GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

# GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

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Date: 27 January 2017

Subject: Chief Officer's Update

Report of: Jon Rouse

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**PURPOSE OF REPORT:**

The purpose of the report is to update the Strategic Partnership Board on key items of interest both within the GMHSC Partnership and also within its partner organisations.

**RECOMMENDATIONS:**

The Strategic Partnership Board is asked to note the content of the brief.

**CONTACT OFFICERS:**

**Thomas Daines**
thomas.daines@nhs.net

## 1.0 NATIONAL COMMISSIONING COMMITTEE

1.1. On 16 December I presented our devolution progress to the NHS England National Commissioning Committee, including the Chair and CEO of NHS England. This was in the context of a wider item on future options with respect to health devolution. The report was well received and the Committee seemed to be overall satisfied with progress.

1.2. I took the opportunity to make a number of key points:

- to present our main devolution 'asks' for 2017/18 onwards (more of which below)
- to discuss our mutual concerns with respect to urgent and emergency care system design and performance, and the need to merge the national programme into the GM devolution governance
- to describe the impact of the social care finance deficit on the GM system.

1.3. The Committee expressed particular interest in:

- our independent review of the commissioning system
- our emerging workforce strategy
- our work on health innovation, particularly medicines

## 2.0 Q2 GM ASSURANCE MEETING

2.1. The Q2 assurance meeting with NHS E and NHS I regional colleagues took place on 22 December. Overall, our performance position was largely 'green' against the parameters of the accountability agreement. The one significant exception was urgent and emergency care on which much of the discussion was therefore focused. There was concern with respect to the 12 hour wait performance, which relates mainly to Pennine Acute and to DTOC performance at a number of Trusts.

2.2. I took the opportunity to re-state the need for there to be one consolidated programme with respect to urgent and emergency care in GM, rooted in the GM devolution governance. Regional colleagues accepted this position in principle. We will therefore consult with commissioners, providers and regulators over coming weeks with an aim of bringing forward a specific report to SPB in February that seeks to establish a single transformation approach to the urgent and emergency care system in GM, incorporating phases 2 and 3 of the national programme.

## 3.0 DEVOLUTION ASKS 2017/18 ONWARDS

3.1. We have identified a number of areas where we think specific value could be secured through wider devolution to the GM Health & Social Care Partnership, and shared these 'asks' nationally and regionally. Those areas include fresh 'asks' relating to:

### 3.2. Commissioning for Reform

3.2.1. Integrated Specialised Service Pathways - GM seeks to secure wider devolution for specialised services where there is a compelling pathway rationale for greater local commissioning and provision control. One of our most important and pressing requests for 2017/18 is some further say in the commissioning of adults and children's specialist mental health services.

3.2.2. Integrated Urgent Care - In order to maximise the potential of integrated urgent care GM seeks to secure place-based commissioning responsibility for ambulance service provision, patient transport services and NHS 111.

3.2.3. Contracts and Incentives - In support of wider alignment through incentivisation, we are keen to take on some degree of local control of the CQUIN process at the earliest opportunity, making explicit connection to the delivery of our STP and ten GM Locality Plans.

3.2.4. Medicines Pricing - We are keen to explore, with both NHS England and the Department of Health, those pricing levers which would enhance the emerging partnership between industry and GM to accelerate medicines innovation and optimisation.

### 3.3. Finance and Capital

3.3.1. System Control Totals - We are exploring the scope for delegating the GM share of STF funding and the proportionate amount of any additional national STF headroom to the GM Partnership alongside responsibility for delivering the associated provider and commissioner control totals. Thinking more broadly around the regulatory system, we would be keen to explore how, where we show GM performance as a whole is exceeding national requirements, we can secure greater regulatory freedoms as GM.

3.3.2. Capital Allocations - We have secured flexibility within the NHS England's SFIs to delegate decision making on the limited allocations of NHS England capital to the GM Chief Officer up to a delegated limit of £5m. We would like to work with colleagues at NHS England and the Department of Health to extend this delegation to elements of the provider capital regime.

3.3.3. Programme expenditure – We are seeking to streamline the NHS England commercial processes through the introduction of a GM commercial committee which would receive delegated power from NHS England for all investments currently subject to cabinet office controls below £1m. Whilst certain spending would still require DH approval the internal NHS England process would be significantly improved.

### 3.4. Assurance and Regulation

3.4.1. Better Care Fund - GM has initiated a discussion with national colleagues on the process to graduate from the BCF. The development of significantly scaled integrated commissioning arrangements provide the impetus to suggest that GM has met and exceeded the original intentions of BCF and is keen to explore the potential to confirm progress from BCF.

3.4.2. Integrated Support & Assurance Process (ISAP) – We have asked and it has been agreed that GM can align the new national Integrated Support & Assurance Process to the considerable tests applied to LCO development considerations undertaken as part of the Transformation Fund process. The panel assessment for the ISAP checkpoints will therefore be undertaken under the accountability of the Chief Officer for the GM Health & Social Care Partnership and aligned substantially to the ongoing Greater Manchester Quarterly Assurance process.

### 3.5. Enabling whole public service reform

3.5.1. Health Education - GM is seeking to design and test the way education and teaching of the health and care workforce will work in the future. This will develop a new place-based method for local areas to align the education and skills system to financial sustainability of the NHS and social care system and the wider social and economic futures of their places. We are about to enter into a detailed MoU with Health Education England and other partners, which is contained elsewhere in this agenda.

3.5.2. Work & Health - We are continuing to develop the relationship with the DWP/DH Joint Health & Work Unit and are exploring opportunities for joint investment in our health & work programme. We believe that there is merit in greater local design and management of the Fit for Work service, which would improve its reach and effectiveness. This could be delivered by co-commissioning the future service with DWP when the current contract ends in 2018. This would also align with the co-commissioning of the Work & Health programme with DWP.

## 4.0 2017/18-19/20 – NHS PLANNING ROUND

4.1. I am very pleased to report that GM was able to complete all CCG plan submissions and all contract negotiations by the deadline of 23 December. This was a

considerable achievement. I would like to express my gratitude to all the commissioners and providers involved in these discussions as time and again in the last few weeks they exemplified the model of partnership we aspire to under the devolution deal.

4.2. At the same time, this achievement should not disguise the very real financial pressures that we face. A small number of our Trusts are unlikely to be able to agree control totals quickly with further work required particularly with respect to Stockport and UHSM. At the same time, I want to commend all the partners involved in the financial planning with respect to Pennine Acute for the rapid and substantial progress we were able to make before Christmas.

## 5.0 DIABETES

5.1. Our cross-cutting work on diabetes has been relatively slow to get off the ground compared to some of our other cross-cutting strategies, e.g. cancer, mental health.

5.2. Nevertheless there is a long history of secondary care, primary care, public health and the voluntary sector working together to improve the outcome of people with diabetes. This has been characterised by secondary care diabetic centres concentrating on people with difficult to manage diabetes, whilst supporting primary care to manage the majority of patients with diabetes. Care of patients in both secondary and primary care has been co-ordinated with the public health commissioned diabetic retinopathy screening. Work across secondary care, primary care and public health has led to an improvement in diabetic care but has still left far too many people with preventable complications at a time of increasing prevalence of diabetes.

5.3. We now have an emerging 'partnership' lead by clinicians that has started to bring together primary and secondary care and public health interests. We were also recently successful in securing resources for the further roll-out of the diabetes prevention programme.

5.4. Building on a couple of closed workshops (the next of which is on 26 January) we have mandated the Strategic Clinical Network to strengthen the partnership whose role will be to bring strong evidence based practice and technological advances together to improve patient outcomes. The partnership will work with public health to implement the diabetic prevention programme, which has recently been funded and to build on the increasing collaboration of all health sectors across NHS England, CCGs, provider trusts, PHE and local authority public health to develop a single Diabetes strategy by September this year that will vigorously reduce the burden of diabetes in Greater Manchester.

5.5. As part of the development of the strategy we will aim to hold a major stakeholder event in March to complement the national diabetes conference which is being held

in Manchester this year. Our medical director, Dr Richard Preece will lead this work on behalf of the Partnership team.

## 6.0 WORK AND HEALTH

6.1. Later on this agenda the Executive will be considering our Population Health Plan, which includes a substantial programme with respect to work and health.

6.2. On 14 December Theresa Grant and I met with colleagues from the DWP/DH joint unit and NHS England to discuss our plans and how the national teams would like to work with us in the context of the Government's own Green Paper on work, health and disability.

6.3. We are pleased to report that the national teams were excited by both the scope and potential scale of our plans and agreed in principle to co-invest. To this end they will work closely with us on the detailed development of the plans, which will also require Transformation Fund development funding. An initial joint workshop will take place on 20 January.

## 7.0 PRIMARY CARE REFORM

7.1. Over the last few months we have been working intensively on some key elements of our delivery plan for the primary care strategy. A full paper will come through next month's SPB cycle that will include:

- A proposed GM approach to enhancing access to General Practice
- A proposed review of 24/7 urgent primary care provision to support the development of an integrated urgent care system both within localities and across GM
- A support and resilience offer for general practice which will make the best use of GM and local networks

7.2. There is considerable national interest in the development and delivery of our primary care plans, as there is a clear expectation that GM will deliver on the Five Year Forward View for General Practice and other relevant national strategies, in part utilising the resources that are in our Transformation Fund. For example, our performance in terms of access to primary care will be one of the key measures on which we will be judged by national Government. Our proposed approach is to deliver the core national 'asks' but to do so in a way that makes sense in terms of our overall GM strategy and the locality plans, is realistic in terms of the demands on general practice, and which makes use of new models of care.

## 8.0 HEALTHWATCH LIAISON OFFICE

8.1. The Strategic Partnership Board Executive this month supported the establishment of a GM Healthwatch liaison office for a 2 year period to support effective collaboration between the ten GM Healthwatch organisations. The collaboration will build on a previous informal network and ensure Healthwatch is able to be an active partner in GM work, and that Healthwatch supports the GM Health and Social Care Partnership in ongoing engagement with patients and the public.

8.2. GM Healthwatch have provided nominated representatives to the GM Health and Social care Partnership across the range of workstreams since the partnership was established. They are also represented on the Partnership Board. That representation has directly supported the involvement of Healthwatch in the development of Taking Charge, the cross cutting programmes and the Taking Charge Together communications and engagement activities earlier this year.

8.3. The Executive Lead, Strategy and System Development and Chief Operating Officer have been asked to engage with GM Healthwatch organisations to develop a work programme for the liaison office which aligns to, and supports, the work of the Transformation Portfolio Board, the Quality Board and the Performance and Delivery Board.

## 9.0 WIDER ENGAGEMENT

9.1. On 5/6 January we received a senior delegation from Surrey for a mutual exchange with respect to our plans, practice and delivery challenges.

9.2. On 9 January I visited the East Cheshire partners to discuss the inter-relationship between our plans and further opportunities for joint working. I will be carried out a similar visit to East Lancashire on 16 January.

9.3. On Friday 3 February I will be leading a delegation on a visit to Glasgow to share our experiences with respect to the integration of health and care services.

9.4. Finally, we have received an invitation from the Chair of the West Midlands Mental Health devolution programme to exchange learning between our two mental health programmes and also to become involved in an international alliance of conurbations taking forward population-wide mental health programmes.

## 10.0 RECOMMENDATIONS

10.1. The Strategic Partnership Board is asked to note the content of the brief.