of integration that will revolutionise the Greater Manchester system; and this is all possible in the context of devolution and Greater Manchester’s emerging and radical governance models.

i

An evidenced based and standardised approach to population health, prevention, and care models that are set at a Greater Manchester level; to reduce unwarranted variation and remove health inequalities.

ii

Local deployment of evidenced based care models that reflect the needs of local populations and empower local neighbourhoods to make improvements to health outcomes and demand reduction.

iii

Horizontal integration of services across acute care and specialist services; to enable standardised care pathways at scale; to reduce unwarranted variation and remove health inequalities.

**Outcomes**

- Improving the health and wellbeing of Greater Manchester’s residents
- Closing the health inequalities gap within Greater Manchester and with the UK
- Contributing to economic growth and prosperity within your communities
- Autonomy in allocating resource, leading to better outcomes
It will be clear how we will work together to ensure we deliver on our potential emerging model of care.

Emerging model of care:
- Radical Upgrade in Population Health Prevention
- Integrated Care in Localities
- Standardised Acute Hospital Care
- Single Specialist Clinical Services
- Consolidated Clinical Support and Back Office Services

Organisational delivery model:
- Relevant unit of planning / scale
- Pan GM, localities and neighbourhoods
- Localise and neighbourhoods
- Clusters
- Pan GM

New organisational form:
Models sit within a continuum of integration - from collaborative through contractual to full consolidation.
FROM APRIL 2016 WE WILL BEGIN TO IMPLEMENT:-

- GM Health & Social Care Transformation
- Place Based Commissioning
- Primary Care at Scale
- Shared Services
- Enabling
- Mental Health Implementation of our GM mental health strategy
Outline Structure of the Plan

Chapter 1 - Ambition for the Strategic Plan
- How health and social care fit into the broader devolution agenda (from SR submission) – pulling in PSR team
- Growth & reform leading to a place based, population health approach – co designed between health and social care
- MOU description, (include paragraph which covers clinical and final sustainability within 5 years) leading to a ‘comprehensive clinical and financial sustainability plan’

Chapter 2 - Work since the MOU
- Principles we have worked to – co design with the system/place focus/outcomes based
- Bringing the system together – Locality Plans, Provider federation
- Governance
- Early wins – published early wins and also early examples of working together i.e. mental health strategy, cancer

Chapter 3 - The transformation themes
- Radical upgrade in prevention & population health
- Integrated Community based care & support
- Integrated acute & specialist services
- Shared service and back office efficiencies
- Enabling for the new models of care

Chapter 4 - Financial Plan
- Outputs from the PWC work against the financial plan

Chapter 5 – Implementation/delivery
- Key areas of focus for Jan - March
- Stakeholders – co-design
- Public engagement
Key messages

• Greater Manchester’s leadership has confirmed its clear support for this direction of travel over recent weeks
• The transformations build upon and are consistent with the ambitions outlined in Locality Plans

Recommendations:

- The Strategic Partnership Board is asked to delegate the Strategic Partnership Board Executive to conclude a draft of the plan by Monday 7th December and present a further plan for the Board on Friday 18th December to support engagement with the public and stakeholders and for individual SPB member governance arrangements.

- The Executive is also asked to receive an outline report on implementation, alongside the Strategic Plan, for presentation to the GM Strategic Partnership Board on 18 December.
Date: 27th November 2015

Subject: Comms and Engagement Plan Dec-March 2016
Report to: Strategic Partnership Board

PURPOSE OF REPORT
To set out the plans to:

– Raise the profile of HSC and wider devolution and promote understanding, adopting Taking Charge as the brand identity for GM devolution: we are taking charge and the deal is we must also take responsibility
– Ensure the HSC strategic plan and locality plans – and their content - land as successfully as possible
– Prepare and provide insight for wider work post March, focused on developing new relationships between people and ‘services’, including significant behaviour change, which will draw in expertise from beyond GM and the public sector to encourage people to take charge and responsibility for their own health

The slides detail the aims, narrative, key messages, approach, creative concept and a summary of the activity

RECOMMENDATIONS:
The Strategic Partnership Board are asked to approve the recommendation of the Strategic Partnership Board Executive:

• To agree Taking Charge as the GM devolution brand identity
• To agree the approach and timings from December to March 2016
• To agree the communications and engagement approach to support the development of long term work to support people and local communities to take charge of – and responsibility for – their own health and other aspects of their lives

CONTACT OFFICERS:
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• Claire.norman@nhs.net
Aims

• To build awareness and recognition among the public and public sector staff that GM is taking charge by:
  – Painting a picture of the challenges today and the opportunity in the future, via examples of where we’re already taking charge and managing the handover of power at the level of individuals, communities, organisations and GM
  – Linking the work now to the many conversations and pieces of work which have already taken place and show this as the culmination of those

• To land the HSC locality and strategic plans safely within this context, taking the time to talk to and listen to people/communities/organisations about:
  – Their views on the LPs and SP
  – What would help them take charge/control of their own health/lives
  – What are the barriers to this happening
  – What’s their understanding of being an active citizen

• To pave the way for a new relationship between people and public services by gaining insight which will help the longer term work to support people and local communities to take charge of – and responsibility for – their own health and other aspects of their lives

• To prepare to galvanize GM’s people and organisations behind one simple set of aims/outcomes which all can contribute towards achieving
What’s our story?

• **Greater Manchester is taking charge** – in a historic first the power - and responsibility - is being handed over to the people here #takingcharge

• **We are doing this because** …..(narrative being shaped to link the HSC and wider reform narrative, drawing on all aspects of GM reform – focus on health, wealth and wellbeing)

• **Our goal** is to see the fastest and biggest improvement to the health, wealth and wellbeing of the 2.8m people of GM

• **Our vision is that we become a place where**……..we take charge and take responsibility to look after ourselves and each other. There’s a role in that for everyone from the individual to the family, the community, the voluntary sector and the public bodies to work together to find the answers

• **So that by 2021** we have delivered the following GM benefits/outcomes eg 6,000 (tbc) fewer people with cancer, improvement in school readiness, reduction in the number of looked after children, increase in employment etc
Key messages – taking charge of a challenge and an opportunity

• **GM is taking charge of the biggest handover of power** to the 2.8m people here which has ever been seen

• We want to see the **fastest and biggest improvement** to the health, wealth and wellbeing of the 2.8m people of GM

• **It’s a challenge** – we’re taking on responsibility for some of the biggest challenges around public health, wealth creation and wellbeing in the country, as well as public services which are not affordable as they are currently set up; this means there will have to be some changes and difficult decisions

• **It’s an opportunity** – we will have the freedom and flexibility to focus on our place and our people, using our new powers in GM to make our own decisions over some of the most important things in our lives. We have a good idea of what’s most important to you – these plans are the **culmination of years of conversations** across GM

• There’s much we can do quickly, but **it’s a long term deal** where we’ll need to take charge and responsibility for looking after ourselves and each other over many years

• There is **a role for everyone in taking charge and responsibility** – individuals, families, groups, communities, organisations, the government
## Illustrating the story

<table>
<thead>
<tr>
<th>Focus areas</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why is GM taking charge?</td>
<td><strong>Aim is to get buy in for the plans and begin to reset the relationship between the public and the ‘authorities’.</strong></td>
</tr>
<tr>
<td>Paint a picture of now – people, systems and money</td>
<td><strong>Communications and PR</strong></td>
</tr>
<tr>
<td>Illustrate the reality of 2025</td>
<td>Multi-channel multi-level #takingcharge campaign working underneath the narrative led by the key facts/stats/outcomes</td>
</tr>
<tr>
<td>if we don’t do this</td>
<td>Pledge based at different levels: #Imtakingcharge / #we’retakingcharge / #oldhamtakingcharge / I want gm ‘takingcharge so.....’</td>
</tr>
<tr>
<td>What could 2025 look like if we do do this</td>
<td>Supported by video and animated content showing the challenge and the opportunity. Case studies to illustrate what’s already happening – individual ‘health heroes’, families, communities, orgs etc focussing on prevention, integration, quality and efficiency (reducing variation), to include wider public sector case studies</td>
</tr>
<tr>
<td>What is the ask of people?</td>
<td><strong>Engagement and involvement</strong></td>
</tr>
<tr>
<td>Understand and accept the challenge and opportunity</td>
<td>To engage with and listen to our staff and the public with a two pronged approach:</td>
</tr>
<tr>
<td>Work with us to achieve the vision: what would help you take charge – design some opportunities to become an active GM citizen</td>
<td>1. Discussing the LPs and draft SP and feeding them in to the final version in March</td>
</tr>
<tr>
<td>Take the opportunities on offer to be an active GM citizen</td>
<td>2. Listening to views on ‘what would help you take charge of your health’ to gaining insight which will help the longer term work to support people and local communities to take charge of – and responsibility for – their own health and other aspects of their lives</td>
</tr>
</tbody>
</table>

**Examples of what can be done when we take charge and responsibility**

- What are we already doing?
  - Case studies at all levels

**Engagement and involvement**

- What is the ask of people?
  - Understand and accept the challenge and opportunity
  - Work with us to achieve the vision: what would help you take charge – design some opportunities to become an active GM citizen
  - Take the opportunities on offer to be an active GM citizen
Example 1

6,000 less people need telling they have cancer

#takingcharge of our health and social care in GM
Example 2 – to note further discussion required about using alongside place based brands
Post March 2016

- Post March planning will take place in the New Year, developed through the Partnership Board Executive and PSR structures

- The work is likely to focus on:
  - The creation of a joint comms and engagement strategic approach
  - Further developing and implementing the Taking Charge devolution brand identity
  - Aligning comms and engagement with the joint GM outcomes
  - Developing the new relationships between people and ‘services’, including significant behaviour change – and drawing on national and international external expertise and creative support to make this happen
PURPOSE OF REPORT:
This paper builds upon the governance principles that were agreed by Greater Manchester in September 2015 and sets out proposals and recommendations from the governance focus session held with representatives of all stakeholders on 17th November. In particular it sets out a role for primary care providers in the governance structure, it confirms the process for agreement of the Strategic Plan and it sets out progress on GM wide joint commissioning arrangements.

RECOMMENDATIONS:
The Strategic Partnership Board are asked to consider and agree the recommendations set out with section 16 of this report.

CONTACT OFFICERS:
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l.treacy@manchester.gov.uk
1. INTRODUCTION

1.1 Across Greater Manchester, we are working together to reform health and social care services. To support Greater Manchester achieve its ambition of improving health outcomes for its residents as quickly as is possible, robust and inclusive governance structures need to be developed and put in place.

1.2 This paper builds upon the governance principles that were agreed by Greater Manchester in September 2015 and sets out proposals and recommendations from the governance focus session held with representatives of all stakeholders on 17th November. In particular it sets out a role for primary care providers in the governance structure, it confirms the process for agreement of the Strategic Plan and it sets out progress on GM wide joint commissioning arrangements.

1.3 The principles that were agreed in September 2015 were set within the context of the MoU signed in February. This update is provided within the context of those principles:

- GM NHS will remain within the NHS and subject to the NHS Constitution and Mandate;
- Clinical Commissioning Groups and local authorities will retain their statutory functions and their existing accountabilities for current funding flows;
- Clear agreements will be in place between CCGs and local authorities to underpin the governance arrangements;
- GM commissioners, providers, patients and public will shape the future of GM health and social care together;
- All decisions about GM health and social care to be taken with GM as soon as possible;
- Accountability for resources currently directly held by NHS England during 2015/16 will be as now, but with joint decision making with NHSE in relevant areas to reflect the principle of “all decisions about GM will be taken with GM.

2. FUNCTIONS OF STRATEGIC PARTNERSHIP BOARD (SPB)

2.1 GM has agreed that the SPB will be responsible for setting the overarching strategic vision for the Greater Manchester Health and Social Care economy.

2.2 As it is not a legal body, its decisions are not binding decisions of its members, but it will make recommendations for its members to formally adopt following their own governance procedures.
2.3 Its primary responsibilities were set out in the report of 25th September and include:

- To set the framework within which the Strategic Partnership Executive will operate.
- To agree the GM Health and Social Care Strategic priorities in accordance with the NHS five year forward view.
- To endorse the content of the GM Strategic Plan for financial and clinical sustainability.
- To agree the criteria that determine access to the Transformation fund.
- To ensure that there remains ongoing and significant organisational commitment across the GM health economy to both the devolution agenda and a devolved health system.
- To agree an assurance framework, developed jointly with regulators where required, that reflects the outcomes required by Greater Manchester.
- To provide leadership across the GM health economy to ensure that the key strategic priorities for a GM health system are achieved.

3. **SPB MEMBERSHIP AND VOTING**

3.1 As previously agreed the membership of the Board will include:

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

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

3.3 In shadow form, the voluntary and community sector will be represented by GMCVO. This is an interim solution which recognises further work will be undertaken to ensure that Greater Manchester is able to appropriately engage the VCS within the new governance structures; across both the Strategic Partnership Board and as part of the Provider Forum.

3.4 In shadow form patient voice representation in the governance structures will be through an agreed Greater Manchester Healthwatch representative. Further work is being developed to ensure that the
patient voice is appropriately represented within the new governance structures, and as part of the public’s engagement on the Strategic Plan.

3.5 There is a report elsewhere on this agenda recommending that primary care providers have four representatives on the SPB, one for each of the principal disciplines: General Dental Practice; General Medical Practice; Optometry; and, Pharmacy. This is reliant on primary care providers developing governance structures that will support representation in this way.

3.6 It is proposed that a Greater Manchester Health and Social Care Workforce Engagement Forum is developed as a joint Greater Manchester wide forum for employers and trade unions to discuss at City Region level matters arising from the planning and implementation of devolution in health and social care across Greater Manchester.

3.7 Over the coming weeks discussions with Trade Union Representatives and Employers will take place to identify the role and remit of such a Greater Manchester Health and Social Care Workforce Engagement Forum. The forum would seek to ensure that the principles of meaningful partnership working operate effectively throughout Greater Manchester and will promote good practice in all areas of staff engagement, development and management.

3.8 The SPB will be supported by an SPB Executive. The SPB Executive will have membership that is representative of the key stakeholder groups, and will work within a framework that is set by the SPB. The form and function of the SPB Executive was agreed by the SPB in September 2015 and consists of 4 representatives of CCGs, Providers, and local authorities. It is proposed that primary care have one place on the Executive.

3.9 The SPB and the SPB Executive will have the same independent Chair. The process for recruiting the Chair will begin in January 2015. As interim measure the SPB and SPB Executive will be chaired by the AGMA/GMCA Portfolio Leader with responsibility for Health and Social Care. The Chair of Association of Greater Manchester CCGs will deputise.

**VOTING ARRANGEMENTS**

3.10 It was previously agreed that the voting arrangements for the SPB would be the with the four principal stakeholder groups: CCGs; Providers; NHSE; and, AGMA/GMCA. For any vote to carry, it was agreed that 75% of the four membership groups eligible to vote must vote in favour of the proposal, with each of the four membership groups holding one vote.
apiece, and the person with that vote being accountable to their constituent stakeholder group.

3.11 However, due to primary care accounting for approximately 90% of contact across the health and social care system; and having agreed, in principle, to put in place accountable governance arrangements, the voting arrangements will be revised. As such it is proposed that primary care will receive one vote, and therefore become the fifth stakeholder group with voting rights.

3.12 The amendment in voting rights is reliant on primary care partners developing the necessary governance structures to support representational aggregated voting.

3.13 As a result of the amendment to voting rights, it is proposed that for any vote to carry at the partnership Board 80% of those eligible to vote, must vote in favour of a proposal.

3.14 As a result of the amendments to the membership and voting arrangements for the SPB, the voting arrangements for the SPB Executive will also be revised to replicate those set out above. Primary Care will continue to have one place on the Executive. These amendments are conditional on Primary Care developing governance arrangements to support representation in this way.

3.15 Meetings of the SPB will be quorate if each of the vote holding stakeholder groups are represented. Attendees with voting rights will be expected to attend with the authority to vote on behalf of the stakeholder grouping the represent.

4. APPROVAL OF GREATER MANCHESTER STRATEGIC PLAN

4.1 The GM Strategic Plan will be recommended to the Board by the Executive in December.

4.2 The role of the SPB is not to agree the plan, but to provide endorsement at a Greater Manchester level, and recommend that it be taken for approval by CCG governing bodies, Council cabinets, and NHS Trust Boards.

5. DECISION MAKING CAPABILITY – TRANSFORMATION FUND

5.1 It is likely that any transformation funding received by Greater Manchester will be channelled from Treasury to NHSE and, it is anticipated, delegated to the commissioners to allocate in line with recommendations from the
SPB Executive which will ensure that GM is able to direct and agree its usage.

5.2 The SPB will determine the criteria for access to the fund, and will receive assurance from both the Chief Officer and SPB Executive on the application of transformation funding, and delivery of expected outcomes from investments made.

5.3 The SPB Executive will review proposals received against the criteria agreed by the SPB, and will recommend the distribution of transformation fund to commissioners.

5.4 The SPB Executive will receive assurance on the outcomes relating to the activities commissioned by commissioners from the transformation fund.

6. ROLE OF THE SPB IN SHADOW FORM AND NEXT STEPS

6.1 In shadow form, the SPB has the following functions:
- To endorse the Strategic Plan, and recommend it for approval by the 37 organisations in Greater Manchester.
- To endorse the ten locality plans as part of the Strategic Plan
- To agree the criteria that determines access to the transformation fund and request that these be developed by the SPB Executive.
- To agree the criteria for judging whether organisational reform or reconfiguration needs Greater Manchester sign off
- To endorse the Greater Manchester joint commissioning strategy, which will be constructed in line with the Strategic Plan.

6.3 The SPB will also hold a system management function. That is, it will be responsible for ensuring that the Strategic Plan is delivered, and that the component parts of the Greater Manchester health and social care economy i.e. the ten localities; and 38 organisations (including NHS England), continue to work within the parameters set by the Plan, and continue to work toward the aims objectives of the Plan.

6.4 The SPB will have clear regard for Vanguard applications both on a Greater Manchester basis, but also at a locality level. The SPB will also provide assurance of the Greater Manchester health and social care system, ensuring that the Plan is delivered. Work is required to further develop the assurance framework for Greater Manchester.

6.5 It is proposed that the SPB will be informed of any applications by organisations and localities in Greater Manchester for additional funding outwith that already in Greater Manchester. It is proposed that such
applications will meet the requirements of the Strategic Plan. Any GM wide applications for additional funding will be agreed by the Board.

7. CONFLICT RESOLUTION

7.1 In the event of dispute at Board or Executive level; or in the event that one or more organisations do not approve the plan, a dispute resolution process will be implemented. The focus of this process will be three fold: to understand why dispute has occurred; to determine/understand the potential implications of the dispute; and to resolve where possible.

7.2 A key principle of the dispute resolution procedure is that disputes will be resolved at the most appropriate place level, i.e. for organisation with a singular district footprint the issue will be resolved at a locality level following consideration by the Chairs and Leaders of all of the stakeholders in the locality.

7.3 Where disputes cannot be resolved at place level, a group comprised of an agreed number of Chairs and Leaders from each stakeholder group outside of the locality representing each of the stakeholder groups will be formed to arbitrate and make recommendations to the parties in dispute. It is intended that the recommendations made by the dispute resolution group are binding on those parties in dispute, however work is ongoing with regulators to confirm the detail of how this could be made to operate.

7.4 A detailed procedure will be drafted through the Governance Sub Group and SPB Executive based on these principles and referred back to the Board for endorsement.

8. JOINT COMMISSIONING BOARD

8.1 The GM Joint Commissioning Board will be a Joint Committee where each participant makes joint decisions which are binding on each other.

8.2 As Specialised Services Commissioning cannot be dealt with by way of s75 arrangements without a change in the s75 regulations, any joint commissioning of specialised services will need to be undertaken through a joint committee made up of NHSE, CCGs, GMCA, and local authorities.

8.4 The GMJCB will have significant commissioning decision making responsibility as the largest single commissioning vehicle in GM.

8.5 In order to comply with regulatory requirements the GMJCB will function independently of providers.

8.6 The key functions of the GMJCB are as follows:
To develop a commissioning strategy based upon the agreed Strategic Plan.

- Be responsible for the commissioning of health and social care services on GM footprint
- Have strategic responsibility for commissioning across GM
- Be responsible for the delivery of the pan GM strategy via its commissioning decisions (local commissioning will remain a local responsibility).
- To operate within existing commissioning guidelines following key principles of co-design, transparency, and broad engagement.

8.7 The GMJCB will only take GM wide commissioning decisions; any decision that currently sits with the commissioning responsibilities of LAs and CCGs will stay with these organisations (or at a locality level where new commissioning arrangements are being developed).

8.8 Whilst the core principle of the GMJCB will be that those commissioning decisions which are currently made in localities will remain in localities, there will be a mechanisms developed to ensure that remit of the GMJCB can be broadened should localities agree that it is in their best interests to do so.

8.9 It is accepted that there are certain specialised services that would be impractical to commission on a Greater Manchester footprint. However, NHSE will work collaboratively with the GMJCB to ensure that these services are not commissioned in isolation of Greater Manchester.

8.10 The GMJCB will be required to produce a clear Commissioning Strategy that is aligned with aims and objectives of the Strategic Plan. The Commissioning Strategy will be reviewed periodically, or at times when the priorities for the Greater Manchester health and social care economy change; thus necessitating a shift in commissioning priorities. Any changes to the Commissioning Strategy would require agreement by the GMJCB in line with voting arrangements set out below (see 9.5).

9. JOINT COMMISSIONING BOARD: MEMBERSHIP AND VOTING

9.1 The membership of the GMJCB will be comprised of the 23 commissioning organisations in Greater Manchester, and the Greater Manchester Combined Authority:
- CA x 1
- NHSE x 1
- The CCGs x 12
- The LAs x 10
9.2 It is anticipated that CCGs will be represented on the GMJCB by their accountable officer, NHSE will be represented by the GM H&SC Chief Officer, the Greater Manchester Combined Authority will be represented by the lead Chief Executive for Health and Wellbeing and local authorities will be represented by their Chief Executive.

9.3 However, organisations may nominate whomever they see fit to represent them. The representative must however attend with a delegated authority and have an ability to participate fully in the decision making process. The seniority of the membership of the GMJCB should reflect both the size of the budget and the significance of the decisions taken.

9.4 The GMJCB will be supported by specialised officer groups such as the Cancer Board, Specialised Service Commissioning Oversight Group, and in recognition of the need for innovation a health research and innovation group will be formed to support the commissioning process.

9.5 The GMJCB will be jointly chaired by local authorities and CCGs. The GMCA, NHSE, CCGs and LAs will each have one vote (i.e. four votes in total). Decisions will require a 75% majority of the participant organisations.

9.6 NHSE will be represented on the GMJCB by the GM H&SC Chief Officer, however there may be circumstances where NHSE has no present interest in a particular matter e.g. where the matter relates to a function that NHSE has delegated to GMCA and/or CCGs. In such circumstances the Chief Office, who would cast the vote on behalf of NHSE, will pass the NHSE vote to CCGs or align their vote to that of CCGs. This will ensure parity across GM commissioning agencies.

9.7 Due to the fact that NHSE commissions many services on a national basis, notably some very specialised services, there will be a proportionate ability for NHSE to notify the GMJCB where an item due for consideration could have significant ramifications for NHSE, eg proposed spending beyond existing budget(s); or potential and significant adverse implications for communities beyond GM.

9.8 The exact circumstances, in which these arrangements apply, have yet to be determined and further is required to develop such criteria. This will be taken forward by the Governance Sub Group. In these instances, any decision will need to be taken with the consent of NHSE.

9.9 NHSE also reserve a right of veto over certain commissioning decisions relating to specialised services. However this right of veto is not absolute,
for it to be exercised it would need to satisfy clear and agreed criteria e.g. where the commissioning of services would give rise to a significant financial risk for NHSE. The exact circumstances, in which this would apply, have yet to be determined and further is required to develop such criteria

10. CRITERIA FOR COMMISSIONING AT A GREATER MANCHESTER LEVEL

10.1 Greater Manchester will need to consider whether it is beneficial for certain services to be commissioned on a Greater Manchester footprint and therefore by the GMJCB. Work is now underway to identify which services can be more effectively and efficiently commissioned on Greater Manchester footprint and therefore delegated to Greater Manchester. It will be for the GMJCB and local stakeholders to formally approve and agree what services these are.

10.2 It is also proposed that the GMJCB consider the commissioning of primary care at a Greater Manchester level; with the exception of general practice which will be commissioned by CCGs. However, the GMJCB will have a significant role to play in developing and implementing a Greater Manchester wide framework within which general practice is commissioned.

10.3 Greater Manchester has already agreed that those services currently commissioned at a local level, will continue to be done so (albeit under potentially significantly differing commissioning arrangements). However, GM will need to develop a clear mechanism to ensure that it is able to commission at both a cluster and GM level.

10.4 The criteria by which existing activity would be commissioned at Greater Manchester level will focus upon whether decisions taken on a broader footprint achieved a greater benefit for the population, e.g. increased value for money; greater levels of efficiency; or increased clinical sustainability.

10.4 The criteria will be designed by commissioners (the GMJCB), and kept under constant review to ensure that commissioning in Greater Manchester can be as efficient and effective as is possible.

10.5 It is acknowledged and recognised that commissioning organisations cannot be compelled to delegate a commissioning function up to the GMJCB against it wishes, as such each organisation currently responsible for commissioning a service/function will have to approve the proposal that is being identified to potentially fall within the scope of the GMJCB.
10.6 It is proposed that any health and social care commissioning activity currently undertaken on a GM footprint, whether it be by AGMA/GMCA, GM CCGs, or NHSE (subject to the general exclusion set out above) will now be commissioned by the GMJCB.

10.7 The GMJCB will need to agree a clear decision making process to ensure that it is able to take decisions about shifting commissioning activity into the GMJCB from localities.

10.8 Where agreement cannot be reached a dispute resolution process would be enacted, following the principles of that set out in section 7. Where the dispute related to the potential commissioning of services on a GM footprint, the GMJCB will reserve the right to proceed and commission on a smaller footprint should it be beneficial (and agreed) to do so. However, the GMJCB can also draw upon the dispute resolution process which will broadly replicate that set out for the SPB (see section 7).

10.9 The dispute resolution procedure will be clearly set out in the written agreement that will be required to support the proposed joint commissioning arrangements; this will either be in the form of a s.75 agreement or follow the structure of such an agreement.

11. JOINT COMMISSIONING BOARD SPECIALISED SERVICE COMMISSIONING

11.1 The key principle by which specialised services will be commissioned is that GM commissioners, providers, patients and the public will shape the future of health and social care provision in Greater Manchester. This is subject to Greater Manchester, via the GMJCB, formally agreeing to accept responsibility for commissioning those Specialised Services that are best served commissioned by Greater Manchester.

11.2 If it is agreed to commission specialised services the commissioning will be in line with the content and direction of the Strategic Plan. The GMJCB will produce a GM commissioning strategy to complement and deliver the Strategic Plan; this plan will require the endorsement of the SPB.

11.3 As part of the GMJCB commissioning process, the GMJCB will be required to clearly define the process that will be followed to commission a service. This process will need the support and approval of the SPB (including NHS Trusts). The process will be required to give due consideration and ultimately make provision for the co-design of services; the actual commissioning of service will remain the sole domain of the GMJCB which will operate fully independently of providers.
11.4 It is recognised that there is no mechanism that Greater Manchester can develop that will eliminate the risk of decisions being challenged, or subjected to a judicial review. However, the governance that is being developed by Greater Manchester and the process that is being outlined to commission services should reduce significantly the risk of decisions being challenged from within Greater Manchester. Where a commissioning process has been agreed by the Strategic Partnership Board and subsequently followed, the GMJCB would not expect the outcome to be challenged by an organisation with Greater Manchester. As the regulatory bodies are SPB members it is anticipated that the outcome of commissioning decisions would be supported by regulators.

11.5 Greater Manchester has already committed to reviewing the existing scrutiny arrangements for health and social care. Scrutiny is recognised as playing a vital role in supporting both service delivery and transformation. It is therefore proposed that prior to a decision taken being referred to an Independent Review Panel, that Greater Manchester reviews a decision at the SPB. However, this does not remove or replace the right of scrutiny committee to refer decision taken.

12. JOINT COMMISSIONING BOARD – SERVICE RECONFIGURATION

12.1 The premise of the Memorandum of Understanding signed in February 2015 was two fold: that decisions about Greater Manchester will be taken with Greater Manchester; and that decisions on health and social care spend would be taken to benefit the residents of Greater Manchester not necessarily be taken based on the institution that serve them.

12.2 The GMJCB have a key role to play in commissioning services across Greater Manchester, as part of the transformation required this may result in significant organisational change.

12.3 The GMJCB will be required to consult with the public about proposals that could result in service reconfiguration, and work collaboratively with the regulatory bodies.

12.4 Any such activity will need to be delivered within the context of the Strategic Plan. Where a proposed change at a Greater Manchester level could potentially adversely impact the sustainability of a service or organisation; and or, have a material impact at a locality level or on the deliverability of a locality plan, the proposal will be referred to the SPB.

13. JOINT COMMISSIONING BOARD – OTHER SERVICES

13.1 There are a number of services that are currently commissioned at a locality level that may be best commissioned within a Greater Manchester
framework of quality and standards. These include General Practice, a significant amount of social care services, and certain Public Health services. The GMJCB will consider the commissioning of such services within its Commissioning Plan.

14. JOINT COMMISSIONING BOARD SUPPORTING STRUCTURE

14.1 The GMJCB will be supported by a smaller executive, which will operate within a framework developed and agreed by the GMJCB.

14.2 The smaller executive will have responsibly for taking forward the next steps set out within this report (see section 15), and will be responsible for receiving clear updates from the commissioning advisory groups (see 8.4), making recommendations to the broader GMJCB as required.

14.3 The membership of the smaller executive will be drawn from the commissioning organisation across Greater Manchester, and be supported by members of the Greater Manchester Health and Social Care Team.

15. JOINT COMMISSIONING BOARD IN SHADOW FORM AND NEXT STEPS

15.1 The GMJCB will meet in shadow form and carry out the following functions:

- To agree the scope of its remit from April 2016, including agreeing line by line which Specialised Services will be commissioned by Greater Manchester.
- To have oversight and be cognisant of those services that will be commissioned on a Greater Manchester footprint from April 2016-17.
- In recognition that commissioning cycle may already be in train, the Joint Commissioning Board will therefore be required to be appraised of those take decisions that need to be taken, and make recommendations to the decision makers.
- To develop the Greater Manchester Commissioning Strategy.

16. RECOMMENDATIONS

1. To agree that primary care providers will receive four seats on the Strategic Partnership Board, and have one seat at the Strategic Partnership Board Executive.

2. To agree that voting arrangements for the Strategic Partnership Board and Strategic Partnership Board Executive are revised to reflect those set out in the report.
3. To agree that the Terms of Reference for the Strategic Partnership Board and Strategic Partnership Board Executive are amended to reflect (1) and (2).

4. To agree that the Governance Sub Group work with Primary Care partners to develop their governance arrangements.

5. To agree the Strategic Plan approval process.

6. To agree the role of the Strategic Partnership Board in respect of the Transformation Fund, and to instruct the Strategic Partnership Board to develop the criteria by which such funding will be accessed.

7. To agree the role of the Strategic Partnership Board in shadow form.

8. To agree the principles of the conflict resolution process for the Strategic Partnership Board, and instruct the Governance Sub Group and Strategic Partnership Board Executive to further develop.

9. To agree the functions and form of the GM Joint Commissioning Board.

10. To instruct the Governance Sub Group to develop terms of reference for the Joint Commissioning Board.

11. To agree that a GM Commissioning Strategy is developed aligned with the Strategic Plan.

12. To instruct the Governance Sub Group to develop the criteria by which NHSE could exercise its ability to request that decisions are not considered at the Joint Commissioning Board.

13. To agree that the Joint Commissioning Board be supported by smaller Executive Group.

14. To agree that the GMJCB establish a research and innovation board to inform its decisions.

15. To agree that existing scrutiny arrangements are reviewed, and request that a report be brought to a future meeting.
PURPOSE OF REPORT:

This report is written to support the Strategic Partnership Board in its discussions around ensuring the governance that will support the Greater Manchester health and social care economy is as transparent as possible.

RECOMMENDATIONS:

The Strategic Partnership Board are asked to approve the recommendation of the Strategic Partnership Board Executive:

1. To agree that the Strategic Partnership Board meets in public; subject to exclusions of the press and public for appropriate items. To be effective from December 2015.

2. To agree that papers are publicly available following the meeting where appropriate.

CONTACT OFFICERS:

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1. **INTRODUCTION**

1.1 This report is written to enable the Strategic Partnership Board to consider the issue of transparency and in particular to recommend how it can respond to the challenge of ensuring that the governance supporting the Greater Manchester health and social care economy is as transparent as possible.

1.2 As the Strategic Partnership Board is not a formal statutory public body, it is not bound by current legislation to meet in public, however it is recognised that any papers that are produced for the Board will be subject to the Freedom of Information regime. That is not to say that papers will be automatically accessible but that each stakeholder group, if requested, will have to consider whether or not the information should be released.

1.3 This paper should be read in the context of Greater Manchester’s health economy transacting its business in an appropriate and transparent manner.

1.4 This paper was taken to the Strategic Partnership Board Executive on 13th November, for consideration, and to make a recommendation the to Strategic Partnership Board.

2. **MEETING IN PUBLIC**

2.1 The transparency and accountability arrangements underpinning access to local government, NHS Trusts and Clinical Commissioning Groups decision making meetings is long established and enshrined in statute.

2.2 All relevant decision making meetings and reports must be open to the public except in limited defined circumstances where statutory provision requires or provides for the public to be excluded.

2.3 For local authorities this applies to any meetings of the Council, its executive, its committees or sub-committees.

2.4 NHS Trusts and Clinical Commissioning Groups are subject to the requirements of the Public Bodies Act 1960. As such their governing bodies are required to meet in public.

2.5 The legislation applicable to each of these bodies and the limitations and exemptions applicable in those circumstances where it may be necessary to exclude public access, is set out in the Appendix. Within these rules, these public bodies must ensure their own local decision making meetings are open and transparent and support democratic accountability and public engagement. In addition, they also have duties as public bodies and data controllers to respond to individual requests under the access related legislation, also summarised in the Appendix.

2.6 However, these legal rules on public access to meetings do not apply to the Strategic Partnership Board as the Board is not a formal statutory public body which takes decisions that are binding on its stakeholders. In many cases the work of the Board will be to consider strategic and policy issues and to enable debate between the parties to inform the formulation of policy.
2.7 In view of the importance of transparency and accountability, the Strategic Partnership Board will no doubt wish to consider whether it intends to hold meetings in public and if it does, what rules should govern public access to reports and the circumstances where it may be necessary to exclude the public.

2.8 There are examples in local government where local groups such as neighbourhood forums and Local Enterprise Partnerships have applied the access to information principles by ensuring that meetings are held in public to enable local people to have the opportunity to see how decisions are being made that affect their community.

2.9 Whilst the Strategic Partnership Board is not a meeting of a local authority executive (or Combined Authority); nor is it a meeting that falls within the scope of the other legislation consideration should be given to whether it is appropriate to adopt the principles of the legislation, i.e. that meetings should be open to public unless there is a valid reason for the exclusion of the public on a specific agenda item(s) for example where the attendance of the public would fetter an open debate on the development of a particular policy.

3. ACCESS TO REPORTS

3.1 The Strategic Partnership Board will also need to consider whether it wishes to adopt a scheme for access to reports reflecting the exclusions in the statutory schemes operated by local government and the NHS Trusts and Clinical Commissioning Groups for public access to reports or whether it considers an alternative model is more suitable.

3.2 The approach needs to recognise that public authority members of the Strategic Partnership Board have duties under access related legislation which may require them to consider publication under FOIA if requested. The publication of non-exempt reports clearly aids transparency and accountability and by adopting a settled publication programme, the incidence of individual access requests is likely to be more manageable.

3.3 It should be possible for report authors to identify such reports at the time of issue and the Board could determine whether or not to agree with that designation at the beginning of the meeting. The public may then be excluded from only that part of the meeting and reports where the whole Board has agreed that it is appropriate to do so.

4. RECOMMENDATIONS

4.1 The Strategic Partnership Board are asked to approve the recommendation of the Strategic Partnership Board Executive:

1. To agree that the Strategic Partnership Board meets in public; subject to exclusions of the press and public for appropriate items. To be effective from December 2015.

2. To agree that papers are publically available following the meeting where appropriate.
APPENDIX ONE

Local Government Act 1972

1) Confidential information means:
   - Information provided to the council by a Government department on terms which forbid the disclosure of the information to the public; and
   - Information which is prohibited from being disclosed by any enactment or by a court order.

2) Subject to determining the public interest, an agenda item and report may be closed to the public because it is not in the public interest to disclose exempt information categorised as including:
   i. Information relating to an individual.
   ii. Information which could reveal the identity of an individual.
   iii. Information relating to the financial or business affairs of an individual.
   iv. Information relating to any consultations or negotiations in connection with labour relations.
   v. Information which could be classed as legally privileged
   vi. Information which reveals that the authority proposes:
       i. to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or
       ii. to make an order or direction under any enactment.
   vii. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

Access to information – individual rights
A statutory right of access to information is also provided under the following legislation:

- The Data Protection Act 1998 (DPA)
- The Freedom of Information Act 2000 (FoIA)
- The Environmental Information Regulations 2004 (EIRs)

The DPA provides a right of access to the subject of the data and generally protects personal information from public disclosure whereas the FoIA and the EIRs provide anyone with the right of access to recorded information held by a public authority, subject to procedural limitations and exemptions.

As well as creating a general right of access on request, the FoIA and the EIRs also place legal obligations on public authorities to proactively publish information. Under the FoIA, an individual making a request is entitled to be informed if the public authority holds that information and if it does, to have that information communicated to them unless a procedural or substantive exemption applies. Similar rights apply under the EIRs.

Substantive exemptions under the FoIA fall into two main categories:

- Absolute exemptions which do not require a public interest test under the FoIA regime
• Qualified exemptions which may involve a ‘harm’ test but always require a public interest test.

Most of the exemptions open to public authorities are qualified and therefore require the routine application of a public interest balancing test.

In practice, this means that there may be circumstances where exempt information is disclosable in the public interest.

In an attempt to reconcile the requirements for public access to reports and meetings, the Local Government Access to Information rules were amended in 2006 to bring the exemptions more into line with those applicable under the FoIA regime. (This is why reports containing exempt information under Schedule 12A of the Local Government Access to Information Regulations require a separate public interest consideration).

Decisions on the application of FoIA exemptions and the balance of the public interest must be determined case by case. However, those FoIA exemptions likely to be of relevance to reports and decision making in relation to the constituent members of the Strategic Partnership Board are:

Section 21 – Information already reasonably accessible i.e. in the public domain already (absolute)

Section 22 – Information intended for future publication (qualified)

Section 36 – prejudice to the effective conduct of public affairs (qualified and only claimable by an accountable person designated by a minister)

Section 41 – information provided in confidence (absolute under FoIA but subject to a public interest consideration under the common law)

Section 43 – trade secrets and prejudice to commercial interests (qualified)
GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

Date:     Friday 27th November 2015
Subject:  Greater Manchester Health and Social Care Team Structure
Report of: Ian Williamson

PURPOSE OF REPORT

The purpose of this report is to present a proposed structure for the Greater Manchester Health and Social Care Team, to be recruited following the appointment of the Chief Officer

RECOMMENDATIONS:
The Strategic Partnership Board are asked to approve the recommendation of the Strategic Partnership Board Executive:

1. To agree the proposed team structure subject to refinements.

2. To agree the suggested next steps.

CONTACT OFFICERS:
Ian Williamson
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1. **INTRODUCTION**

1.1 The purpose of this report is to present an option for the configuration of the Greater Manchester Health and Social Care Team, to be recruited following the appointment of the Chief Officer.

1.2 This team structure has been identified as a result of engaging in a range of stakeholder discussions, and has the potential to shape the way work is undertaken and the nature of relationships, across localities, sectors and Greater Manchester.

2. **SUMMARY OF THE ENGAGEMENT PROCESS**

2.1 A first draft of a team structure was produced as a basis to stimulate discussions with some key stakeholders. The draft was primarily informed by the job description of the Chief Officer role.

2.2 Engagement of stakeholders included 11 people through telephone discussion, 4 people through email feedback, the current wider leadership health and social care team, and the Association of Clinical Commissioning Groups, over a three week period. People engaged were from Local Authorities, Clinical Commissioning Groups, Provider organisations and NHS England.

2.3 Following feedback and identification of key themes from stakeholder discussions, design principles were refined, functions identified, and a further team structure produced (See Appendix).

3. **KEY DESIGN PRINCIPLES**

3.1 The team needs to be radically different from previous and current structures to reflect the nature of reform and transformation, and the pivotal role it has in driving and leading the devolution agenda.

3.2 The team needs to be a blended team and not appear to be predominantly NHS or Local Authority in basis.

3.3 The team needs to reflect innovation and signal accelerated change.

3.4 The team form needs to be radical and brave.

3.5 The team needs to be small in number and flexible, with an ability to source expertise from within and outwith Greater Manchester.

3.6 The skill set of the team needs to be appropriate and the best possible fit for the task in hand, which may require new skills combinations than in previous structures.

3.7 The team structure needs to be an integral part of the Greater Manchester system rather than existing in parallel to other bodies and structures.
establishing and maintaining the critical links with stakeholders and bodies crucial to enabling devolution to deliver reform and transformation.

3.8 The team structure needs to be able to incorporate the relevant staff from the NHSE, Lancashire and Greater Manchester Team to support the health and social care devolution work, as well as the delivery of relevant ongoing NHSE functions.

3.9 The overhead cost of the team structure needs to be met within the existing cost parameters within a two year transition period.

4. PURPOSE OF THE TEAM

4.1 The Greater Manchester Health and Social Care Team exists to drive the devolution, reform and transformation agenda for the integration of health and social care services within Greater Manchester, accelerated across a four year period (2016 – 2020).

4.2 The team will deliver on finance, strategy, transformation and reform, innovation, improvement and quality.

5. CORE FUNCTIONS AND DELIVERABLES

5.1 During the first 12 months, the team will be expected to deliver on;

- Completion of the GM Health and Social Care Strategy, ready to operationalise by March 2016
- Development of an implementation plan from April 2016 to drive the investment strategy and deliver on the implementation plan.
- Financial performance.
- Overseeing and driving governance across GM.
- Enabling the implementation of locality plans and ensuring they support the direction of GM health and social care.
- Assuring the operational delivery of health and social care, in line with the devolved functions from NHSE, such as Clinical Commissioning Group assurance, plus specialised and primary care commissioning.
- Leading GM commissioning where agreed and endorsed by the Partnership Board and Joint Commissioning Board.
- Sponsoring, driving and facilitating GM transformational projects.
- Facilitating GM population and cross sector involvement in health and well-being improvements.
- Understanding the overall performance and delivery of services across the whole system within GM and therefore, identifying and managing risk.
• Establishing effective working arrangements with health and social care regulators.

• Leading on the development and delivery of public and political engagement.

5.2 The team structure will be reviewed during 2016/17, and adjusted as necessary to reflect the different stages of implementation.

6. TEAM STRUCTURE

6.1 The proposal is to recruit to five Executive Lead roles (Director level), which would have direct report to the Chief Officer role. There are 6 key areas of responsibility for the Chief Officer role:

• Strategic development and leadership of health and social care services in GM including development and implementation of the GM Sustainability Plan.

• Direct management of all functions, programmes of work and teams that operate at a pan GM level, including “Healthier Together”, the acute health sector reconfiguration programme, and the GM public health function.

• To support and develop the concept of subsidiarity within the GM Health and Social Care system whilst developing collaborative working across organisational boundaries.

• Assurance of Clinical Commissioning Groups [CCGs] in line with the requirements of the Greater Manchester Strategic Partnership Board and NHS England and in relation to any jointly held funds with Local Authorities.

• Direct Commissioning of all functions including but not exclusively specialised services and non-medical primary care services for the population of GM.

• Collaborating with regulators and national bodies to influence and shape their interactions with any part of the GM Health and Social Care System.

6.2 The five direct report posts will have corporate responsibility across the health and social care devolution agenda, but will have lead areas of responsibility. The team will work closely as one unit to ensure integration of expertise and provide business continuity. The posts will have a focus on system leadership.

6.3 The five posts are:

• Chief Operating Officer

This role will be the Deputy to the Chief Officer post and will operate on a day to day basis to anticipate and manage on specific workstreams and emerging agenda, on behalf of the Chief Officer. The role will be primarily GM focused enabling the Chief Officer post to be positioned at a national level as well as
within GM. This role will oversee the day-to-day performance management agenda across the GM system.

- Executive Lead for System and Service Integration

This role is primarily responsible for GM strategy implementation and enabling the delivery of locality plans, together with working to secure standardisation in the delivery and access of health and social care. Specialist and primary care commissioning will fall within this role remit, commissioning being a key vehicle to achieve reform. The role will be the lead contact for Clinical Commissioning groups, provider organisations, Councils and regulators in relation to the strategy, working across GM.

- Executive Lead for Innovation and Transformation

This role is primarily responsible for taking a long term perspective in terms of transforming models of care and therefore the health and well-being of the GM population, within the wider context of GM Growth Reform and the economic vitality agenda, as well as the wider determinants of health and well-being. The role will take the lead on engaging the broad church of stakeholders and establishing those relationships, facilitating cross sector working and identifying new ways to engage the GM population.

- Executive Lead for Investment

This role is primarily responsible for ensuring that financial sustainability is achieved across GM with the involvement of all relevant parties. The role will incorporate a requirement to lead on the Transformation Fund, and to develop the investment decision-making processes required to ensure this fund is allocated for best effect and impact, as well as developing the approach and processes for economic modelling and scenario planning. This includes the day-to-day operational finance responsibilities. The lead for the contracting process at GM level will sit within this role.

- Executive Lead for Quality

This role is primarily responsible for assuring the quality of care delivery within GM. NHSE functions such as re-validation of doctors and nurses, and quality surveillance groups will be included in the role. This role is likely to be occupied by a clinician, and will provide the key link to a wide network of clinical leadership across GM, together with other key professional groups such as Directors of Adult and Childrens’ Services, and other professional groups.

6.4 The Programme Management Office (PMO) will be the delivery arm of the team and work across all five posts to effect reform and transformation. It will be expected that the PMO will work closely with the Public Sector Reform Team, establishing opportunities for integrated working.

6.5 The supporting and enabling structure for the team will include services such as; administrative support, operational I.T. support, operational H.R. support,
legal support. It is likely that some of these services can be commissioned on a “just in time” basis, or be shared with other bodies or organisations within Greater Manchester.

6.6 The team will require strong development input and support from the beginning, in order to facilitate new ways of working and behaviours which will needed to realise the potential of this team structure.

6.7 Discussions are ongoing with NHSE regarding the appropriate method of recruitment to these five posts once the Chief Officer has been appointed. The recruitment process will be open, transparent and robust.

6.8 Once the team structure is agreed, the appropriate salary levels and employment arrangements will need to be assessed and benchmarked to provide a full costing, linked to a two year financial transition period.

7. NEXT STEPS

7.1 The next steps as agreed with Strategic Partnership Board Executive are:

- Refinement of the role descriptions; with the NHSE CFO and a small cohort of other stakeholders to work through detail
- Identification of timeline from producing role descriptions to the recruitment of people into post
- Production of job descriptions
- Identification of skills/knowledge required to fulfil the job descriptions
- Production of person specifications
- Assessment and benchmarking of salary levels
- Set up recruitment process once the Chief Officer post has been appointed and the team structure has been finalised
- Take the proposals through the agreed GM governance structures as required.

8. RECOMMENDATIONS

8.1 The Strategic Partnership Board are asked to approve the recommendation of the Strategic Partnership Board Executive:

1. To agree the proposed team structure subject to refinements.

2. To agree the suggested next steps.
Appendix One
DRAFT GREATER MANCHESTER
HEALTH AND SOCIAL CARE
TEAM FORM

GM Partnership Board

Chief Officer

Chief Operating Officer

Executive Lead Quality

Executive Lead Investment

Executive Lead System & Service Integration

Executive Lead Innovation & Transformation

GM Public Sector Reform Agenda and Team

Programme Management Office, including supporting functions eg admin, ICT, transactional HR

GM governance system
Stakeholder groups
Clinical engagement
Population groups
PURPOSE OF REPORT:
This paper sets out a proposal to ensure that effective engagement mechanisms are developed to ensure primary care has a consistent, representative voice in the developing devolution governance framework.

RECOMMENDATIONS:
The Strategic Partnership Board is invited to review the content of the attached draft and to approve the Strategic Partnership Board Executive recommendations as follows:

1. To consider and agree the proposals for primary care representation at the Programme Board, Strategic Partnership Board and Strategic Partnership Executive.

2. To consider and support the creation of a primary care advisory group and discipline specific advisory groups model described in the report.

3. To agree the next steps and issues set out in the report.

4. To agree to receive further updates where any material changes or developments to the model are proposed.

CONTACT OFFICERS:
Rob Bellingham
robbellingham@nhs.net
1. INTRODUCTION AND CONTEXT

1.1 As the health and care transformation programme moves forward apace, it is increasingly clear that Primary Care will form a central part of the emerging models of care and new way of working. The Transformation Initiatives graphic below clearly illustrates this central role:

1.2 When referring to Primary Care in this context, we include the following disciplines:
- General Dental Practice
- General Medical Practice (GPs)
- Optometry
- Pharmacy

1.3 There are circa 2,000 points of Primary Care delivery across Greater Manchester, consisting of approximately 700 Community Pharmacies, 500 General Practices, over 450 Dental Practices and over 300 Optometry practices. Something over 90% of all healthcare contacts take place in Primary Care, representing the first and sometimes only port of call for most service users.

1.4 Given this wide breadth of providers and volume of service delivery, it is recognised that effective engagement mechanisms need to be built to ensure primary care has a consistent, representative voice in the developing devolution governance framework.

1.5 This paper sets out a proposal for this necessary level of input. It has been developed by a group of primary care leaders drawn from all disciplines, with ideas taken from workshop meetings held on 26th October and 16th November. The work is subject to an agreed process of further development and review, particularly in terms of the role and function of the discipline specific advisory groups. It is anticipated that this will be completed and signed off at the next workshop meeting scheduled for 13th January, with the aim of commencing the operation of the structure described below thereafter.

2. PROPOSAL AND RATIONALE

2.1 The diagram below illustrates the proposed model to ensure effective primary care engagement, strategic input and advice to the wider reform programme.
3. **COMMENTARY ON THE PROPOSAL**

3.1 **Programme Board** – Recognition that this is effectively a task and finish group, so no proposals to alter current arrangement with Dr Tracey Vell continuing to be a member.

3.2 **Strategic Partnership Board** – Recognition of the inclusive nature of this group and the importance of the Primary Care voice at this forum. Proposal for one member drawn from each of the four disciplines. Given that primary care represents circa £750m of the £6bn health and care expenditure in GM, this level of representation is felt to be broadly proportionate.

3.3 **Strategic Partnership Board Executive** – A single Primary Care representative drawn from the cohort of members of the Strategic Partnership Board. This mirrors the arrangement already in place for the Strategic Partnership Working Group.

3.4 **Primary Care Advisory Group** – A forum drawn from all four disciplines, seeking to ensure that primary care providers have a strategic forum to consider opportunities and implications of wider strategic change. Critically, this will seek to ensure a consistent and coherent voice for primary care at the Strategic Partnership Board and the wider strategic planning process.

3.5 **Discipline Specific Advisory Groups** – These will facilitate wider, discipline specific engagement providing an opportunity for a more detailed “drill down” into issues and to inform the Primary Care Advisory Group. Colleagues in dental have already given some thought to the role and function of such a group, which could inform colleagues in other disciplines as we move towards a consistent/compatible approach in all four areas. These groups may have a broader remit than purely primary care based issues, eg the Dental Advisory Group is likely to consist of a wide ranging membership, considering the pathway through to secondary care services and the wider oral health improvement agenda. It is recognised that further work will take place in this area to ensure a model emerges which will meet the needs of each of the stakeholder groups.

3.6 **Note on membership** – Although Primary Care as a discipline could be viewed as being somewhat disparate in its make up, with multiple independent providers, it does
benefit from an infrastructure of formal representative bodies as well as other joint working fora and associations. These include:

- Local Representative Committees, (eg LMCs for General Practice, LPC for Pharmacy etc) – LRCs are representative bodies, composed of elected members, representing the four Primary Care disciplines. They are recognised by successive NHS Acts as the professional organisations representing contractors and/or performers depending on the discipline.
- Local Professional Networks (LPNs) – LPNs exist in Dental, Eye Health and Pharmacy. Their role includes providing robust clinical advice to primary care commissioning decisions, engaging with patients and partner organisations and driving improvements in patient outcomes, aligned to local and national priorities.
- Federations – Federations are groupings of primary care providers, who have agreed to work together to develop and deliver services at a scale over and above that of an individual provider. For example, many of the additional access to General Practice schemes across Greater Manchester are delivered by federations.

3.7 It is felt that, by appropriate engagement with the above groups and their representatives, it will be possible to ensure a system of meaningful and effective engagement whilst keeping numbers to a level which is manageable and supports effective working. Clearly, a key function of those involved in the process will be in seeking advice and input from their colleagues and communicating outcomes in a timely and accurate fashion.

4. NEXT STEPS AND ISSUES

4.1 In developing the outline design and principles set out in this paper, a series of issues/items requiring further work have been identified. A final workshop of the design group has been scheduled for the 13th January where all of these issues will be considered in the light of feedback and responses:

- Ongoing requirement for locality engagement – This proposal provides a framework for a GM level framework linked to the wider devolution governance. This cannot be at the expense of effective local engagement at a CCG/ Local Authority level to ensure that the place based locality plans are inclusive of primary care.
- Patient/citizen voice – a recognition that effective engagement with GM citizens needs to be at the heart of the process
- What existing work can be stopped or refined to take these new arrangements into account – thought to be given to the ongoing/complementary role of the LPNs, interface to the Primary Care Transformation Group, opportunities to influence the co-commissioning agenda etc
- Independent advice/assurance – Once the proposal is firmed up and feedback incorporated, it has been agreed that the model will be shared by independent experts to ensure that our plans match with any identified national/international best practice for engaging professional groups in a large scale transformation programme of this nature.
- Developing terms of reference/membership for the advisory groups.
5. RECOMMENDATIONS

The Strategic Partnership Board is invited to review the content of the attached draft and note the Strategic Partnership Board Executive recommendations to:

1. To consider and agree the proposals for primary care representation at the Programme Board, Strategic Partnership Board and Strategic Partnership Executive.

2. To consider and support the creation of a primary care advisory group and discipline specific advisory groups model described above.

3. To agree the next steps and issues set out above.

4. To agree to receive further updates where any material changes or developments to the model are proposed.
GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

Date: 27th November 2015
Subject: Primary Care Development Update – Delivering Primary Care at scale
Report of: Rob Bellingham

PURPOSE OF REPORT:

This briefing document provides a high level overview of the work in progress to develop new models of at scale primary care, in the context of the wider GM programme of Health and Care Reform.

RECOMMENDATIONS:

The Strategic Partnership Board is invited to consider the content of this paper and to support the process and indicative timeline described within.

CONTACT OFFICERS:
Rob Bellingham
robbellingham@nhs.net
1. INTRODUCTION AND VISION

1.1 A great deal of time and energy has been spent over recent months, exploring and developing the conditions and criteria needed to create a sustainable system of integrated, out of hospital care. This paper attempts to firm up some of this work, creating an “investable proposition” to support delivery in a number of areas in 2016/17.

1.2 The criticality of this work is summarised in the list of issues/ themes below:
  • Tackling the demand issue is central to the delivery of clinical and financial sustainability
  • Plans for secondary care reform are predicated on prevention and better care targets being achieved
  • The evidence base indicates that primary care needs to be at the centre of this process
  • Therefore, there is a requirement for General Practice and the wider primary care system to modernise, integrate and co-operate at scale.

1.3 We believe that the nature of what we are proposing in this paper is at a significant scale and level of ambition, proposing some key reforms to parts of our primary care system. Therefore, we should not underestimate the order of magnitude surrounding this and particularly, the level of engagement, dialogue and finessing of proposals which will be required to create a mutually acceptable model.

1.4 The graphic below sets out the GM Transformation initiatives. The proposals set out in this paper, place a particular emphasis on boxes 1 and 2 below, (supported by the concepts in box 5), offering the opportunity to ensure similar levels of design rigour, economic modelling and analysis as may already be in place for boxes 3 and 4.
2. A POTENTIAL MODEL FOR DELIVERY

2.1 It is recognised that each local system will need to take control of developing and designing their own delivery models. However, it is important that at a system level we identify some core characteristics of these new systems of care. These can act as both a “blueprint” to support local systems in their thinking, as well as a benchmark to be used when assessing relative levels of ambition in locality plans. The graphics below show an initial depiction of these core characteristics. We recognise that this modelling work will be subject to significant further review, challenge and iteration but has been included here as an indication of the work in progress in this area.
### GM Model for Integrated Care & Support in Communities – The Locality Care Organisation

#### Features
- Knowledge and communication
- Access and shared decision-making support
- Patient and community empowerment
- Technology, where appropriate, supported and integrated
- Behaviour change

#### Scope
- Workforce training & development supporting human factors
- Patient education programmes

<table>
<thead>
<tr>
<th>Connected Places</th>
<th>Maximising our potential to reduce demand on crisis services and normal care through effective joint working across all public sector</th>
<th>Integrated Neighbourhood Management</th>
</tr>
</thead>
</table>
|                  | - A Single Integrated Contract for Community Level Provision  
|                  | - Integration of Care  
|                  | - Care coordination  
|                  | - Quality management  
|                  | - Integrated Health, Social and Recovery Action  
|                  | - Integrated Change Management  
|                  | - Paramedic Support  | - Primary Care Services  
|                  | - Social Care  
|                  | - Community Enterprise  
|                  | -Bucket lists  
|                  | - Virtual Care  
|                  | - VCFP Resolution  
|                  | - Health Protection & Wellbeing Services  
|                  | - NESC Community Services  |

#### Connected Technology – Uniting our intelligence & sharing our knowledge through shared systems, shared care plans, service user and family involvement
- Integrated shared record
- Data sharing

#### Connected Clinical & Professional Support & Shared Back Office Functions
- Care and Support Common Standards
- Audit and validation
- Aggregate information – Designed Including COPIN

#### Reporting and Governance
- Directory of Accountability
3. CONTRACTUAL AND ORGANISATIONAL FORM

3.1 We have identified a series of tests of readiness, with regard to implementing this new delivery model, as follows:

- **Broad consensus around the delivery model**

- A cohort of partners willing to implement the model, (initially in shadow form). This could include GP Practices, other primary, secondary and community providers, social care, other providers, as well as the support and sign up of local commissioners. This triumvirate of support from commissioners, primary care providers and other providers of out of hospital care is a critical pre-requisite for moving forward.

- An agreed contractual model and organisational form with which to engage.

3.2 In the GM context, we believe that we are well advanced with regard to the first two bullet points on the above list and are working at a level of...
detail to ensure we are able to deliver on the third point. Clearly, a key part of this will be our aspiration to become an early adopter of the new national contract during 2016/17.

3.3 A series of practical considerations relating more specifically to General Practice are set out below:
- Recognition that this is a voluntary process for General Practice and therefore we will need to consider a series of initial safeguards, for example in respect of income, right of return to previous contractual arrangement for a defined period
- There is an opportunity to make a step change with regard to the General Practice estate, linked to the wider public sector estate review process within devolution. This will link into the delivery of the new service models described here.

4. IDENTIFYING AREAS FOR IMPLEMENTATION

4.1 The process of developing this paper has made it clear that its implementation most appropriately fits into an approach where decisions are made in the context of the delivery of the place’s locality plan, coupled with an assessment of the state of readiness to deliver. Such a process is characterised by its emphasis on co-production and strategic fit, rather than a more traditional process of bids and pilots. We believe this process will see implementation sites quickly emerge as a result of this process of appreciative enquiry and as a natural part of the delivery of the ambitions described in the relevant locality plan.

4.2 Our intention is to identify a number of areas who implement new models of integrated care in shadow form from April 2016. We envisage that at least one of these areas may be at a whole locality scale, (ie circa 200 – 250k), with others potentially operating at single or multiple neighbourhood level, (circa 30 – 50k).

4.3 We anticipate that we may achieve a series of implementations, which together could deliver population coverage of circa 500k in our shadow year of 2016/17. (This will be subject to confirmation as we run the process described in this paper).
4.4 We have started to consider the sorts of issues we will need to consider when assessing the state of readiness, with the following representing current work in progress:

**Commissioners:**
- Is this clearly signalled in your commissioning intentions and strategy?
- Are you prepared to novate all of your relevant contracts in this new model?
- Can you bring all the key parties to the table?
- Do you have a pooled budget already so you can bring social care and health resources into play quickly?
- Do you understand what this will mean for your role as a strategic commissioner? Do you know what capabilities you will need to build to manage the contract effectively?
- Do you have protocols in place for dealing with conflicts of interest for CCG and provider GPs?

**GPs:**
- Are you prepared to agree to the new voluntary contract?
- Do you have an established GP Federation?
- Are you prepared to work in a formal multi-organisation venture to deliver a wide range of services?
- Do you understand the financial risks and responsibilities involved in the proposed new model?
- Can you bring all (or the great majority) of GP practices with you?

4.5 Clearly, given the process described above, not all areas will wish to consider implementation in 2016/17 and this is entirely acceptable, consistent with the commitment for this to be locally owned and led. Areas may wish to consider joining the process at a later stage and there will be an opportunity for action learning sets to be established, along with other opportunities to share good practice.

4.6 Our process to specify, identify and subsequently implement the programme will require set up resources to be made available. We are working on this currently with national colleagues, taking into account factors such as:
Experience from elsewhere  
Level of access to national input potentially available, (eg legal advice)  
Relative stage of development/maturity of national products and therefore requirement for local developmental activity

4.7 Interested parties will work together, with support available, to assess the opportunity in their local context, as well as assessing their state of readiness. As described above, it is envisaged that this will include a triumvirate of stakeholder groups as follows:

- Commissioners
- Primary Care providers
- Other providers from health and social care

4.8 The initial proposal will provide an outline of the service model and operational plan, which will be further worked up over the following months. Workforce and public engagement will be critical and so the model must include detail of how this will happen.

4.9 A high level timeline is outlined below:

<table>
<thead>
<tr>
<th>Indicative Dates</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>By end of November</td>
<td>Publish details of the opportunity to work on this programme, following consideration by Strategic Partnership Board Executive, (13th November), Association of CCGs, (17th November) and Strategic Partnership Board, (27th November)</td>
</tr>
<tr>
<td>Mid December</td>
<td>Local systems come together as described above to develop an initial plan and assess their state of readiness</td>
</tr>
<tr>
<td>Early January</td>
<td>Confirm areas who will seek to implement from April 2016</td>
</tr>
<tr>
<td>End of January</td>
<td>Submission of operational plan</td>
</tr>
<tr>
<td>Feb – March 2016</td>
<td>Preparatory work – design of service model, delivery of operational plan, establishment of governance arrangements</td>
</tr>
</tbody>
</table>
From April 2016

Implementation – commence go live ‘new models of care’ – shadow year

4.10 During the financial year 2016/17, as well as running a shadow model, significant further detailed work will take place to facilitate full live running in 2017/18. Key tasks include:

<table>
<thead>
<tr>
<th>Indicative Dates</th>
<th>Action</th>
</tr>
</thead>
</table>
| Apr – Jun 2016   | Commissioners - work on 2017 contract design, commercial model, procurement process  
 |   | Providers – OD work on formation of formal partnerships, including drawing up of multi-party MOUs |
| July 2016        | Joint work on risk sharing, timing, phasing and implementation plan for new contracts |
| Aug – Oct 2016   | Commissioners – detailed work on final contract, contract value, legals  
 |   | Providers – provider collaborative due diligence, governance and commercials across and between participating organisations |
| Nov – Dec 2016   | Evaluation, contract award and signing |
| Jan – March 2017 | Mobilisation |

5. **RECOMMENDATIONS**

5.1 The Strategic Partnership Board is invited to consider the content of this paper and to support the process and indicative timeline described within.
APPENDIX 1 - GM CLINICAL AND FINANCIAL SUSTAINABILITY PLANNING PROCESS

Resulting Components of the GM Model
1. A Shared Movement for Change
2. Evidence-based Care across all settings
3. Locality-based (CDO/KDO) operating a common prospectus
4. New Hospital Models
5. Health Innovation Manchester
6. Single Patient Record
7. Single Workforce Transformation Plan
8. Single Information Governance and Data Sharing Agreement

Locality plans (10)
Set out local ‘place view’ and key focus on integrated care approach: Consistent format and structure that can be aggregated

Provider Collaboration Plans
Set provider intentions and opportunities on how we will deliver better care and productivity, combined with estates requirements

GM Workstreams
Set out plans for GM-wide initiatives including provider reform/technology and key enablers
PURPOSE OF REPORT:

To update the Strategic Partnership Board on the progress of Specialised Commissioning Services.

RECOMMENDATIONS:

1. To support the direction of travel that has been set for the specialised service mapping and devolution.
2. To be aware that further iterations of governance arrangements may be required.
3. To support the development of the transformation process using OG and urology as early implementer.

CONTACT OFFICERS:

Gina Lawrence, Chief Operating Officer, Trafford CCG
Gina.lawrence@nhs.net
1. **INTRODUCTION**

1.1 This report has been written to provide the Strategic Partnership Board with an update on work undertaken to progress the specialised service commissioning agenda.

1.2 The report provides an update with respect to:
- Governance
- Services
- Finance
- Transformation
- Workforce and Commissioning Arrangements

2. **GOVERNANCE**

2.1 A number of focused governance meetings have been held to consider the governance arrangements that will be required to commission specialised services under the devolution agenda.

2.2 At the time of writing this report specialised services are intended to be commissioned through the developing joint commissioning arrangements in Greater Manchester. However we are awaiting further guidance, to ascertain what the appropriate legal form to commission specialised services will be.

2.3 The chart below shows the agreed draft governance structures.
3. **ALLOCATION OF SERVICES**

3.1 All 247 specialised services have been considered using a software system that allows each service to be triangulated and plotted on to a spider diagram to look at volumes of service provision and co-dependency. This has resulted in the services being allocated into 3 groups: services that are required to have national direction and commissioning; services that need to be co-commissioned at regional level; and, those that can be commissioned directly at GM level.

3.2 This has then been reviewed by a multi-agency team and agreed through Greater Manchester’s 12 CCGs. This has been further validated through the NW specialist team and finally at national level.

3.3 The groups are defined by the following set of principles:

3.3.1 **Group 1 (Greater Manchester)** – this has 86 services within it (financial mapping is being completed at the moment to understand % split)

- These services are considered discrete
- Inter-dependencies are not significant
- Work on a GM footprint
- Population base of 3 million people
- Services can sit within a GM construct
- Services within this group will be considered for early transformation

3.3.2 **Group 2 (Regional)** – this has 83 services within it

- More appropriate to be commissioned on a wider than GM footprint
- Profile means difficult to split service
- Large net importer from other areas
- To be managed jointly by Devolution Manchester with other NW CCG’s under the guidance of the NW Spec Commissioning Team
- AGG under Devolution Manchester would offer high level input
- These services have an opportunity in future to move into full commissioning within Devolution Manchester

3.3.3 **Group 3 (National)** – this has 78 services within it

- Highly specialised services
- Small number of patients
- One/two centres in the country
- Input from National Team

3.4 The piece of currently being undertaken allows us to map services through the governance structures and allocate to the following:

1. Full devolution to Greater Manchester (Group 1)
2. Co-commissioning with the North West (Group 2)
3. Collaborative commissioning with the Northwest and the national team (Group 3)
4. **FINANCE**

4.1 The financial mapping of services has been completed by the CCG Directors of Finance group. This is now being shared with providers to ensure that everyone is in agreement with the baseline and starting position for the services that will likely come into GM.

4.2 There are three main risks that need to be considered:
- Fair shares and pace of change
- In year financial risk
- Capacity and capability within Greater Manchester to support Specialised Commissioning

5. **TRANSFORMATION – NON COMPLIANT CANCER PATHWAYS**

5.1 A detailed programme of work is underway.

5.2 We are using the two non-compliant cancers of urology and oesophago-gastric to develop a process for transformation which can be used for all specialist commissioned services as we move forward. This is being developed by adopting the principle of co-design between commissioners and providers to set new standards and specifications.

5.3 Step one of this process has been completed with patients and clinicians coming together to develop standards that are clinically viewed as world class and provide the best patient experience. This has then been shared across the cancer community through a cancer summit attended by clinicians, patients, regulators etc.

5.4 A proposed set of transformation steps has been described below, together with the governance of this work.
Specialised Urology and OG Cancer Surgery: Proposed Transformation Process

1. Why is change needed?
2. What does best care for patients look like?
3. A GM Clinical Cancer Summit
4. What does the current OG and Urology service look like?
5. Design new model of care
6. Engagement with Health Overview and Scrutiny
7. Public Discussion
8. Commissioning process and options appraisal - decision on best option for GM patients

The Transformation Process

Governance and Assurance

[OG & Urology Ca] Specialised Services Transformation and Commissioning Delivery Structure

Delivery & Decision Making

GM Joint Commissioning Board / Joint Committees
Decision making from Apr 16

GM Specialised Services Commissioning Oversight Group (GM SSCOG)

SLA Specialised Services Commissioning support

Technical support

GM Specialised Services [OG & Urology Ca] Transformation Delivery Team

External Assurance

NHS England Reconfiguration Assurance Process

External Clinical Assurance Panel (ECAP)

GM JHSC

GM Clinical Congress

Standard Setting

Manchester Cancer Provider Board

GM OG Pathway Board

GM Urology Pathway Board

GM Clinical Cancer Summit

GM Clinical Reference Group (GM CRG)

GM Cancer Patient Group

GM Specialised Services [OG & Urology Ca] Transformation Delivery Team

Technical support

SLA Specialised Services Commissioning support

GM Joint Commissioning Board / Joint Committees

Decision making from Apr 16

GM Specialised Services Commissioning Oversight Group (GM SSCOG)
6. TRANSFORMATION - IDENTIFICATION OF FUTURE AREAS FOR TRANSFORMATION

6.1 A large stakeholder provider and commissioner meeting has taken place to set the context of specialised services and shape how we will be handling them under health and social care devolution. The process of transformation, as described above, was shared and supported, and will be reviewed through the first two services of OG and urology.

6.2 The next step was an agreement to have a prioritisation process for the other services that required transformation. A matrix for prioritisation of transformation of services is currently being developed through a task and finish group, and will be presented back to the next provider meeting to gain consensus.

7. TRANSFORMATION - CANCER VANGUARD

7.1 The Cancer Vanguard is a very important part of the devolvement of specialised services as it gives the opportunity for early work around integration of specialised services into whole pathways of care. This combined bid between the Royal Marsden and UCLH is taking shape with the three teams working closely together and developing a value proposition which is due for submission to the National team at the end of November. All stakeholders are being engaged to ensure they are part of the GM Cancer Vanguard.

8. TRANSFORMATION - WORKFORCE AND COMMISSIONING ARRANGEMENTS

8.1 GM CCGs are currently developing a Memorandum of Understanding with the North West Specialist team to identify resource that will support the commissioning of services within Greater Manchester. Commissioning arrangements will be developed for discussion and approval through devolution governance before March 2016. In the interim, Trafford CCG will continue to lead the work with the GM Service Transformation Team.

9. RECOMMENDATIONS

1. To support the direction of travel that has been set for the specialised service mapping and devolution.

2. To be aware that further iterations of governance arrangements may be required.

3. To support the development of the transformation process using OG and urology as early implementer.