Greater Manchester
Health and Care Board

Date: 25 January 2019
Time: 10.00 to 11.30am
Venue: Conference Rooms 1 & 2, GMPF Offices, Guardsman
Tony Downes House, 5 Manchester Road, Droylsden,
Manchester, M43 6SF

- Car Parking instruction attached, including a car parking pass for
  Market Street/Ashton Hill Lane, Droylsden M43 7UB (sat nav for the car
  park)

- Nearest tram stop is Droylsden Town Centre

  Wifi Network: GMPF-Guest
  Password: GMPF!Gue35t

AGENDA

1. WELCOME AND APOLOGIES

2. CHAIR’S ANNOUNCEMENT AND URGENT BUSINESS

3. MINUTES

   To consider the approval of the minutes of the meeting held on 9 November
   2018

4. CHIEF OFFICER’S REPORT

   Report of Jon Rouse
5. **GREATER MANCHESTER - STRATEGIC PRIORITIES AND THE NHS LONG TERM PLAN**
   Report of Warren Heppolette

6. **GM AUTISM FRIENDLY STRATEGY 2019 - 2022**
   Report of Warren Heppolette

7. **GREATER MANCHESTER TEACHING CARE HOMES**
   Report of Dr Richard Preece and Professor Alison Chambers

8. **MEDICINES EXCELLENCE**
   Report of Dr Richard Preece

9. **WINTER PRESSURES UPDATE**
   Report of Steve Barnard

10. **TAMESIDE LOCALITY PRESENTATION**
    Presentation of Steven Pleasant

11. **DATES OF FUTURE MEETINGS**
    
    Friday 08 March 2019  
    10:00am – 12 noon  
    TBC

    Friday 31 May 2019  
    TBC  
    Trafford

    Friday 26 July 2019  
    TBC  
    TBC
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<tr>
<th>Organization</th>
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<tr>
<td>Wigan Council</td>
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<td>Bolton MBC</td>
<td>Rachel Tanner</td>
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<td>Bury MBC</td>
<td>Councillor Andrea Simpson</td>
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<td>Geoff Little</td>
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<td>Andrea Fallon</td>
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<td>Salford City Council</td>
<td>Councillor John Merry</td>
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<td>Charlotte Ramsden</td>
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Pennine Acute NHS Trust
Jim Potter

Tameside NHS
Karen James

Wigan, Wrightington & Leigh NHS FT
Tony Warnis

Primary Care Advisory Group (GP)
Tracey Vell

Primary Care Advisory Group (Pharmacy)
Adam Irvine

Primary Care Advisory Group (Optometry)
Dharmesh Patel

Primary Care Advisory Group (Dental)
Mohsan Ahmad

GM H&SC Partnership Team
Jane Brown
Laura Browse
Steve Barnard
Steve Barnard
Julie Cheetam
Katie Galvin
Warren Heppolette
John Herring
Terry Manyeh
Claire Norman
Nicky O’Connor
Dr Richard Preece
Jon Rouse
Vicky Sharrock
Steve Wilson
Janet Wilkinson
Janet Wilkinson
Rosie Ryves-Webb

GMCVO
Alex Whinnom

Healthwatch
Jack Firth
J Ahmed

TfGM
Stephen Rhodes

NW Boroughs FT
Sandeep Ranote

The Alliance for Learning
Lisa Fathers

Cedar Mount Academy
Mia Bjedov
Sam Bamidele

Salford University
Polly Smith
HCB 43/18 WELCOME AND APOLOGIES

The Chair extended a warm welcome to Sandeep Ranote (Medical Director of NW Boroughs FT and co-chair of GM CYP MH Board), Lisa Fathers (Director of Teaching School & Partnerships), Mia Bjedov, Sam Bamidele (Students from Cedar Mount Academy) and Polly Smith (Head of Student Support for Salford University) to the meeting of the Health and Care Board.

Apologies were received from Councillor Rishi Shori, Donna Hall, Tim Dalton, Karen Bliss, Neil Thwaite, Chris Brookes, and Tony Hunter.

HCB 44/18 MINUTES OF THE MEETING HELD 14 SEPTEMBER 2018

Consideration was given the minutes of the meeting held on 14 September 2018.

RESOLVED/-

That the meeting minutes be approved as a correct record.

HCB 45/18 CHIEF OFFICER’S REPORT

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership (GMHSCP), provided an update on the activities relating to health and care across the Partnership. The report also included key highlights relating to performance, transformation, quality, finance and risk. A summary of the key discussions and decisions of the Partnership Executive Board were also provided.

The following items were highlighted:

- As part of the National Budget the NHS would receive extra funding, and details on how the resources will be deployed will be contained in a combination of the forthcoming 10 year plan for the NHS and the 2019 Spending Review.

- The budget did not provide a long term settlement or clarity on the Social Care and Public Health budgets. This is something that GM has frequently made the case for and will continue to so in the run up to the 2019 Spending Review.

- The Board were informed that Government required that the GMHSCP Partnership along with all other Sustainability and Transformation Partnerships need to produce a refreshed 5 year plan by next summer.

- The Board received an update on system performance and in particular on cancer. There had been a welcome increase in numbers of patients being diagnosed earlier, leading to improved survival rates. The increased demand in the number of patients being referred and treated had placed some
pressure on waiting times. It was also reported that further work needed to be done on the maturity of transformation programmes at local level.

- Members were advised that the first Q2 assurance meetings had been held in Bury and Wigan with key common areas of focus for Q2 across all districts being Early Years and School Readiness; and post diagnostic support for those with dementia and their carers.

- Members were advised that work with the Provider Federation Board was underway that would seek to develop system efficiency and productivity in terms of organising outpatients and surgery across GM.

The Mayor thanked Jon Rouse and the Partnership for backing A Bed Every Night campaign which so far has supported 92 individuals. He further thanked the Partnership for providing flu-jabs and mental outreach in support of the campaign.

RESOLVED/-

- That the update be noted.

- That the work of the GM HSCP in support of the Bed Every Night Campaign be recognised.

HCB 46/18 SAFETY REPORT

Dr Richard Preece, Executive Lead for Quality and Medical Director, Greater Manchester Health and Social Care Partnership, introduced a report that updated members on GM’s refreshed approach to health and care safety. It was further reported that Health and Care safety was a main agenda item on the first ever GM Clinical Leaders’ Summit which took place on 2 November 2018.

The Quality Improvement Framework focuses on the key components of Health and Care quality improvement that should be reflected at the whole system level across all Health and Care.

It was reported that the Clinical Leads Summit was a successful event with 150 Clinical Leads in attendance. The event was focused on how to improve care for service users with a key focus on safety.

The Board acknowledged that there is a need to develop a safety matrix that measures improvement and to integrate health and social care into non-hospital settings. Therefore, it is crucial to work together as a whole system to provide the necessary safety and care to all patients. In considering Care Homes CQC ratings, the Chief Officer commented that it was crucial to the Partnership that all Care Homes meet the safety requirements.
Members were advised that a summary on the Clinical Leads Summit will be considered at the Partnership Executive Board and will be brought to the GM Health and Care Board in due course.

RESOLVED/-

- That the Board supports the established health and care safety model
- That the Board supports the development of the model by the Quality Board in consultation with localities, Primary Care Advisory Group, Provider Federation Board, Joint Commissioning Board, and other stakeholders groups
- That a report on the Clinical Leads Summit be considered by the Partnership Executive Board and the GM Health & Care Board.

HCB 47/18 MENTAL AND EMOTIONAL WELLBEING IN EDUCATION SETTINGS PROGRAMME

Warren Heppolette, Executive Lead Strategy and System Development, Greater Manchester Health and Social Care Partnership, provided an update on the progress of the GM Mental and Emotional Wellbeing in Education Settings Programme, including achievements to date, ambitions and ongoing priorities.

The report was supplemented by a presentation by Sandeep Ranote (Medical Director of NW Boroughs FT and co-chair of GM CYP MH Board), Lisa Fathers (Director of Teaching School & Partnerships), Mia Bjedov, Sam Bamidele (Students from Cedar Mount Academy) and Polly Smith (Head of Student Support for Salford University). The presentation provided an overview of the work being undertaken by the pilot in education settings across GM.

In discussing the challenges faced by young people, it was recognised that building resilience at a very young age was key in order to deal with future challenges. The Board also recognised the importance of bringing back creative arts to secondary schools as a resilience building exercise.

In discussing the work of the programme, the Board recognised the need for the programme to link with existing services and resources to provide the required support to young children across GM. The Board also acknowledged the need to establish a one stop shop and a whole system approach to ensure the right support is provided to young people.

The Mayor commented on the importance of physical activity for younger children and suggested that all schools should consider linking with the daily mile challenge. He also reported that he has been working with the Youth Combined Authority to introduce the Curriculum for Life programme to secondary schools and that he recognised the need to link mental health and wellbeing with this programme in order to fully equip young people for life after school and college. In conclusion, he added
that it is vital that the programme does not work in isolation and that schools feedback on how the national curriculum is affecting the mental health and wellbeing of younger people.

The Board were thanked for their input and were reassured that the programme aims to work with different cohorts of young people to ensure that the right support is place.

**RESOLVED/-**

- That the update on the progress be noted.
- That the approach outlined on the Mental and Emotional Wellbeing in Education Settings Programme be endorsed.

**HCB 48/18 UPDATE ON LOCAL PROFESSIONAL NETWORKS**

Dharmesh Patel, Primary Care Advisory Group (Optometry), updated the Health and Care Board on the progress of the Local Professional Network (LPN) plans to date and the ambition for the future. The Greater Manchester LPNs continue to implement the plans, working with local clinicians, system leaders, patients and carers and commissioners to deliver the ‘fastest and greatest improvement in the health and wellbeing of the 2.8million population of Greater Manchester, creating a strong, safe sustainable health and care system for the future’.

It was reported that over the past year there have been substantial steps forward achieved by the LPNs to improve patient care and experience, whilst developing proposals to develop a sustainable and supportive system, both for providers and commissioners to ensure delivery of services within a culture of patient safety.

Members welcomed the report and noted the progress made by GM’s Local Professional Networks. It was further noted that the collaborative approach has supported general health improvement and has enabled transformation of care across GM.

The Mayor thanked the Partnership for delivering a specialist service in providing dental care to homeless people in GM which has received national recognition. Care is provided through a ‘pop-up’ service delivered in a mobile unit which travels to many different centres run by community groups and charities. This is in addition to a weekly drop in service which is delivered alongside the GM Homeless Medical Service.

It was further reported that the Local Eye Health Network (LEHN) is supporting the Greater Manchester Homelessness and Health Plan with a proposal to significantly expand and support access to NHS sight tests for homeless people and this proposal will be implemented over the next twelve months.

Members acknowledged that there was a need to provide cross professional support to individuals from deprived communities in order to improve their quality of life and
potential for employment. It was further reported that the Partnership has been working with different communities including those who are homeless, with learning disabilities, dementia and their carers to develop a tailored plans for patients.

RESOLVED/-

- That the Health and Care Board continue to support the Local Professional Networks programmes of transformation;

- That the ongoing work of the LPNs embed initiatives locally into the emerging models of care to the benefit of patients.

HCB 49/18 URGENT AND EMERGENCY CARE (UEC): WINTER PREPAREDNESS

Anthony Hassall, Salford CCG, provided the Board with an overview of the UEC plan, the planned implementation process and associated programme governance along with additional detail on the planned improvement and transformation activities within the implementation plan.

It was reported that the focus of the programme was to improve access to Primary Care appointments, developing urgent care services as an alternative to emergency departments and to use a GM single escalation tool to cope with increase in services during peak periods.

Members acknowledged that it was crucial to triage and stream patients away from Emergency Departments and non-admitted pathways to reduce hospital attendances and to connect patients with local services much earlier in the UEC pathway. More importantly this will increase capacity to deal with the higher acuity 999 calls.

The Mayor thanked Anthony Hassall and all colleagues that were involved in this programme. He reported to the Board that discussions were being held with GM’s Night Time Tsar, Sasha Lord, around the safety of city town centres over the festive period and proposed that the Partnership consider using a ‘safe haven’ approach to create simple provisions to relieve pressure on A&E’s.

Members supported the idea and shared initiatives that have begun in their districts.

Members noted the need to ensure urgent care services are configured in the right way to ensure patients are directed to primary care services within their communities and to their GP’s rather than to A&E’s.

RESOLVED/-

- That the contents of the report be noted;

- That the Greater Manchester Health & Care Board support the winter planning approach outlined in the paper.
UPDATE ON HEALTHIER TOGETHER PROGRAMME

Su Long, HT Programme SRO and Chief Officer Bolton CCG, introduced a report that provided an update on the implementation of the Healthier Together programme which covers three frontline hospital services—General Surgery, Acute Medicine and Accident and Emergency services across Greater Manchester (GM).

It was reported that the programme was aimed at improving Greater Manchester patient outcomes in three frontline hospital services—accident and emergency, acute medicine and general surgery and bringing services in line with the best performing hospitals in England.

Dr Jane Eddleston, consultant in Intensive Care Medicine and Anaesthesia, acknowledged that the implementation of Healthier Together forms an integral part of the five-year vision for GM, as articulated in ‘Taking Charge Together’. She further reported that since the beginning of the programme there has been considerable progress in acute services across GM along with standardised pathways for ambulatory and emergency general surgery patients. She further advised that there was a need to develop innovation that would support early detection and help hospitals deliver the final phase i.e. surgery.

Members acknowledged that it was absolutely crucial for services to work together to overcome challenges outlined in the report.

RESOLVED—

- That the contents of the report be noted

- That the achievements of the Healthier Together Programme and the impact of the Business case process for the population of Greater Manchester be noted.

WORKFORCE RACE EQUALITY

Terry Manyeh, Chair of the Workforce Race Equality Steering Group, Reclaim and John Herring, Strategic Lead for Organisational Development, Greater Manchester Health and Social Care Partnership, provided the Board with an overview of the work in relation to workforce race equality, why it is critical to our public services across Greater Manchester, how we aim to tackle the critical issues and what the focus of the work will deliver.

It was reported that a number of partners have signed up to this programme with a steering group overseeing the work and that the Board was in the process of securing a lead provider to work with all organisations across GM.

Members noted the need of working with under-represented communities by providing training and apprenticeship opportunities.
The Mayor highlighted that it was essential that GM represents all communities in the decision making process in order to fill gaps in services and provide services to all communities impartially. He further reported that a Caribbean African Health Network had been set up in order to convey where gaps are and better align services to the need of the community.

Members acknowledged that it is important that GM’s workforce is a true reflection of GM communities. Therefore, it imperative to uphold ethos of equality and fairness by providing opportunities to all members of the community irrespective of their ethnicity.

RESOLVED/-

- That the contents of the report be noted;
- That the Health and Care Board support and champion the work taking place on workforce race equality, by talking openly about the issues and creating a positive narrative about workforce race equality;
- That the Health and Care Board hold to account the public sector organisations across Greater Manchester who need to deliver to this agenda.

HCB 52/18 STARTING WELL IN SALFORD - OUR APPROACH 0-25

Anthony Hassall and Charlotte Ramsden, Salford CCG introduced a presentation that outlined the work delivered in Salford along with other partners to support young children and their families. The approach was based on people, place and joint commissioning programmes with a focus to improve performance and delivery across all areas. The presentation also highlighted the work done under the early intervention model which has empowered women to have proper choices on maternity care.

Members acknowledged the need to take into account local circumstances and work together with partners to deliver a place based strategy.

RESOLVED/-

That the presentation be noted.

HCB 53/18 DATES OF FUTURE MEETINGS - TBC
SUMMARY OF REPORT:

This report provides the GM Health and Care Board with an update on activity relating to health and care across the Partnership. It includes key highlights relating to performance, transformation, quality, finance and risk.

The report also provides a summary of the key discussions and decisions of the Partnership Executive Board.

PURPOSE OF REPORT:

The purpose of the report is to update the GM Health and Care Board on key items of interest across the GMHSC Partnership.

RECOMMENDATIONS:

The GM Health and Care Board are asked to note and comment on the content of the update report.

CONTACT OFFICERS:

Vicky Sharrock, Deputy Director Strategic Operations, GMHSC Partnership  
Vicky.sharrock@nhs.net
1.0 KEY UPDATES AND ISSUES

1.1 People updates

1.1.1 Sir David Dalton, Chief Executive of the Northern Care Alliance announced his upcoming retirement on 31 March 2019. David has dedicated over 40 years service to the NHS, 18 of which have been as the Chief Executive of Salford Royal and for the last 3 years also taking on the role of CEO at Pennine Acute Trust. Sir David has done an outstanding job, with Salford Royal one of the very best Trusts in the country. Sir David has also been a prominent influence in Greater Manchester, having a significant role in securing the original devolution agreement, enabling a focus on ensuring the best possible services for residents. Sir David has also had a considerable impact nationally, helping to shape and guide the development of key aspects of health policy. He is also renowned for his commitment to digital innovation, patient safety and quality improvement. The Greater Manchester Health and Social Care Partnership is immensely grateful for the contribution Sir David has made and wishes him well for the future.

1.1.2 Martyn Pritchard, former Chief Executive at Yorkshire Ambulance Trust has joined Trafford CCG as their Accountable Officer. Martyn has had a number of successful previous roles including as Chief Executive of a Provider and a Primary Care Trust and more recently at Alzhiemer’s UK. His experience will be a valuable addition to Trafford and to the GM HSC Partnership.

1.1.3 Louise Robson started as the Chief Executive of Stockport NHS FT on 7 January from her previous role as Deputy Chief Executive of the Newcastle Upon Tyne Hospitals NHS Foundation Trust. Louise joins us with 21 years experience working at board level within NHS organisations. We welcome Louise and look forward to working with her; she will undoubtedly be a great addition to the Stockport system and GM.

1.1.4 Caroline Kurzeja, has taken on the interim role of Accountable Officer for Wigan CCG, following the announcement of Donna Hall’s retirement. Caroline has been in post as the Deputy Chief Officer at Wigan and brings with her a wealth of experience of the Wigan system as well as her experience from her previous role as the Chief Officer at South Manchester CCG. Donna will leave her role at the council next month. We want to place on record the Partnership’s thanks for Donna for her superb contribution to the work of the Partnership, particularly with respect to the interface with wider public service reform.

1.2 National update

1.2.1 NHS 10 Year Plan

1.2.2 NHS England’s Chief Executive Simon Stevens launched the NHS 10 year plan in early January. The plan sets out the ambition for the NHS in the context of a number of years of austerity and funding concerns as well as increasing inequalities and a population that is both growing and ageing. The plan sets out key priorities for the
NHS aimed at improving the quality and safety of care with a focus on prevention, improving the quality of care and increased use of digitally enabled care. Successful delivery of the plan will require a whole public sector approach taking the widest view of what impacts on health and wellbeing and care.

1.2.3 There is a specific emphasis on cancer care and mental health services, with an overall focus on better integration for the benefit of patients. To achieve this, the plan recognises the need for a high quality workforce, who feel supported and enabled to deliver the best possible care. To support this there will be a specific focus on growing the medical workforce in particular in general practice, supporting community based care.

1.2.4 Prior to the 10 Year Plan the Prime Minister had already announced a financial settlement that will see an increase in funding of £20.5bn, equating to an average of 3.4% real-term increase over the next five years. This will be aligned to the priorities now confirmed in the NHS plan.

1.2.5 The Greater Manchester Partnership has already been drawing together a prospectus that reaffirms our commitment to fully implementing “Taking Charge” and realising the ambitions that underpinned our devolution agreement. It offers an honest reflection of what we have achieved. We can see the early signs of the impact of transformation, in areas that have implemented new models of care in the context of Greater Manchester’s fresh thinking on public service delivery.

1.2.6 We believe the GM Prospectus offers a compelling picture of how the intentions of the NHS Long Term Plan are already being delivered, and can be built upon, in the context of Greater Manchester as a place with a vision which connects the whole of public service, the VCSE, the business sector, academia and civic leadership. There is a separate item that covers this ground in more detail.

1.2.7 NHS England and NHS Improvement Alignment

1.2.8 NHS England and NHS Improvement have announced their new senior leadership team as part of the closer working relationship between the two organisations. The Regional Director for the North of England will be Bill McCarthy. Bill is currently Deputy Vice-Chancellor (Operations) and Honorary Professor of Health Policy at the University of Bradford and Chair of Bradford Teaching Hospital NHS Foundation Trust. Previously Bill was the Government’s principal policy adviser on health reforms and has served on various national bodies including the NHS Constitution Forum and the Health and Local Government Strategy Board. This role will be a critical relationship for the GM HSC Partnership and we look forward to working with Bill on our GM journey.

1.3 GM System updates

1.3.1 Development of GM governance
1.3.2 It has been very encouraging over the last few months to see the development of our Joint Commissioning Board (JCB) and Provider Federation Board (PFB). The JCB is now jointly led by political and clinical leadership, representing all ten localities, ably supported by GM Health and Care Commissioning, our dedicated support team. The JCB now has a well-developed work programme, a clear process for decision-making, and is developing supportive sub-governance. Under the JCB oversight, we are currently undertaking a review of the next steps in the development of our commissioning framework that will reflect our needs and the expectations of the national Long Term Plan. This is being jointly led by Ian Williamson (MHCC) and Sarah Price (GM HSC team.)

1.3.3 The Provider Federation Board is also maturing and increasingly able to take on importance pieces of work, including working jointly with Joint Commissioning Board where appropriate. For example, they will be undertaking work over the next few months on imaging and organisation of other supporting clinical and non-clinical services under theme 4 of our transformation programme.

1.3.4 As the GM governance becomes stronger the intention is to enable and support the GM system itself to lead governance and oversee key areas of work. This is an approach we already adopted in areas such as urgent & emergency care, mental health and population health, but we will now be looking to extend more clearly to other programmes such as elective care and cancer.

1.3.5 Stockport CQC Inspection

1.3.6 Stockport Foundation Trust underwent a CQC inspection towards the end of 2018. The outcome was an overall assessment of Requires Improvement. However the report identified a number of areas of outstanding practice at the trust including stroke services, which is the top performing unit nationally. The report also noted the impact being made through the integrated transfer team to support discharge of elderly patients who are medically fit to leave hospital, minimising delays for individuals. An overall summary of the report would be: progress made but still much more to do. The trust is working hard to improve the areas identified through the report to ensure services meet the expectations of the Stockport residents.

1.3.7 Evaluation Partner

1.3.8 Cordis Bright have been appointed the successful evaluation partner to undertake the six locality evaluations for the GM-led procurement following the completion of the process and will begin their work in the coming weeks. The locality evaluations will cover the period of up to the end of March 2021. The overall aim of the local evaluations is to undertake a detailed process and impact evaluation of progress in localities. The localities taking part are, Bolton, Bury, Oldham, Rochdale, Wigan, Trafford. The four localities which chose not to be part of the GM-led procurement all have a local evaluation approach already in place that aligns with the agreed GM framework.

1.3.9 Visit by Ian Dalton, Chief Executive NHS Improvement

1.3.10 Greater Manchester hosted a successful visit from Ian Dalton, Chief Executive of NHS Improvement to GM on 11 January. During the visit he met with senior GM leaders involved in the Pennine Acute Transaction process and toured the North
Manchester and Oldham Royal sites involved in the Pennine Acute Transaction before meeting with the Mayor Andy Burnham.

1.3.11 Lord David Prior Visit

1.3.12 GM hosted a successful visit from Lord Prior, Chair of NHS England to GM on 16 January. During the visit he met with senior GM leaders at a session at Manchester University Foundation Trust, visited some of the MFT innovation work including the Genomics Centre, made a site visit to the Family and Community Hub to hear about GM’s Children’s work and then want to a general practice in West Gorton to hear from leaders in the City of Manchester, concluding with a meeting with the Mayor Andy Burnham.

2.0 SYSTEM PERFORMANCE

2.1 There are a number of performance measures that the GM Health and Social Care Partnership are monitored against. Current performance against these is outlined in appendix A. The key performance measures within this set are outlined in more detail below:

- **Urgent Care 4 hour standard** - The published 4 hour performance position for all attendance types for Greater Manchester DCO for December 2018 was 83.5%, compared with a November 2018 position of 85.8%. During December, Greater Manchester saw between an extra 1500 to 2000 patients attend hospital every week when compared with previous year. This is a serious increase. The GM Urgent and Emergency Care (UEC) Service Improvement Plan continues to focus on the four areas: Stay Well; Home First; System Flow; and Discharge and Recovery. Localities are now in the delivery phase of their winter plans. There is a separate report on work on handling winter pressures later in the agenda.

- **Delayed Transfer of Care** - Published data for NHS England shows that there were an average 216.1 beds per day occupied by Delayed Transfers of Care. This is compared with an average 229 beds per day, demonstrating an improvement in performance. DToC is part of the UEC Service Improvement Plan under the “Discharge and Recovery” section.

- **Referral to Treatment** - The published data for November 2018 shows GM has not achieved the 92.0% standard with a performance of 89.4%. This is a small deterioration of 0.3% on the October reported position. GM has commissioned an external consultancy to deliver a piece of work around the whole elective pathway, with the outputs looking at both productivity gains and how to make the best use of our available capacity through mutual aid between organisations. The outputs of this work are due in February 2019. This will be a lead in to a transformation programme including reform of outpatients services, as set out in the national Long term Plan.

- **Elective Waiting List Growth (National Standard is there is no increase at March 2019 on the number on the waiting list as at the end of March 2018)** - At November 2018 GM was 9.0% above the March 2018 position and there were
54 over 52 week waiters (18 in Plastic Surgery; 15 in General Surgery). We need to make urgent progress in reducing down the waiting lists, while recognising this is a nationwide problem. We also need to deal with variation in performance within greater Manchester. The numbers of 52 week waiters have reduced to under 25% of the numbers earlier in the year but we still need to make further reductions.

- **Diagnostic Waiting Times** - The published data for November 2018 shows that GM's performance in diagnostics waiting time is 1.1%, which is an improvement of 0.1% on the October 2018 position, almost at national standard (1%) and is better than both the North (2.1%) and England (2.4%). Endoscopy is still the major performance issue and the elective consultancy work referenced earlier will include outputs for improving the diagnostic performance, both in terms of machine capacity and reporting scope.

- **Cancer** – Performance on cancer has improved on the October position; though GM has still only achieved four out of eight cancer waiting standards, which matches the October performance.

  The areas where GM did not meet the standards are: patients seen within two weeks of suspected cancer referral by a specialist, where only 90.1% of patients were seen within 2 weeks compared with a standard of 93%; two weeks wait (breast symptoms, cancer not suspected), where 86.2% of patients were seen within 2 weeks compared with a standard of 93%; patients treated within 62 days of their initial referral, where 79.3% of patients were treated within the timeframes compared with the standard of 85%; and finally patients treated within 62 days following a referral from a screening service, where 89.7% of patients were treated within the timeframes compared with the standard of 90%.

  Performance in cancer waiting times is being supported through a focused piece of work led by the Performance and Delivery Oversight Group. The bespoke work with the Northern Care Alliance has also delivered some improvements. All CCGs now have cancer improvement plans and these are being monitored by the same group. These plans outline how to better manage demand and ensure that waiting times are met in hospitals.

  Cancer is an important part of the elective consultancy work and will be specifically referenced in the output.

- **Improving Access to Psychological Therapies recovery rate (IAPT)** - GM has achieved IAPT Recovery rate standard in the published October 2018 data with 50.1% rolling quarter figure against a standard of 50%. This is slight deterioration of 0.4% on the September position.

- **Improving Access to Psychological Therapies access rate** - GM has achieved the rolling quarter standard in October with a performance of 5.29% and this is an improvement of 0.32% on the GM October position.
2.2 The table shows the actual activity, variance against plan and growth against the same period last year. GM is outside a 5.0% variation against plan for non-elective activity, at 5.0%, within this cohort zero days length of stay, at 8.0%. However, as much of this growth represents positive use of same-day emergency care, often ambulatory, the key measure is actually 1+ bed days where our performance in-year is improving slowly but it would be good if we could make further improvements before year end in March. These variations from plan are discussed with localities and there are different causes across the GM footprint.

<table>
<thead>
<tr>
<th>GM Total</th>
<th>YTD Actual Activity</th>
<th>YTD Planned Activity</th>
<th>YTD % Var. to Plan</th>
<th>Year on Year Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals (Total)</td>
<td>769,122</td>
<td>784,335</td>
<td>-1.9%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>GP Referrals</td>
<td>454,682</td>
<td>461,642</td>
<td>-1.5%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Other Referrals</td>
<td>314,440</td>
<td>322,693</td>
<td>-2.6%</td>
<td>-3.5%</td>
</tr>
<tr>
<td>OP (Total)</td>
<td>1,990,011</td>
<td>2,045,491</td>
<td>-2.7%</td>
<td>-2.2%</td>
</tr>
<tr>
<td>OP 1st Attendances</td>
<td>669,780</td>
<td>686,951</td>
<td>-2.5%</td>
<td>-1.6%</td>
</tr>
<tr>
<td>OP Follow Up Attendances</td>
<td>1,320,231</td>
<td>1,358,540</td>
<td>-2.8%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Elective (Total)</td>
<td>265,321</td>
<td>269,243</td>
<td>-1.5%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Elective (Day Case)</td>
<td>226,832</td>
<td>229,577</td>
<td>-1.2%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Elective (Ordinary)</td>
<td>38,489</td>
<td>39,666</td>
<td>-3.0%</td>
<td>-7.3%</td>
</tr>
<tr>
<td>Non Elective (Total)</td>
<td>250,145</td>
<td>238,176</td>
<td>5.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>0 day LOS</td>
<td>91,760</td>
<td>84,929</td>
<td>8.0%</td>
<td>9.8%</td>
</tr>
<tr>
<td>1+day LOS</td>
<td>158,385</td>
<td>153,247</td>
<td>3.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>7+day LOS</td>
<td>41,341</td>
<td></td>
<td></td>
<td>2.5%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>820,297</td>
<td>809,298</td>
<td>1.4%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

2.3 Children and Young People’s Mental Health

2.3.1 We’ve worked together across Greater Manchester to make some big improvements and have started to make good progress to ensure mental health is treated as seriously as physical health. We are doing this by improving mental health treatment services but also by investing in prevention.

2.3.2 In October last year, the Mayor of Greater Manchester, Andy Burnham announced that, by the end of the year, Greater Manchester will be the first place in the country to start collating and publishing waiting times data for children and young people’s mental health services in an attempt to ensure transparency. The data we have published relates to 1st April 2018 to 30th September 2018. As this is a new set of data being collected and published we will work over the coming months to refine our reporting processes and ensure the information is increasingly accurate.

2.3.3 The current NHS England access standard is for 32% of children and young people with a diagnosable mental health condition to receive treatment from an NHS-funded community mental health service. Nationally, performance is at 30.5%. In Greater Manchester, we are performing at 38.5% significantly above the national target and
8% above performance nationally. Greater Manchester’s performance is also within the top 3 ‘sustainability and transformation’ areas across the country.

3.0 QUALITY

3.1 General Practice Nurses

3.1.1 New Care models are developing across GM, with generalist and specialist nurses working together to promote quality care in long term conditions. Following three launch pad events of the GM Marvellous Mentor (MM) programme, Consultant cardiologists are now working with community nurse specialists and primary care nursing to develop group clinics in community and outpatient settings. This was supported by the charity Pumping Marvellous. As a result of this work, the GMHSCP Nursing Team received a Special recognition award from the charity. The awards are presented every December to Health Care Professionals chosen by their national patient community for their contribution and support to raising awareness of heart failure.

3.2 Quality in Care Homes

3.2.1 The Quality Improvement and Best Practice Group has now incorporated care at home or ‘living well at home’. As part of this work we have drafted a set of GM standards for quality in care, life and partnerships which incorporates a self-assessment tool for organisations to undertake. Localities will be able to use this standard, compliance against which will result in bronze, silver and gold awards.

3.2.2 As part of raising the profile of Care homes Jane Cummings, NHS England’s Chief Nurse, visited Greater Manchester as part of which she went to two care homes in Bury. This was a really positive visit for the care homes in particular their staff and residents.

3.2.3 We are currently in discussions with NHS Professionals, who currently provide the majority of our trusts with agency staff, around the potential to extend their remit in GM into the Care Home sector. It has been agreed in principle that Greater Manchester will become the pilot site for NHSP to provide the bank and agency Registered Nurses and Health Care Assistants to the independent care sector. This will reduce their current spend on agency staffing and offer some assurance to GM in preventing staff moving around agencies when there are concerns around conduct or competence.

3.2.4 The numbers of care homes and domiciliary care agencies rated good or outstanding continues to rise in Greater Manchester s seen in the tables below. This is encouraging to see. However there is more work to do as we remain below the Northwest and all England figures.
3.3 Workforce

3.3.1 Our first Nursing Associates will qualify in January 2019. Organisations across GM have been undertaking workforce modelling in order to integrate the new role into their wider nursing workforce.

3.3.2 The four higher Education Institutions in GM have been recruiting to the 2018/19 pre-registration Nursing and midwifery programme. Across GM we have a target to recruit an additional 350 nursing students and 30 midwifery students following the 227 Nursing and Midwifery students who already started in September 2018. Within this there is a specific focus on attracting students from diverse backgrounds.

4.0 FINANCE - UPDATE AS AT OCTOBER 18 (MONTH 7)

4.1 GM has a revised deficit plan of £35.1 for 18/19 which reflects improvements in plans by a number of CCGs (in taking up national incentive scheme offer) and an improvement by a Provider Trust. Our financial performance as at month 7 at a GM level is as follows:-

- Year to Date (month 7) – an adverse variance of £9.3m compared to month 7 plan.
- 18/19 Forecast – currently forecasting an adverse variance of £20.5m compared to our revised plan.

4.2 The position remains challenging within GM given significant savings targets and inherent risks in some areas. The table below shows the Headline financial performance by sector:
### 2018-19 Financial Position - Surplus / (Deficit)

<table>
<thead>
<tr>
<th>Sector</th>
<th>Financial Plan surplus / (Def)</th>
<th>2018-19 Financial Position - Surplus / (Def)</th>
<th>Performance Mth 7</th>
<th>Forecast at Mth 7</th>
<th>Variance on plan</th>
<th>Forecast</th>
<th>Variance on plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>GM H&amp;SCP Direct Funding</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Commissioning Groups</td>
<td>12.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Providers (Acute &amp; MH)</td>
<td>(48.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Authorities</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall GM Financial Position</td>
<td>(35.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(65.4)</td>
<td>(9.3)</td>
</tr>
</tbody>
</table>

### 2018/19 Forecast Financial Performance

<table>
<thead>
<tr>
<th>Month 7</th>
<th>2018/19 Forecast Financial Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan surplus / (Def)</td>
</tr>
<tr>
<td></td>
<td>£’m</td>
</tr>
<tr>
<td>GM Financial Position (excl Spec Comm)</td>
<td>(35.1)</td>
</tr>
<tr>
<td>Adjusted for:-</td>
<td>Element of PSF within Provider Position</td>
</tr>
<tr>
<td></td>
<td>CCG Incentive Offers</td>
</tr>
<tr>
<td></td>
<td>Provider surplus improvement</td>
</tr>
<tr>
<td>GM Performance for system improvement plan</td>
<td>(155.5)</td>
</tr>
</tbody>
</table>

### 4.3

Whilst the headline position described above shows a forecast deficit of £20.5m against plan, there are adjustments to be made when assessing GM performance against the overall financial target set by national NHS bodies for GM, the system control total. Allocations from the Provider Sustainability Fund (PSF) do not count against the system control total and as such any shortfall in those allocations, for performance or financial reasons, is excluded. In addition, NHS England has offered an incentive for CCGs to improve their financial position in 2018/19 in return for access to their historic financial surpluses in 2019/20. This has improved our 2018/19 forecast as well as creating access to additional funding in 2019/20. The table below shows the impact of these adjustments in assessing GM performance 18/19 against the system control total (SCT) highlighting **performance against the SCT is forecast to be a £40.8m surplus**:

- **NHS Provider sector** – Providers have a collective plan deficit of £48m and forecasting a deficit of £20.6m against plan. The forecast deficit against plan is all due to lost PSF due to A&E performance. There remains inherent risk within Provider positions and risk on CIP delivery of £10.9m is forecast. Providers are currently forecasting to receive £80.9m of the £101.5m eligible PSF in 18/19 although this will be refreshed on a monthly basis. As at month 7 an amount of £9.5m PSF has been foregone in 18/19 reflecting unearned A&E performance PSF.

- **CCGs** – some of our CCGs have taken up the NHSE Incentive scheme which has resulted in £34.7m surplus offered to support NHS national position in 18/19. This has been reflected as a £12.9m improvement in Plans and
£21.8m allocation deductions. Those CCGs contributing to the scheme will have guaranteed access to their historic surplus in 19/20 of c£69m in accordance with the scheme offer. Whilst this is pleasing and supported within GM, it must be noted that there still remains net risk of c£12.8m in 18/19 within some CCGs with mitigating actions still be worked through on a wider GM basis.

- **Local Authorities** – our Local Authorities continue to face significant financial challenges, especially around external residential placements for Looked After Children and foster care. In addition, some Authorities are experiencing an increased client need across Adult services. Whilst investments are being made into new models of preventative services, this is taking time to impact on the client numbers presenting. Local Authorities had planned for combined efficiencies and access to reserves of c£85m although at month 7 are forecasting an increased access to reserves of c£42m (£127m support in total required) to ensure a break-even position can be delivered.

### 5.0 TRANSFORMATION PORTFOLIO

5.1 The Transformation Fund submission for £1.1m for the Maternity Transformation Programme was approved at the December Partnership Executive Board. The Greater Manchester and Eastern Cheshire Local Maternity System (LMS) have developed the plan to implement Better Births locally. A subsequent action plan to support the implementation has informed the submission to the GM Transformation Fund to deliver the objectives within the action plan.

5.2 There are main aims of the plan are:

- Promoting safe and effective maternity and neonatal care
- Improving choice and personalisation
- Ensuring continuity of care
- Improving neonatal care
- Improving postnatal care
- Mental health and well-being in the perinatal period
- Commissioning for better outcomes

### 6.0 MANAGING OUR RISKS

6.1 Key risks in delivering our GM vision for health and social care and the actions being taken to mitigate those risks are outlined below:

- **Locality plans do not deliver activity shifts and financial shifts as intended:** Monthly monitoring of performance against plan is taking place and areas of significant variation are challenged and escalated where necessary. The 2019/20 Operational Planning is due to start and this will provide further clarity on requirements and delivery targets.
• **GM programmes do not deliver quickly enough to release intended benefits:** GM programmes have been requested to detail their projects for 19/20. This is to include any emerging projects and consideration of whether those projects previously identified are still required for implementation in 2019/20. Once collated, it is intended that the project list will be shared with JCB and the wider GM system.

• **How we rapidly progress programmes that have had a strategy agreed, but do not have a fully funded route to implementation identified:** GM programmes are being requested to detail their projects for 19/20. This is to include any emerging projects and consideration of whether those projects previously identified are still required for implementation in 2019/20. Once collated, it is intended that the project list will be shared with JCB and the wider GM system.

• **Ensuring robust measurement systems are in place to assure transformation delivery.** New reporting processes are being developed to align Locality Dashboards to capture activity with the existing highlight reports to ensure we have the supporting narrative. This will ensure that the newly developed Transformation Metrics are aligned with the Highlight Reporting process.

• **Lack of available capacity and resources to prioritise and deliver the totality of the Portfolio across the system.** Completion of the prioritisation exercise and the review of the 2019/20 project list will inform this, including a review of programme governance arrangements which need to be supported.

### 7.0 GOVERNANCE

#### 7.1 Strategic Partnership Executive Board Decisions

7.1.1 The Health and Care Board is asked to note the recommendations supported by the Partnership Executive Board at the meetings on 18 October and 22 November. These are outlined in more detail in the decision log in Appendix 2.

#### 7.1.2 18 October 2018 Partnership Executive Board:

- **Target Operating Model** – The Partnership Executive Board discussed the initial work undertaken to develop a prospectus for GM health and social care setting out what has been delivered to date, restating our ambition and reaffirming GMs aims:
  - Health creation as a population health system
  - A sustainable health and care system
  - Unlocking economic potential

- **Neighbourhood Insights** – PEB had a demonstration of the Tableau tool which enables analysis of data in a way that provides insight around the factors affecting performance at the neighbourhood level.
• **Transformation Fund Update** – An update was provided to PEB setting out the current position with the GM Transformation Fund. A specific request was made for £3.71m funding for the Clinical and non-clinical support services programme.

• **Workforce Race Equality** – PEB discussed the work progressing around workforce race equality. The whole of the public sector in GM have signed up to this commitment.

• **GM Mental Health Programme: Green Paper Proposal – Mentally Healthy Schools** – Partnership Executive Board discussed an outline framework through which GM would implement the ambitions of the government’s proposals around mentally healthy schools. The funding available to support this work is less than had been initially anticipated. However, trailblazer pilot sites have been selected and are progressing with the work.

### 7.1.3 22 November 2018 Partnership Executive Board:

• **GM HSC Prospectus and Supporting Documents** – progress update on the development of the GM Health and Social Care Prospectus following the discussion at the previous meeting. The paper also proposed the process for the development of the supporting papers and alignment with the anticipated national NHS long term plan.

• **Workforce** - progress updates were provided on key areas of the workforce programme: nursing and midwifery; GM medical workforce and an updated agreement with Health Education England setting out how they will support the overall GM workforce programme.

• **Health and Faith Sector Update** – proposal for a memorandum of understanding with the faith sector in support of impact the sector can have to promote health and wellbeing.

• **Standardising Acute and Specialist Care Programme update** – Progress report on the overall programme confirming governance structures for decision making, risk management and option development process.

• **Proposed Management of Planning Contract Round** – Proposals for responding to the national planning and contracting requirements including the timetable, communication and engagement activity.

### 8.0 RECOMMENDATIONS

8.1 Greater Manchester Health and Care Board is asked to:

• Note and comment on the contents of the update.
Appendix 2 - GM HSC Partnership - Financial Performance Dashboard (month 7)

1. Financial positions by type of organisation (appendices 3-7)
   - **GM HSC/P ext. Spec. comm:**
     - Income: £442.9, Expenditure: £442.9
     - Variance: £0.0, Income: £128.0, Expenditure: £126.9
     - Variance: £1.1
   - **CGG:**
     - Income: £4,168.6, Expenditure: £4,175.0
     - Variance: £6.4, Income: £2,659.1, Expenditure: £2,656.6
     - Variance: £2.5
   - **Providers:**
     - Income: £4,961.9, Expenditure: £4,041.0
     - Variance: £920.9, Income: £3,994.1, Expenditure: £3,022.8
     - Variance: £969.3
   - **Local Authorities:**
     - Income: £1,375.5, Expenditure: £1,375.5
     - Variance: £0.0
   - **PSYCH NEC spec comm:**
     - Income: £0.0, Expenditure: £0.0
     - Variance: £0.0
   - **Spec comm:**
     - Income: £1,099.1, Expenditure: £1,099.6
     - Variance: £5.5, Income: £643.4, Expenditure: £643.3
     - Variance: £0.0
   - **TOTAL:**
     - Income: £5,162.0, Expenditure: £5,162.1
     - Variance: £1.1, Income: £2,659.1, Expenditure: £2,656.6
     - Variance: £2.5

2. Financial position by locality based on location of host provider (appendix 2)
   - **Bolton:**
     - Plan surplus: £12.7, Actual: £0.2
     - Variance: £2.5, Income: £11.6, Expenditure: £11.2
   - **Bury:**
     - Plan surplus: £88.9, Actual: £0.1
     - Variance: £88.8, Income: £0.0, Expenditure: £0.0
   - **Manchester:**
     - Plan surplus: £35.1, Actual: £4.7
     - Variance: £27.6, Income: £21.7, Expenditure: £13.4
   - **Oldham:**
     - Plan surplus: £0.0, Actual: £0.7
     - Variance: £0.7, Income: £0.0, Expenditure: £0.0
   - **Rochdale:**
     - Plan surplus: £0.0, Actual: £0.1
     - Variance: £0.1, Income: £0.0, Expenditure: £0.0
   - **Salford:**
     - Plan surplus: £9.4, Actual: £4.1
     - Variance: £5.3, Income: £5.0, Expenditure: £4.4
   - **Stockport:**
     - Plan surplus: £33.9, Actual: £21.9
     - Variance: £12.0, Income: £32.0, Expenditure: £32.0
   - **Tameside:**
     - Plan surplus: £16.1, Actual: £13.2
     - Variance: £2.9, Income: £13.0, Expenditure: £10.1
   - **Trafford:**
     - Plan surplus: £0.0, Actual: £0.1
     - Variance: £0.1, Income: £0.0, Expenditure: £0.0
   - **Wigan:**
     - Plan surplus: £1.7, Actual: £2.8
     - Variance: £1.1, Income: £2.5, Expenditure: £1.6
   - **Spec. Comm:**
     - Plan surplus: £25.3, Actual: £14.8
     - Variance: £10.5, Income: £25.3, Expenditure: £0.0
   - **Out of Area:**
     - Plan surplus: £0.0, Actual: £0.0
     - Variance: £0.0, Income: £0.0, Expenditure: £0.0
   - **TOTAL:**
     - Plan surplus: £35.1, Actual: £26.5
     - Variance: £8.6, Income: £26.5, Expenditure: £10.6
     - Variance: £16.9

2018/19 Forecast surplus; variance vs plan by type of org

Month 7 key headlines (revenue)

- Overall forecast M7 position is £55.5m deficit which represents a deterioration of £93.7m from March 6.

- The reported Specialist Commissioning position now includes the release of GM reserves and contingency.

- The 2018/19 forecast CCG position and GMHSCP position have not changed since last month.

- The 2018/19 forecast Provider position deterioration from March 6. of £81m is mainly related to Manchester NHFT who are experiencing operational issues and Bolton FT who have pay award and CP pressures. All trusts are forecasting to achieve the control total excluding PHI although there is significant risk to this.
Appendix 3 - GMHSC Partnership Decision Log

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GM HSC Partnership Executive Board - 18 October</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target Operating Model</strong></td>
<td>The Partnership Executive Board were asked to:</td>
<td>Partnership Executive board agreed the way forward.</td>
</tr>
<tr>
<td>The report provided an update on the development of the GM Health and Social Care Prospectus, setting out the next phase of the Partnership. The paper set out the achievements to date, the remaining challenges for GM and reaffirms the GM aims for:</td>
<td>- Agree the tone and content of the Prospectus</td>
<td>PEB also recognised the need to align with the up-coming NHS 10 year plan and the linkages to both the GM Strategy and the GM Industrial Strategy.</td>
</tr>
<tr>
<td>- Health creation as a population health system</td>
<td>- Agree the next steps in relation to engagement with national partners and the development of the future Target operating Model for GM</td>
<td></td>
</tr>
<tr>
<td>- A sustainable health and care system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Unlocking economic potential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There will be 6 supporting papers to the prospectus which will provide the detail on how the GM ambition will be achieved. Drafts of these papers are to be brought to a future PEB meeting for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neighbourhood Insights</strong></td>
<td>As this was a system demonstration there</td>
<td>PEB supported the development being progress through the use of</td>
</tr>
<tr>
<td>Partnership Executive board received a presentation of the Tableau system which brings together information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Report summary

from across GM to help develop a greater understanding of performance and the drivers of performance.

Recommendations

were no specific recommendations

Outcome

Tableau and recognised the importance of appropriate data to support the development of improvement plans and delivery of outcomes.

Transformation Fund Update

The update provided Partnership Executive Board with the latest position in relation to the Transformation Fund. This included:

- A stocktake of the allocations to date
- Overview of the submissions that have not yet been considered
- Request for funding for clinical and non-clinical services programme
- A summary of the recurrent financial commitments arising from Transformation Fund Investments

The Partnership Executive Board were asked to:

- Note the results of the stocktake
- Approve the process for the remaining submissions
- Approve the funding request for Clinical and Non-clinical Services
- Consider the material conditions attached to the approval of funding
- Note the recurrent commitments from transformation fund investments to date

The recommendations within the report were agreed and the funding for Clinical and Non-clinical Services approved.

Further clarification was sought in relation to anticipated recurrent funding for the Maternity Transformation Programme. It was proposed this should be taken to the Joint Commissioning Board for further discussion.

Workforce Race Equality

The report provided PEB with an overview of the

The Partnership Executive Board were asked to:

The Partnership Executive board fully supported the
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>development of the work in relation to Workforce Race Equality and why it was critical to public services across GM.</td>
<td>• Support the direction of travel and the proposed outcomes&lt;br&gt;• Support future resourcing of the work to ensure sustainable impact on the issue&lt;br&gt;• Agree the work can have real impact when delivered on a Gm footprint&lt;br&gt;• Commit as group of senior leaders to be visible and engage with the issues of race equality within our workforce</td>
<td>recommendations in the paper</td>
</tr>
<tr>
<td>There are five key priorities within this work:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing and using GM level data and metrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing and sustaining organisational and system cultures which are truly diverse and inclusive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Having visible senior leadership prepared to engage with the agenda and building a strong narrative for change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enabling recruitment and talent management systems to address the issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sharing good practice and lessons learnt across professions, organisations and localities</td>
<td></td>
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</tbody>
</table>

**GM Mental Health Programme: Green Paper Proposal - Mentally Healthy Schools**
### GM HSC Partnership Executive Board - 22 November

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GM HSC Prospectus and Supporting Documents</strong></td>
<td>The Partnership Executive Board were asked to:</td>
<td>The proposals were agreed by PEB with a suggestion that in finalising the documents there should be greater involvement of the VCSE and emphasis on the outcomes that can be enhanced through their work.</td>
</tr>
<tr>
<td>Following the discussion at the previous Partnership Executive Board meeting, members were updated on progress with the GM HSC Prospectus, setting out the next phase of Taking Charge.</td>
<td>- Give final sign off to the GM Health and Social Care Prospectus as a document that can be used in informal discussions with national partners in anticipation of the publication of the NHS Long Term Plan</td>
<td></td>
</tr>
<tr>
<td>The paper focused on confirming the final stages of development and agreement of the Prospectus and the process for progressing the supporting papers.</td>
<td>- Agree that following discussions the document can be finalised and a public facing summary developed</td>
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<td>- Agree the process for signing off the supporting papers</td>
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<p>| Workforce | The Partnership Executive Board were asked to: | Partnership Executive Board supported the nursing and midwifery and the medical workforce programmes. It was suggested that digital aspirations should be |
| Partnership Executive Board received three updates from the Workforce Programme: | - Note the progress and support the ongoing actions with the nursing and midwifery programme | |
| - GM PMO Nursing and Midwifery workforce Programme – An increase in the number of | | |
| | | |</p>
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<th>Report summary</th>
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<th>Outcome</th>
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| nurse and midwifery students commencing programmes in September 2018. 201 Nursing Associates are due to qualify in January 2019 and there are currently 348 trainee Nursing Associates apprentices on the Nursing Associate Apprenticeship Programme. The feasibility of developing the programme to primary care was proposed. | • Support the establishment of the GM medical workforce PMO and the governance around the programme  
• Endorse the identified priorities for progressing the medical workforce programme  
• Endorse the memorandum of Understanding with Health Education England | acknowledged within the GM Workforce programme.  
Members of PEB supported the MoU. They were advised this would be reviewed in April 2019 and again in April 2020 to reflect GM priorities and any future national changes. |

• Establishment of the GM Medical Workforce PMO – The Gm medical and workforce PMO commenced on 1 October 2018. They will work with a GM delivery group to deliver key priorities: growing our own capacity; filling difficult gaps; talent management and leadership and the GM employment offer

• GMHSCP and Health Education England Memorandum of Understanding – This agreement supports stronger working relationships to support the delivery of the workforce priorities for GM

Health and Faith Sector Update

The GM HSC Partnership and faith groups across GM

The Partnership Executive Board were asked to:

Partnership Executive Board recognised the importance of the relationship with the faith sector but
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| are committed to working together to support GM residents, families and communities. A draft Memorandum of understanding was shared with PEB for discussion and approval. The document set out the role the faith sector has in promoting health and wellbeing and supporting those with long-term illnesses | • Discuss the proposed MoU including the proposed governance structures  
• Note the activity to explore avenues to support the MoU | proposed that this should be brought together with the existing MoU with the voluntary, Community and Social Enterprise sector.  
PEB also requested a more detailed understanding of the relationships that already exist within localities before a specific MoU be considered. |

**Standardising Acute and Specialist Care Programme update**

The report updated on the progress to date with the programme, specifically in relation to the acute services yet to reach an implementation stage.

It was noted that progress was significant and they would shortly be able to bring back options for service configurations.

The Board were advised that a review had been commissioned focused on minimising risk.

The Partnership Executive Board were asked to:

• Note the content of the report

PEB suggested it would be helpful for localities to meet with stakeholders engaged in the workstreams for a more detailed overview and to broaden knowledge.

It was agreed that the Joint Commissioning Board would need to be well advised and supported to make necessary decisions to take the work forward.
## Proposed Management of Planning Contract Round

The report provided Partnership Executive Board with an update on the operational planning round. This set out the process and communications in place as well as the finance, organisational change and strategic considerations specific to the GM system.

The paper also set out the timetable for meeting the national deadlines.

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<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Proposed Management of Planning Contract Round</strong></td>
<td>The Partnership Executive Board were asked to:</td>
<td>PEB noted the national requirements and the timetable for responding</td>
</tr>
<tr>
<td>The report provided Partnership Executive Board with an update on the operational planning round. This set out the process and communications in place as well as the finance, organisational change and strategic considerations specific to the GM system.</td>
<td>• Note the content of the paper an specifically the timetable</td>
<td></td>
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<tr>
<td>The paper also set out the timetable for meeting the national deadlines</td>
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SUMMARY OF REPORT:

A wide range of plans on both the future of the NHS and Greater Manchester will culminate in the early part of 2019. All of these plans are inter-related and it is important to set them in a wider context about the future of Greater Manchester. Each will play a vital part in accelerating the delivery of the Greater Manchester Strategy Our People, Our Place.

This paper sets out this wider strategic context. In particular, it focuses on the relationship between the Greater Manchester Health and Social Care Prospectus and the new NHS Long Term Plan.

KEY MESSAGES:

In this time of national uncertainty, socially and economically, Greater Manchester is taking the initiative and setting out bold plans to give people, communities and businesses hope and confidence for the future. This will be expressed through the finalisation of a number of key Greater Manchester plans in the first few months of 2019 stretching across jobs, transport, housing and the environment.

For health and care we will be setting out the next 5 years for Taking Charge, our plan for health & social care transformation. We will publish a Prospectus for the next 5 years setting out how Greater Manchester will meet, and go beyond, the ambitions in the new NHS Long Term Plan – published in January 2019.

The Prospectus is a key part in the next phase of Greater Manchester’s journey as a devolved system and links to a number of key pieces of work underway in GM.
PURPOSE OF REPORT:

To describe the relationship between key plans both within Greater Manchester and nationally that will culminate in the first part of 2019; in particular, that between the Health and Social Care Prospectus and NHS Long Term Plan.

RECOMMENDATIONS:

The Greater Manchester Health and Care Board is asked to:

- Note the relationship described between the key emerging GM plans and between the Health and Social Care Prospectus and the NHS Long Term Plan

CONTACT OFFICERS:

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

Paul Lynch - Deputy Director - Strategy and System Development
paul.lynch@nhs.net
1.0 INTRODUCTION

1.1. The early part of 2019 will see the culmination of a number of pieces of work that will reaffirm Greater Manchester’s ambitions as a devolved city region.

1.2. In this time of national uncertainty, socially and economically, Greater Manchester is taking the initiative and setting out our bold plans to give people, communities and businesses hope and confidence for the future. This will be expressed through the finalisation of a number of key Greater Manchester plans in the first few months of 2019.

1.3. Each of these plans will move us further and faster towards realising the vision set out in the Greater Manchester Strategy Our People, Our Place.

1.4. Health and Social Care will be central to this. Principally, this will be through the completion of the Greater Manchester Prospectus on Health and Social Care - Taking Charge: Our Prospectus for the Next Five Years.

1.5. The Prospectus will set out our long-term health and social care strategy in Greater Manchester. It will set out how Greater Manchester will respond to the ambitions in the new NHS Long Term Plan published in January 2019 and update how the Health & Social Care Partnership will contribute to the wider vision for Greater Manchester.

1.6. The Prospectus is a key part of an exciting next phase in Greater Manchester’s story. This includes:

   - The White Paper on GM Public Services
   - The GM Independent Prosperity Review
   - The GM Local Industrial Strategy
   - The GM Spatial Framework
   - The GM Clean Air Plan
   - The GM 2040 Transport Strategy

1.7. This paper provides further detail on the areas of work described above. These will all contribute to, and culminate in, Greater Manchester’s submission to the Government Spending Review – expected in mid-2019.
2.0 THE GM HEALTH & SOCIAL CARE PROSPECTUS & THE NHS LONG TERM PLAN

2.1 We are now finalising the Health and Social Care Prospectus in the light of these key local and national contributions. The Prospectus seeks to update the story of Greater Manchester’s health and social care devolution journey – as set out in Taking Charge.

2.2 It has been developed in the context of the major GM strategies described in this paper and with the changing national NHS picture in mind. This is mainly: the integration of the two lead national bodies – NHS England and NHS Improvement; and the release of the NHS Long Term Plan.

2.3 The Prospectus describes the progress we have made in GM since April 2016; the challenges we face; and how we are addressing them.

2.4 We emphasise the features that make us unique in Greater Manchester – such as the potential our devolved system provides to unlock the economic potential of health innovation; and our ability to integrate health and care with wider public services. We set out how we will use these core characteristics of our system to make rapid progress in three areas. – population health, integrated health and care system, contribution to economic development.

2.5 At its heart, the Prospectus reaffirms our ambition to take GM beyond other integrated care systems in England to create a comprehensive population health system anchored in the capabilities and hopes of our residents.

2.6 In the last few months, there has been wide engagement on the Prospectus. The document has been refined to reflect this and, as we enter the New Year, the key tasks are now to respond to the key asks of the national 10 year plan, and to align locally with the IPR, White Paper, and Local Industrial Strategy as appropriate.

2.7 The NHS Long Term Plan was published on 7th January 2019. The Plan lays out the path for the NHS over the next decade. It confirms the funding arrangements for the NHS over the next five years: a settlement that averages an increase of 3.4% a year. The Plan can be found at: https://www.england.nhs.uk/long-term-plan/

2.8 From a Greater Manchester perspective, there is much to welcome in the Plan. It is notable that many of the initiatives in the Plan mirror those underway here and the drive to population health and wider system accountability reflects the journey that we are on.

2.9 We’re supporting people to improve their own health and reduce the harms caused by alcohol, obesity and smoking. For example, we’re the first place in the country to offer addiction treatment to hospital patients that smoke: http://www.gmhscc.org.uk/wythenshawe-hospital-becomes-first-in-the-uk-to-offer-addiction-treatment-to-all-patients-who-smoke/.
2.10. Alcohol Care Teams will be rolled out in hospitals with the highest number of alcohol-related admissions and will support patients and their families who have issues with alcohol misuse. The plan refers to work in Bolton and Salford that has seen a reduction in A&E attendances, bed days, readmissions in the number of ambulance call outs: https://www.england.nhs.uk/2019/01/nhs-long-term-plan-will-help-problem-drinkers-and-smokers.

2.11. Earlier this year, we introduced plans to make sure all children and young people get the best start in life, focusing on mental health support, reducing avoidable hospital admissions and making sure they're school ready by the age of 5: http://www.gmhsc.org.uk/gm-plan-to-give-thousands-of-children-and-young-people-the-best-start-in-life/.

2.12. In March 2018, with the support of a number of partners including across the voluntary sector, community and social enterprise sector, we rolled out a pilot with over 30 of our schools here in Greater Manchester to help children and young people look after their emotional health and wellbeing and provide specialist support where needed. We are working on plans to extend this to 10% of Greater Manchester schools over the coming two years, starting later this month, and then meet an ambition for support in all Greater Manchester schools: http://www.gmhsc.org.uk/sports-stars-back-project-to-help-greater-manchester-kids-stay-mentally-healthy/. Funding mental health support teams in schools is reflected in the plan.

2.13. The plan emphasises early diagnosis of cancer and that over the next two years, the lung health checks piloted in Manchester will be extended: https://www.mhcc.nhs.uk/news/north-manchester-pilot-quadrupling-lung-cancer-early-diagnosis-rates/.

2.14. Pathway, a charity, helps the NHS to create hospital teams in Manchester, to support homeless patients and involves in-hospital GPs and nurses working with others to address housing, financial and social issues of patients. This video looks at our work on homelessness: https://www.youtube.com/watch?v=9KRYRDE-t89s&feature=youtu.be.

2.15. The Mayor of Greater Manchester announced last year that all nursing students in Greater Manchester will be guaranteed a job after graduating. The NHS Long Term plan states this will now happen across the entire country. We have four big priorities in our workforce plan: helping our leaders, carers and volunteers to develop; supporting our staff, apprentices and people on placements; improving our offer of employment; and filling difficult roles - http://www.gmhsc.org.uk/wp-content/uploads/2018/05/13_Workforce_Strategy_and_Implementation_Plan_SPB_28.07.2017_combined_FINAL_v1.0.pdf.

2.16. The plan contains welcome reference to improving end of life care, specifically a preferred place to die. Statistics show almost half of the 23,866 deaths in Greater Manchester from September 2017 to June 2018 occurred in hospital, even though in some cases there was no clinical need for patients to be there and surveys suggest most people would not choose hospital as their preferred place to die:
http://www.gmhsc.org.uk/today-marks-the-start-of-hospice-care-week-an-annual-celebration-which-aims-to-raise-the-profile-of-the-remarkable-work-these-homes-do-in-our-communities/. We’re looking at new standards, working with both James Frith, MP Bury North and co-chair of the All Party Parliamentary Group on hospice and palliative care as well as the national charity, Dying Matters, on a set of standards to improve services and choice.

2.17. The NHS Long Term Plan looks at making better use of data and digital technology. Recent announcements on Greater Manchester being a local health and care record exemplar and our work with Health Innovation Manchester show what we are doing but also scale of ambition: http://www.gmhsc.org.uk/greater-manchester-awarded-7-5m-to-drive-forward-integration-of-health-and-care-records/.

2.18. Central to this will be the further integration of health and care with wider public services – the Greater Manchester vision for this reformed public service model will be set out in the White Paper (see section 3 of this paper).

2.19. Equally, we will go beyond the ambitions for population health in the Long Term Plan. For instance, the Plan recognises the health consequences of poor air quality but its response to this is limited to modernising the NHS estate and vehicle fleet.

2.20. In Greater Manchester, through operating on a pan public-service basis, we can create the conditions for our residents to demand better health and then apply a far greater range of solutions to problems such as poor air quality – including via our transport system, housing and our approach to economic growth.

2.21. We will also make the case that, whilst increases in NHS funding are welcome, it is vital that, through the Spending Review process, sustainable financial settlements are agreed for both Social Care and Public Health. In GM’s submission to the 2018 Autumn Budget we were clear that health and care integration would be undermined without long-term, sustainable financing of Social Care and Public Health.

2.22. Equally, it is not yet clear that the full range of commitments in the Long Term Plan can be adequately supported through the additional funding available and given the workforce challenges of the coming period. We expect further detail from the national bodies on this, but, we will also review the commitments against our GM-level plans for 2019-20 and beyond.

2.23. For some time, we have highlighted that national legislative changes would help to remove some of the barriers to further health and social care integration. We are therefore positive about the list of potential legislative changes for Parliament’s consideration. In particular, the creation of Integrated Care Trusts; the removal of impediments to place-based commissioning; and the ending of general competition rules and powers that can adversely affect the integration of care.

2.24. Our Prospectus, supported by a detailed implementation plan that will include how we will deliver the requirements of the Long Term Plan, will ensure that we meet the
expectation set by the NHS nationally for all local systems to have five year plans in place by autumn 2019.

2.25. We expect to seek this Board’s approval for the Prospectus in March 2019 and then to launch the document formally shortly after that. In doing so, we will seek, as far as is possible, to align this with the launches of other key GM-wide strategies.

2.26. This paper now outlines those significant GM strategies and draws out the opportunity for each to both complement and strengthen the Health and Social Care Prospectus.

3.0 THE WHITE PAPER ON GM PUBLIC SERVICES

3.1. We can only support people to achieve their full potential and ensure that we are creating the Greater Manchester we all want to live in if we change the way in which our public services work.

3.2. The GM Model of Public Services White Paper will set out a radical new approach to how public services will be delivered across Greater Manchester. This will see communities, public services and the voluntary sectors working hand in hand to reform services and focus on delivery, breaking down the silos between services.

3.3. The White Paper is vital in confirming an integrated, pan-public service reform model in GM – with health and social care playing its full role in this. For example, it clearly identifies the neighbourhood (30,000 to 50,000 populations) as the main delivery point for public services – matching the model being put in place through Local Care Organisations.

3.4. The Paper will form one of the key pillars for delivering the overarching aims of the Greater Manchester Strategy and on how we can progress further and faster as a devolved city region.

4.0 THE GM INDEPENDENT PROSPERITY REVIEW & LOCAL INDUSTRIAL STRATEGY

4.1. The GM Independent Prosperity Review (IPR), in a similar way to the Manchester Independent Economic Review (MIER) before it, is expected to form the analytical backbone of GM’s engagement with Government for the coming decade, as well as providing a sound evidence base for the Local Industrial Strategy.

4.2. The IPR is being guided by an Independent Advisory Panel. The Panel has reviewed GM’s existing evidence base and commissioned new studies, which provide a deep and cutting-edge analysis of key economic issues affecting the city-region. The IPR’s findings are expected to be announced in February 2019.

4.3. The 2017 Autumn Budget agreement between the GMCA and Government (HMG) set out that Greater Manchester’s Local Industrial Strategy (the LIS) will reflect the main themes of the National Industrial Strategy, but also take a place-based
approach that builds on the area’s unique strengths and ensures all people in GM can contribute to, and benefit from, enhanced productivity, earnings and economic growth.

4.4. The Strategy will be clear on our strengths in GM and help to attract new business and new industries. It will also highlight the challenges we face particularly around skills, infrastructure and the poor health experienced by many of our residents. It will bring a sharper focus to where greater investment is needed in GM. It is being jointly developed with Government and will be agreed in March.

4.5. Both the Prosperity Review and Local Industrial Strategy are crucial to our aim of unlocking the potential of the health and care system to contribute to innovation and productivity. This particularly applies to areas such as life sciences, clinical trials and digital interoperability and will form a major part of the Health and Social Care Prospectus.

5.0 THE GM SPATIAL FRAMEWORK

5.1. The Greater Manchester Spatial Framework focuses on creating sustainable places in Greater Manchester where people can achieve their full potential.

5.2. That requires important decisions to be made about the pattern of future growth, taken in an integrated way, to reflect the inter-relationships between all communities and parts of Greater Manchester socially, environmentally and economically.

5.3. The Health and Social Care Partnership will participate fully in the consultation on the Spatial Framework. The existence of Greater Manchester's active connection across the full range of public service and civic leadership gives us an opportunity to view and progress the Spatial Framework as a framework for health creation. The scope of the framework, affecting green spaces, walking and cycling connectivity, inclusive growth, prosperity, homes, and digital connectivity has the potential to be Greater Manchester’s foremost statement on population health. We very much welcome the long-term view that the Framework takes and will work with all partners in GM to reaffirm that the health and well-being of the population is a vital consideration in this.

6.0 THE GM CLEAN AIR PLAN

6.1. The Clean Air Plan will aim to ensure that our city region can grow in a sustainable way that promotes opportunity and better health for all.

6.2. Although no decisions have been made yet, the GM Clean Air Plan will aim to safeguard all our residents from air polluted by high levels of Nitrogen Dioxide whilst protecting the poorest in our communities from any financial penalties.

6.3. The Health and Social Care Partnership will play its full part in this work. As described in section 2 of this paper, we want to work with all partners to make sure
that the health challenge of poor air quality is met by a response across the public sector and civic society.

7.0 THE GM 2040 TRANSPORT STRATEGY

7.1. The Greater Manchester Transport Strategy 2040 (2017) set out a future vision for “world class connections that support long-term sustainable economic growth and access to opportunities for all”.

7.2. Its ambition is to deliver a fully integrated and sustainable transport system that provides real choice to people travelling in GM and enables us to reduce car use to no more than 50% of daily trips, with the remaining 50% undertaken through public transport, cycling and walking.

7.3. This would mean a million more trips each day using sustainable transport modes in Greater Manchester by 2040 and would help to make our communities less congested and polluted, and safer for everyone.

7.4. The Health and Social Care Partnership will continue to engage in the implementation of the Transport Strategy to ensure that we capitalise on the health and well-being benefits it offers. This includes the opportunity to increase physical activity across our city region – linked to the GM Moving programme.

8.0 RECOMMENDATIONS

8.1. The Greater Manchester Health and Care Board is asked to:

- Note the relationship described between the key emerging GM plans and between the Health and Social Care Prospectus and the NHS Long Term Plan
SUMMARY OF REPORT:

This report provides a summary of GM's first autism strategy and the work that has taken place to develop it. The strategy has been written by multiple stakeholders including autistic adults and family members of autistic people living in Greater Manchester. The challenges in the strategy speak across a number of agendas across public, private and voluntary sectors and seek to bring cross cutting improvements for Autistic people and their carers.

KEY MESSAGES:

- The strategy is a clear vision to work towards making Greater Manchester an autism friendly place to live, where people receive a timely diagnosis and support, professionals have a good understanding of autism, reasonable adjustments are made when required, where people can feel safe, have aspirations and fulfil their potential, and be full member of the local community.

- A joint governance structure is now in place to oversee all the autism work in GM and will be accountable for delivery of the strategy. This is the GM Autism Delivery Board (formerly called the GMAC Steering group).

- The Greater Manchester Autism Consortium Project has led on this work working with multiple stakeholders including the two GMAC advisory groups (one for autistic adults and one for family members), professionals, commissioners and service providers.

- The Strategy is called Making Greater Manchester Autism Friendly and to this end there are 4 priorities identified within the strategy. Some of the work has already
been started by the GMAC project and partners and some of the work will look at new areas of work.

- The strategy has already been presented to and supported by Greater Manchester Directors of Adult Social Services, CCG directors of commissioning and the GMCA wider leadership team.

- Action plans for each objective are in place or in development and we will be setting up task and finish groups on to work on the implementation of the strategy.

- A separate GM strategy for learning disabilities has been developed. Implementation of the strategies will be joined up where possible and the leads for the strategies are working closely together to prevent duplication.

**PURPOSE OF REPORT:**

The purpose of this report is to seek support from GM Health and Care Board for the Greater Manchester Autism Strategy. This is GM’s first autism strategy and we believe it is the first regional autism strategy in the country. It has been led by the Greater Manchester autism consortium and has been written by autistic people and their families/carers with involvement from a range of professionals. The aspiration is that it will steer the work of GMHSCP, GMCA and locality CCGs and local authorities over the coming years and continue to support our working relationships with autistic people in GM and their families.

**RECOMMENDATIONS:**

The Greater Manchester Health and Care Board is asked to:

- Review and approve the GM autism strategy

**CONTACT OFFICERS:**

Mari Saeki- Project Lead for GMAC

mari.saeki@nas.org.uk

Rachel Tanner – DASS lead for GM ADASS
1.0 BACKGROUND

GM autism consortium (GMAC) is made up of the 10 GM local authorities, 10 CCGs and Greater Manchester Health and Social Care Partnership. All stakeholders contribute financially to the consortium and in summer 2017 the National Autistic Society won a three-year contract to support the consortium and lead on its work plan. This project is known as the Greater Manchester Autism Consortium project. One of the key tasks identified in the contract by the consortium was development of a GM autism strategy.

1.1. In his manifesto for the mayoral election, Andy Burnham committed to making Greater Manchester ‘autism friendly’. An event was held in December 2017, hosted by Andy Burnham, to bring autistic people, family and carer representatives and a range of professionals together to start work on what an autism friendly GM would look like.

1.2. The strategy brings together the work requested by the mayor on making GM autism friendly and fulfils GMAC’s request for development of a GM strategy.

1.3. In December 2017, work started to develop a GM learning disability (LD) strategy which was finalised and approved by the Health and Care board in July 2018. A decision was made by GMAC that it would develop a separate strategy distinct from the LD strategy as there are a number of unique issues that autistic people face which are not experienced or experienced in a different way to people with a Learning Disability. The implementation plans for the LD strategy and autism strategy will be linked where appropriate to prevent duplication and ensure best use of resources.

1.4 The strategy is aimed at young people 14yrs and above and adults, it is intended that over the life of the strategy further linkages with the Children’s plan will be progressed to ensure the strategy will develop to be all age.

2.0 STRATEGY DEVELOPMENT

2.1. A number of stakeholder events were held during April and May 2018 on a range of themes including criminal justice, housing and health to gather views from people on what the key issues are and what is needed to tackle them. Autistic people, commissioners, health care professionals and social workers attended these events.
2.2. Alongside this, GMAC undertook a detailed data collection exercise with all GM local authorities and CCGs to gather information on the existing services available and data held on the autistic populations in each locality.

2.3. The strategy has been overseen and drafted by the GM autism consortium steering group and two advisory groups, one for autistic adults and one for families/carers of people with autism. This has ensured the strategy effectively reflected the experiences and needs of autistic people and their families in GM.

3.0 PRIORITIES

3.1. The table below summarises the four priorities identified in the draft strategy, the work already in place to tackle them and the next steps currently planned.

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<th>WORK ALREADY UNDERWAY</th>
<th>NEXT STEPS</th>
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<tr>
<td>Access</td>
<td>Public services for autistic people should be <strong>accessible</strong> and appropriate reasonable adjustments** should be made in mainstream settings (i.e. services that are not specialist for people with autism or learning disabilities but aimed at the general population) and staff in these settings trained. This will include <strong>housing and general council services</strong>. This is also about ensuring public facilities, such as leisure and cultural spaces are welcoming, inclusive and autism friendly.</td>
<td>A reasonable adjustments guide has been produced by GMAC and will be available for publication by late 2018. Autism training is available in some localities for council and other public sector staff. The project have worked with a number of cultural and leisure services within GM to increase understanding on autism.</td>
<td>GMAC will convene a task and finish group with housing to start identifying common gaps in relation to autism and to promote the reasonable adjustment guides GMAC and stakeholders will start work on a GM autism “passport” or profile to help autistic people explain what they need as Reasonable Adjustments GMAC and stakeholders will work with the Mayor’s disability access committee on what this means for autistic adults and scope out the development of a GM ‘kitemark’, building on work in Liverpool and the National Autistic’s Society’s autism friendly award. Eligibility criteria on concessionary travel to be reviewed with a view to ensuring that autistic people who could benefit are able to access concessionary travel passes, regardless of whether they also have a learning disability.</td>
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<td>Community</td>
<td>Autistic people and their families have access to <strong>accessible information</strong> so that they are able to take part in their communities, be <strong>active citizens and access the help to which they are entitled</strong>. They are also supported to participate in the local planning of services. This strand also looks at addressing additional barriers faced by certain groups including those in the <strong>criminal justice</strong> system, older adults, women, ethnic minority communities and LGBTQ+ communities. An autism friendly Greater Manchester has to be inclusive to all in the community.</td>
<td>The project has already developed some materials on social care assessments and transitions and this will be expanded upon. The project has been meeting with a stakeholder group known as the North West Autism Criminal Justice Forum for over 10 years and this group has many GM members. GMAC will convene a GM version of this group and add to this group.</td>
<td>GMAC will ask localities to audit the information they give out on autism and on services and provide additional resources to support localities in their information provision GMAC will write an engagement plan with GM organisations that support older people, women, BME people and LGBTQ+ people GMAC will convene a task and finish group on criminal justice with to develop training and autism specific pathways through the criminal justice system.</td>
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### THEME

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<td>This includes ensuring access to <strong>diagnosis and post-diagnostic support</strong> in every area, making sure that health and care have the right <strong>information on local need and are planning</strong> the right services locally and making sure health and care staff have appropriate levels of <strong>training</strong> in line with the Autism Act. No area can be autism friendly unless statutory services are providing appropriate care and support.</td>
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<td>A mapping exercise has identified the services currently in place across GM. Standards have been produced for GM localities on diagnostic and post diagnostic support services. A draft service specification has also been developed working with commissioner, professionals and autistic people and their carers. Training standards have been written (currently in draft) and these will be shared soon with the localities.</td>
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<tr>
<td>The specification will be finalised and localities will be asked to develop plans for implementing this over the coming 12 months. Localities will benchmark their training strategy against the standards. The GM autism training group (supported by GMAC and Pathways Associates) will identify providers who meet the GM training standards and start developing a GM training plan to complement the locality plans. A GM autism register is to be established through GP surgeries [subject to further discussion with health services across GM].</td>
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<td>Some localities commission supported employment services which are available to a limited group of autistic adults. GMAC have produced some resources on transition called Growing up with autism in Greater Manchester and also some parent workshops with a stakeholder group called Autism and Transition.</td>
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<td>Autism will be one of the client groups within the proposed GM specialist employment service which will involve additional investment in supporting people into employment. The project is currently in development phase and will involve access to ESF; it is expected to be in place during summer 2018. The transition group will be reconvened to work on more resources for the localities.</td>
</tr>
</tbody>
</table>

### Employment and transition

Including employment and transition into adulthood for autistic people and family members. Greater Manchester will not be autism friendly unless we tackle the autism employment gap.

### 4.0 RESOURCES FOR DELIVERY

4.1. The strategy development and infrastructure are collaboratively funded through the Local Authorities and CCG’s in GM; many of the aspects of the strategy require minimal resources to deliver beyond this.

4.2. Where additional resources are identified over the life of the strategy they will be considered by the appropriate commissioning routes. It is anticipated that the first priority relating to diagnosis and post diagnosis will bring forward a business case to the Health and Care Joint commissioning board in year 1.

4.3. The partnership with the National Autistic society as a voluntary organisation will enable GMAC to access other national and external resources where appropriate.
5.0 NEXT STEPS

5.1 GMAC has prepared a number of documents and sent them out to the localities to prepare for implementation in April 2019. Localities have been asked to benchmark themselves against these documents and to discuss implementation in their local groups.

5.2 GMAC will convene core groups as task and finish groups on housing, criminal justice, employment and transition to start setting out terms of references for the groups. Most of the groups will be run jointly with the Learning Disability implementation leads and draw a mixed membership that will include people with lived experience.

6.0 RECOMMENDATIONS

6.1 The Greater Manchester Health and Care Board is asked to:

- Review and approve the new Greater Manchester autism strategy provided at appendix a.
Making Greater Manchester Autism Friendly 2019-2022 (version 10) FINAL

A. Vision
To work towards making Greater Manchester an autism friendly place to live. This means a place where you can; get a timely diagnosis with support, meet professionals with a good understanding of autism, find services, organisations and employers that make reasonable adjustments when required, where people can feel safe, have aspirations and fulfil their potential, and become a full member of the local community.

B. Introduction
The first Greater Manchester autism strategy has been commissioned by the Greater Manchester Autism Consortium (GMAC) - a partnership of adult services of the 10 local authorities of Greater Manchester, the 10 Clinical Commissioning groups (CCG) and the Greater Manchester Health and Social Care Partnership (GMHSCP). The governance for the consortium is in Appendix 1. The work has been coordinated by the Greater Manchester Autism Consortium project, run by the National Autistic Society.

Reflecting the remit of the Autism Act 2009, the strategy focuses on autistic adults, but also includes young autistic people in transition. However, during the course of the development of the strategy, it has become increasingly clear that in order to achieve our vision, we will need to expand the strategy to all ages in the future. This would require buy-in, engagement and funding from children’s and education services across the region.

By 2021, the GMAC project will therefore work with children’s services across the region to draw up a proposal for extension of the strategy to all ages.

The content of the strategy is based on information gathered from a stocktake exercise via a questionnaire to the 10 areas in April 2018, and a series of events between December 2017 and May 2018 plus a survey filled in by over 150 people.

This strategy covers all autistic people and their families within Greater Manchester including those with a learning disability, those without a learning disability and also those with other co-occurring conditions such as a mental health problem or physical health problems. We will ensure that we are linking closely with the Learning disability strategy and the Mental Health and wellbeing strategy in particular as some of the areas we have not covered within this strategy are covered by those two strategies.

We acknowledge that the priorities identified in this strategy may not cover every priority that needs work, but we hope that this is the first of many strategies on this issue and that this is just the starting point for Greater Manchester.

From this work, it became clear that to make Greater Manchester autism friendly, we would need to work across four key areas:

Access. This is about making sure that public services for autistic people are accessible and that appropriate reasonable adjustments are made in mainstream settings (i.e. services that are not specialist for people on the autism spectrum or with learning disabilities but aimed at the general population) and that staff in these settings are trained. This includes housing and general council services.

Community. To make sure that autistic people and their families are able to take part in their communities, be active citizens and access the help to which they are entitled, accessible
information available needs to be available and autistic people and their families should be participating in the local planning of services. This strand also looks at addressing additional barriers faced by certain groups including those in the criminal justice system, older adults, women, Black, Asian and Minority Ethnic (BAME) communities and Lesbian, Gay, Bisexual, Transgender, Queer and Others (LGBTQ+) communities.

**Health and support.** This includes ensuring access to diagnosis and post diagnostic support in every area, making sure that health and care have the right information on local need and are planning the right services locally and making sure health and care staff have appropriate levels of training in line with the Autism Act.

**Employment and transition.** This includes employment and transition into adulthood for autistic people and family members.

**Terminology-** This strategy uses identity-first language (i.e. “autistic people” rather than “people with autism”) as this was the stated preference of many of the autistic group of stakeholders who engaged with this work. This also aligns with research based on the response of over 3,000 people, led by the National Autistic Society. ([https://www.autism.org.uk/about/what-is/describing.aspx](https://www.autism.org.uk/about/what-is/describing.aspx)) We do, however, acknowledge that some people prefer the term person with autism. The term autistic also covers those who identify as having Asperger Syndrome.
## Glossary of Terms used in this report:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Expanded Version</th>
<th>Meaning (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADASS</td>
<td>Association of Directors of Adult Social Services</td>
<td>ADASS is the association of directors of adult social services in England. We are a charity and the association aims to further the interests of people in need of social care by promoting high standards of social care services and influencing the development of social care legislation and policy.</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
<td>Autism spectrum disorder (ASD) is the name for a range of similar conditions, including Asperger syndrome, that affect a person’s social interaction, communication, interests and behaviour.</td>
</tr>
<tr>
<td>BAME</td>
<td>Black, Asian and Minority Ethnic</td>
<td>used to refer to members of non-white communities in the UK</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
<td>Clinical Commissioning Groups are responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012.</td>
</tr>
<tr>
<td>EHCP</td>
<td>Education, Health and Care Plan</td>
<td>An EHC plan is a legal document that describes a child or young person’s special educational, health and social care needs.</td>
</tr>
<tr>
<td>GM</td>
<td>Greater Manchester</td>
<td>A city region consisting of ten localities: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan.</td>
</tr>
<tr>
<td>GMAC</td>
<td>Greater Manchester Autism Consortium</td>
<td>The Greater Manchester Autism Consortium’s Project provides information, advice and support to individuals, family members, carers and professionals about all issues relating to autism - children and adults.</td>
</tr>
<tr>
<td>GMCA</td>
<td>Greater Manchester Combined Authority</td>
<td>The GMCA is made up of the ten Greater Manchester councils and Mayor, who work with other local services, businesses, communities and other partners to improve the city-region.</td>
</tr>
<tr>
<td>GMHSCP</td>
<td>Greater Manchester Health and Social Care Partnership</td>
<td>The GMHSCP was formed to oversee the devolution of health and social care services. They aim is to achieve the biggest, fastest improvement to the health and wellbeing of GM.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
<td>A doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
<td>Joint Strategic Needs Assessment is a core function of health and wellbeing boards. To be fit for purpose, JSNAs should support strategy and commissioning by providing “an objective analysis of local, current and future needs for adults and children, assembling a wide range of quantitative and qualitative data, including user views”</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disability</td>
<td>A learning disability is defined by the Department of Health as a “significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood”.</td>
</tr>
<tr>
<td>LGBTQ+</td>
<td>Lesbian, Gay, Bisexual, Transgender, Queer and Others</td>
<td>LGBTQ+ stands for lesbian, gay, bisexual, transgender, questioning and “plus,” which represents other sexual identities including pansexual, asexual and omnisexual.</td>
</tr>
<tr>
<td>NAS</td>
<td>National Autistic Society</td>
<td>The National Autistic Society is a British charity for autistic people. The purpose of the organisation is to improve the lives of autistic people in the UK.</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
<td>The National Health Service (NHS) is the publicly funded national healthcare system in the United Kingdom.</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Health and Care Excellence</td>
<td>Provide the NHS, and those who rely on it for their care, with an increasing range of advice on effective, good value healthcare.</td>
</tr>
<tr>
<td>SAF</td>
<td>Self Assessment Framework</td>
<td>A questionnaire commissioned by Public Health England (PHE) to allow PHE, local authorities and their partners to monitor their progress in implementing the Autism Strategy</td>
</tr>
<tr>
<td>SEN</td>
<td>Special Educational Need</td>
<td>Special Educational Needs (SEN) is a legal term. It describes the needs of a child who has a difficulty or disability which makes learning harder for them than for other children their age.</td>
</tr>
</tbody>
</table>
C. Context

As a result of the Autism Act 2009, there are clear duties and expectations on local authorities and the NHS to plan and commission appropriate services for autistic adults and their families.

At the core of this, there is a duty on every local area to have:

- A pathway to diagnosis for adults
- A named joint commissioner/senior manager to lead commissioning of care and support services for autistic adults
- A meaningful local autism partnership arrangement that brings together different organisations, services and stakeholders locally (including autistic adults) to set the direction of services locally
- A means of collecting data and information on the needs of the local autistic population and inclusion of this information in the Joint Strategic Needs Assessment (JSNA)
- A joint commissioning plan for services for autistic adults based on the JSNA
- A plan to make sure that staff across health and care have training in autism, appropriate to their roles
- Specific training in place for community care assessors

There are additional duties and expectations as a result of the Act, which are incorporated throughout this strategy. **However, every local authority area in Greater Manchester must ensure that at the very least areas are Autism Act compliant, meaning that the above is in place by end of March 2019, when the strategy starts.**

The devolution of health and social care within Greater Manchester gives us opportunities to look at how these core elements of the Autism Act, as well as the wider duties and expectations of the Act can be delivered through joint working, as referenced in the GMHSCP Plan “Taking Charge”.

It is also important to note that this strategy will link up with other programmes of work being taken forward at Greater Manchester level. Notably, this includes the Greater Manchester work on Building the Right Support and any successor programme, the Greater Manchester Learning Disability Strategy, the Mental Health and Wellbeing strategy, the Suicide Prevention Strategy and the Greater Manchester Housing Strategy. It will also seek to link with the delivery of the work and health programme in the region.

D. Principles and Values

In developing the strategy, we have been mindful of the following principles for delivering services and support in Greater Manchester as set out in Our People, Our Place:

- A place where all children are given the best start in life and young people grow up inspired to exceed expectations.
- A place where people are proud to live, with a decent home, a fulfilling job, and stress-free journeys the norm. But if you need a helping hand, you’ll get it.
- A place of ideas and invention, with a modern and productive economy that draws in investment, visitors and talent.
- A place where people live healthy lives and older people are valued.
- A place where all voices are heard and where, working together, we can shape our future.

Building on the final principal, it is important to note that partnership working will be fundamental to the success of the strategy. In developing, implementing and reviewing the strategy, we will work in partnership with all stakeholders from decision makers to people with lived experience.
Evidence based and ongoing review – The strategy is based on evidence of need of autistic people and their families. We will continue to gather evidence of need and of what works. The strategy will need to be seen as a living document and we will keep it and the action plan under regular review to ensure we are making best use of resources to achieve the outcomes we seek.

We are also committed to principles of equality, recognising that there may be additional barriers to accessing support and help for some autistic people and their families. This is why we are committed to identifying and addressing the barriers to support and participation experienced by specific groups such as older people, people from BAME communities, women and those who are LGBTQ+.

E. Strategy
For the Action plan please see link here

**Access** - This strand is about making sure that public services for autistic people are accessible and that appropriate reasonable adjustments are made in mainstream settings (i.e. services that are not specialist for people with autism or learning disabilities but aimed at the general population) and that staff in these settings are trained. This will include housing and general council services.

**Vision:** *To ensure that mainstream services and facilities in the community are welcoming to autistic people and their families and that those services work towards achieving a Greater Manchester Autism Friendly Award to demonstrate their commitment to making the necessary changes so that autistic people feel included and welcome.***

**How do we get there?**

1. In the previous self-assessments of progress in implementing the Autism Act and in the recent stocktake of services, making appropriate reasonable adjustments to their mainstream services was identified by local authorities across Greater Manchester as a key challenge.

As a result, the GMAC project worked alongside autistic people, family members and professionals on the development of reasonable adjustment guides for different settings. These included guides for GP surgeries, Jobcentre Plus, housing offices, general council services. As well as promoting these guides (available in December 2018), we will develop new reasonable adjustment guides on public transport, other Primary Care settings and mental health and also develop plans around training that might be available within Greater Manchester.

Each local area will be expected to take these guides to their partnership boards and develop a plan for dissemination.

2. The group working on the reasonable adjustment guides identified that not only do organisations and services need to understand what reasonable adjustments are, but autistic people should be supported to explain what they need clearly in a variety of settings. Working with autistic adults and family members, we will develop a personalised reasonable adjustment profile or passport that autistic people can use in different settings across the region and ensure that this is recognisable by public services across the region.

3. Building on this work, we will develop, alongside the mayor’s office, a Greater Manchester kitemark for public spaces, facilities and mainstream services to show how they have worked to become autism friendly. The National Autistic Society has experience in this area through its autism friendly award. **We will build on this experience and work with autistic adults**
across Greater Manchester to identify the facilities that they want to become autism friendly and with additional funding we’ll roll out a kitemark in key areas across the region.

In the meanwhile, we will also work with the Mayor’s Disability Access Committee to ensure autism is included in this work.

Through our stakeholder events we were aware that transport is often a barrier to accessing support. so working with the Mayor’s office and Transport for Greater Manchester, GMAC will raise the issue of concessionary bus passes for autistic people across Greater Manchester to address the need for a consistent approach to this.

4. The last Autism Self Assessment Framework (SAF) identified that most of the areas in Greater Manchester struggled to engage housing in partnership boards nor consider them in the training delivered. The stocktake reflected this too and several areas identified that they would like help in this area.

To develop a regional and local approach to housing for autistic people, we will establish a housing task and finish group by April 2019 to report by April 2020. Part of the purpose of this group will also be to consider training needs for this sector. This will be a joint group with those leading on the learning disability strategy.

Community-. To make sure that autistic people and their families are able to take part in their communities actively participate in the local community and access the help to which they are entitled, this strand is about making sure that there is accessible information available and that autistic people and their families participate in the local planning of services. This strand also looks at addressing additional barriers faced by certain groups including those in the criminal justice system, older adults, women, (BAME) communities and LGBTQ+ communities.

Vision: Autistic people and family members can access timely, updated relevant information and support about every stage of life to and to reduce the barriers to accessing support in their community.

How do we get there?

1. The stakeholder events, stocktake and survey have shown clearly that autistic people and family members struggle to access the information they need about what is available and what care and support they are entitled to.

   GMAC have built up a website with information on different services and support available in each local council area. Each council area should review the information we have about their area on an annual basis and feedback on what needs to be added or amended.

   GMAC will also develop some information that can be shared with autistic adults and family members about the services they are entitled to by April 2019. Each locality should develop a plan for disseminating this information by April 2020.

   GMAC will also identify and share good models for sharing information and promote these to the localities at a good practice sharing event in each of the 3 years of the strategy.

2. The stocktake, the last SAF returns and the stakeholder events showed that localities are struggling to engage with criminal justice services to develop training and clear pathways for autistic adults.
3. We will establish a joint task and finish group with those key stakeholders in the criminal justice system and those with lived experience of autism and the criminal justice system to consider areas of joint working in relation to data, reasonable adjustments and training. By 2021 we will have identified some joint working plans that may involve a business case.

4. The last SAF and the stakeholder events and survey identified that the consortium needs to do more work to engage with communities that are severely under-represented in terms of diagnosis and access to support.

We will set up an engagement plan with community organisations working with BAME communities, LGBTQ+ communities, older adults and women for autistic adults and family members in order to try to understand what those barriers are and to encourage people from those communities to access support and services. After a period of scoping we will develop a plan for each of those groups to increase engagement (future business case likely).

Health and Support - This includes ensuring access to diagnosis and post-diagnostic support in every area, making sure that health and care have the right information on local need and are planning the right services locally and making sure health and care staff have appropriate levels of training in line with the Autism Act.

Vision - That autistic people and their families across Greater Manchester have timely, local, high quality access to diagnosis and post diagnostic support, social care support and information given to them by well trained professionals within well planned services that understand and can anticipate the level of need.

How do we get there?

1) Page 2 sets out the key duties and expectations on local authorities and the NHS to plan and commission appropriate services for autistic adults and their families. We will make sure that every partnership board in the 10 localities has a summary of these key duties and they will be expected to set out their next steps in each of these areas by April 2019. Below we set out some specific areas of work that will help support localities in making sure they are meeting these duties.

2) Diagnostic pathways vary considerably across Greater Manchester. In December 2017, the GMHSCP collated information on the diagnostic assessment process in every area. It found in some areas there is a specialist multi-disciplinary team that meet National Institute of Health and Care Excellence (NICE) guidance and in others diagnosis is carried out by single professionals.

To ensure that across the region, in line with the Autism Act, autistic adults can access a quality diagnostic assessment in a timely way, we will develop a clear service specification for diagnostic services, which all areas will meet by April 2021.

3) We also know from looking across autism services nationally that where autistic people have a better experience of services locally, this is often as a result of the existence of an autism specific team in their area. Where these teams have been particularly successful, they have involved diagnosis, post diagnostic support and a social care or local facilitator role who
helps to identify other agencies locally who need support to be upskilled to better support autistic people. These teams will usually only take on a very small number of direct case coordination work, for those who cannot be supported elsewhere. These teams are usually NHS led.

Research by the National Audit Office in 2009 showed these teams to be highly cost effective. In Greater Manchester, the Trafford Extended Service is an example of such a team and meets most of the green standards in the new GM standard on diagnosis.

We will work alongside health services across Greater Manchester with a view to securing coverage from this type of team across the region by 2021.

4) On post diagnostic support (which we have defined as the support available within the first year of the diagnosis and related to understanding the diagnosis), the differences between each area are even greater than for diagnosis. Some areas offer no post diagnostic support at all unless specifically requested and others offer a comprehensive package.

By 2020, we will bring together good practice across the region and beyond to showcase to CCGs within Greater Manchester what is achievable and at what cost. **We will use this information to develop a business case by the end of 2020 for the development of services that could be offered across Greater Manchester as part of a post diagnostic ‘offer’ for the region.**

5) While, as a result of the Autism Act, there are clear duties on health and care to deliver training in autism to staff at all levels, we know from the stocktake that most of the 10 areas do not have a strategy on delivering autism training locally. Training for specific groups such as social care assessors varies greatly across Greater Manchester and most of the 10 areas do not have access to regular training.

Local authorities, CCGs and NHS Foundation Trusts must make sure that they are complying with the requirements on training as set out in the Autism Act. The GMAC project will provide information on those requirements to autism leads and partnership boards to help them to review compliance.

To support better training in autism across the region, we will also use the new competency framework currently being developed by Health Education England, to develop a Greater Manchester training plan for health and care services. This will include clear expectations on localities to ensure that they are meeting statutory duties, but also identify where delivery of training may be appropriate in partnership across locality areas.

6) We know that local areas are struggling to collect accurate data on the needs of their local autistic population. This means that they aren’t able to plan effectively, based on local needs.

In line with the Autism Act statutory guidance, there is some data that local councils should already be collecting. We will identify this, share with autism leads and ask them to report back on how they will ensure they are collecting this data by April 2019.

We will also identify good practice in data collection on autism within local councils and share this with autism leads and partnership boards.
In addition, from April 2018, NHS trusts have been required to collect data on diagnosis waiting times as well as the services they provide to autistic people. In addition, there are also moves to develop a national GP autism register. This is currently a recommendation by the NICE to NHS England, following a pilot in number of CCG areas in England.

We will work with the Health and Social Care Partnership to ensure that the region uses the information from NICE’s pilot to introduce a GP autism register by the end of 2020 and that protocols are established so that anonymised data from NHS Trusts and from the register can be shared with local councils.

7) Within Greater Manchester, there are a number of specialist posts that support the implementation of the local autism strategy. These posts vary but most of the posts support the partnership boards, deliver training and as highlighted under point 3 above are often embedded into the post diagnostic offer and support. Evidence from the SAF returns show that such posts help secure local implementation of the strategy. We will share with localities business cases for these types of roles and job descriptions.

8) There is a significant unmet need for autistic adults not eligible for social care support, who may need some help in their day to day lives to prevent social isolation and the development of mental health problems.

There are a number of local small community groups and support groups who provide some of this support. We will work with local GM community groups such as the council for voluntary services to develop a network of these groups and support them to build up their capacity, identify where they could work together and where they could access funding. This group, alongside other key stakeholders including the GMAC Advisory Group will also help in identify key priorities, projects or support that aim to counter social isolation within Greater Manchester and gaps in the post diagnostic offer available (including where those who have been diagnosed were not offered post diagnostic support at the time). This will include work to increase resilience with autistic adults. During 2020-2021 the group will develop a business case on GM wide services or support that would address some of those gaps

We will also look at the feasibility of establishing National Autistic Society Branches in Greater Manchester. National Autistic Society research has shown that 81% of people involved in their local branch felt less isolated as a result.

9) Autistic people and their families tell us that mainstream health services do not always meet their needs. In particular, they feel that appropriate reasonable adjustments are not made within health settings. In the October 2017 GMAC service specification there was a target to develop plans for Autism Friendly hospitals. This will require further investments and we will gather the evidence to develop a business case for this during the life of this strategy.

In the meantime, we will write reasonable adjustment guides for acute hospital settings as well as adding to the reasonable adjustment guides we have already developed on GP surgeries to extend this guide to other primary and secondary health care settings

10) GMAC have developed carers’ resilience programmes and parent seminars and we will increase capacity for these programmes in a variety of ways, including running “train the trainer” sessions and supporting parents to fundraise to run them.
Employment and transition- which includes employment and transition into adulthood for autistic people and family members

Vision: All autistic people and their family members are given the right information to prepare for adulthood and that those autistic adults who are able to work can access the support they need to find and maintain work, including from employers who understand them.

What do we need to do?

1. There are clear statutory duties that all local areas should be complying with already regarding transition. We will circulate a check list to each partnership board for them to check their compliance against statutory duties.

2. The stocktake, stakeholder events and survey identified that there is a gap in information and support for parents with respect to transition to adulthood.

   We will promote the resource “Growing up with autism in Greater Manchester”, previously developed by GMAC. We will also gather examples of good practice around transition and preparation for adulthood and hold an event to share this practice with commissioner and practitioners across the region.

   Localities will be expected to take the resources to the autism partnership boards and children’s boards, as well as information from the good practice event and develop a plan for using the resources or building on the good practice to improve transition processes in their area.

3. We have also developed a transition workshop programme for parents which localities can use. A roll out of the workshops across Greater Manchester will require additional funds.

4. We will reconstitute the autism and transition group that developed the “Growing up with autism” materials and invite extra stakeholders to start to identify other gaps in transition across GM. The group will consider what other resources could be developed to support better transition and how the previously developed resources could be better utilised across GM.

5. In Greater Manchester, we want to lead the way on transition for young people on the autism spectrum and ensure planning for those who don’t have an Education, Health and Care Plan (EHCP) still happens. We will use the resources outlined above to develop a framework for a transition review for 14 year old autistic young people on Special Educational Need (SEN) support. This framework will be developed with localities and be ready to begin rolling out from the school year starting in September 2020.

6. GMAC will work with children’s services across the region to draw up a proposal for extension of the strategy to all ages.

7. The stocktake and stakeholder events reinforced the importance of employment on the wellbeing of autistic adults. To reach employers in the region, we will work with the mayor’s office on the GM Employer’s charter and ensure that autistic people will be included in this.
8. The stocktake, the Learning Disability Strategy Sub Group on supported employment and stakeholder events identified how much variance there is across Greater Manchester in the provision of employment support was for autistic adults. More widely, autistic people have identified the need for support in finding, staying in work and progressing at work.

A task and finish group on employment will be established by April 2019. The group will develop a plan for improving the support available across Greater Manchester and this will be a joint group with those leading on the learning disability strategy. This will include looking at developing standards for employment support (to complement the standards that the learning disability sub group are developing for supported employment), working with Jobcentre Plus, ensuring employment is part of local autism strategies, identifying actions around self-employment and looking at preparation for work. A business case will be developed if we identify common gaps across GM by this group.

**Next steps**

Once the strategy has been signed off, the task and finish groups will be convened and an engagement plan implemented. Membership will be drawn from autistic people and family members, relevant professionals support organisations and commissioners. The groups will report back to the Greater Manchester Autism Consortium Steering group on a quarterly basis. The strategy and in particular the action plan will be updated quarterly to reflect latest developments.

Tim Nicholls, Mari Saeki, Emma Roberts, Debbie Waters and Abigail Gibson

**GMAC Updated January 2019**
Date: 25 January 2019
Subject: Greater Manchester Teaching Care Homes
Report of: Dr Richard Preece, Executive Lead for Quality, GMHSC Partnership and Professor Alison Chambers, Pro-Vice-Chancellor, Faculty of Health, Psychology and Social Care, Manchester Metropolitan University

SUMMARY OF REPORT:

This paper outlines the proposed approach to develop a sustainable Greater Manchester Teaching Care Home (TCH) Model which will lead and embed a culture of collaboration for continuous learning and development, supporting ongoing improvements in the care home sector.

The Greater Manchester TCHs will be equipped with the ability to support the ever changing requirements and expectations of the ageing population within Greater Manchester, fully supported by innovative technology and research. Developing a research and innovation platform, the programme will support the provision of an environment that enables student placements, apprenticeships, work experience, etc. In doing this, the TCH model will encourage a much needed cohort of new professionals to enter the health and social care sector.

By developing strong intergenerational relationships within the community and providing a platform for information and advice sharing, we will strive to create an environment that lends itself to cultivating, encouraging, supporting and promoting these relationships; in turn, changing the perception of living and working within a care home, which will be an integral part of the community.

A Greater Manchester TCH is not a medical education centre but a training, innovation and development centre for all health and social care staff and future health care professionals, including student nurses, social workers, etc.

This programme will build on the national Teaching Care Home pilot. Initially training and developing all health and social care staff within a care home setting, then going forward, developing an ongoing innovative, forward thinking sustainable plan for future generations of both individuals and the workforce.
By developing this model the staff will be able to transfer skills and learning into other sectors of social care, for instance care at home. This aligns to the NHS long term plan. The TCH programme will also offer training, support, mentoring and advice and encourage personal self-development. This will create a strong career path in social care, going some way to plugging the gap in the recruitment and retention issues faced within the current market.

By initiating all of this, it is within our gift to stabilise the current situation of quality delivered within some of the settings across Greater Manchester. We will not only support, encourage and promote cultural change, but support all employees, family members and advocates. By undertaking all of the above, we will ultimately enhance the lived experiences of all the individuals who reside in any care home setting across Greater Manchester. This will go some way to ensuring any individual who receives services via social care feels valued, empowered, purposeful, respected and continues to feel part of their wider community. Making a care home setting a positive place to live and work, being mindful that this is the individual’s home.

By testing the model with selected care homes across Greater Manchester, we have the potential to improve, change, shape and mould not only the lived experience of over 750 residents but enhance the blended skill set that already exists in the cohort of over 1,040 employees.

**KEY MESSAGES:**

Extensive engagement has taken place during the initial scoping exercise with a wide range of stakeholders including providers, the Care Quality Commission, Directors of Adult Social Services, Directors of Commissioning (Clinical Commissioning Groups), third sector providers, universities and vanguards which are focusing on the social care sector.

Engagement has and will continue; this has included developing an international partnership with the Schlegel Villages, Research Institute for Ageing and Conestoga College in Canada. It was very encouraging to realise the programme that the Schlegel Villages, alongside the Research Institute for Ageing, have implemented was aligned to what we have proposed and had numerous similarities. This gives us a good platform of evidence based achievement that they are willing to support and share with us going forward, to ensure the success of the programme. The Research Institute for Ageing are fully supportive of fostering a strong partnership.

Engagement has also taken place with other stakeholders including NHS England’s Chief Nursing Officer, Deputy Chief Nursing Officer, National Lead for Community Nursing and the Project Manager for the National Leading Change Adding Value team; with NHS England North’s Director of Nursing/Independent Care Sector Regional Lead. These have been positive meetings and they have requested updates and case studies. Engagement continues to take place and the GMHSC Partnership’s communications team and links to the programme have been made.
A Task and Finish Group has been established with membership from key stakeholders, including the Care Quality Commission, Skills for Care, Universities and commissioner representatives.

In order to select the care homes to test the model, a rigorous selection programme was undertaken, with the first stage being an expression of interest from care homes backed and supported by the local authority. These then went to a panel of health and social care professionals for selection. Seventeen care homes have been carefully selected across Greater Manchester. The chosen care homes have already shown great enthusiasm at being involved in the transformational work of the Greater Manchester devolution, which is encouraging at this early stage. Site visits have taken place and we have already been able to identify best practice within these care homes, which will be shared across Greater Manchester.

Several of the care homes have areas rated as “Outstanding” and this programme will assist in understanding how other care homes can achieve and sustain this rating, ultimately striving for outstanding.

Sharing the learning with the other test sites and not working in isolation will only allow for positive best practice dissemination to other care homes, encouraging and developing strong partnership working. The evaluation from the research being undertaken by Manchester Metropolitan University and Salford University will clearly show custom and practice that needs developing and others that can be enhanced allowing for the smooth roll out across the Greater Manchester care home sector in the future.

The launch event for the testing of the model is currently being planned for 8 February 2019. The Greater Manchester TCH Model will be further developed on the day of the launch to ensure that, from the beginning, it is co-designed, developed and implemented by the selected care homes and other key stakeholders having full involvement from all key partners.

By co-designing the model with the selected care homes and other professional stakeholders the Greater Manchester TCH model will become an innovative centre for learning and development for all, upskilling a much needed workforce, creating a strong route for quality improvement, developing a strong sustainable career path in care. Also ensuring intergenerational and community inclusion becomes a key driver in the lived experience for the individuals who reside in the settings.

PURPOSE OF REPORT:

This paper outlines the proposed approach to develop a sustainable Greater Manchester Teaching Care Home (TCH) Model across Greater Manchester which will lead and embed a culture of collaboration for continuous learning and improvement. It will also lead on the cultural change management programme that is required to allow for the intergenerational relationships and community inclusion programmes to be designed, developed and implemented with success.
RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Endorse the testing of the Greater Manchester Teaching Homes Programme.
- Endorse the progress made to date in taking this work forward.
- Note the current position of the programme.

CONTACT OFFICERS:

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1.0 INTRODUCTION

Greater Manchester Health and Social Care Partnership (GMHSC Partnership) was approached by Manchester Metropolitan University (MMU) regarding a proposed Teaching Care Home (TCH) Model. The MMU had been involved in the national TCH Pilot which was a Department of Health funded programme of work led by Care England (the leading representative body for independent care services in England).

“The pilot set out to change and challenge prevailing perceptions: recognising that the key to sustainability in the sector is through workforce training and development and through this delivering improved health and care outcomes for residents. It aimed to ensure that people who are training to be the next generation of health and social care professionals, could learn from the experience of the care home sector, and would be better equipped to manage the health complexities and social care needs of an ageing population.” (Care England, http://www.careengland.org.uk/teaching-care-home-pilot). At that time, there were 5 care homes involved in the pilot and, although they had produced a draft vision, they had not identified the key elements/standards required to become a TCH.

1.1 It was therefore agreed that the GMHSC Partnership would explore the TCH Model and attempt to define what the model would be and what the minimum standards would be required for them to be recognised as a TCH.

1.2 Following the initial scoping exercise which involved care home visits, stakeholder engagement and researching key publications, it become apparent that there is a clear case for a much needed programme of change within the care home sector. The programme has continued to progress which has included engagement with key stakeholders, establishment of a Task and Finish Group (which includes the Care Quality Commission, universities and commissioner representatives), identification of work streams and leads and development of draft principles of a Greater Manchester TCH Model.

1.3 It is proposed that a Greater Manchester TCH model is developed and tested within selected sites in Greater Manchester over a 12 month period and that, in parallel to this, the standards within all care homes are improved in line with the Quality Improvement Framework. Care homes have expressed an interest and 17 have been selected across Greater Manchester and are excited to be part of this innovative programme.

2.0 PRINCIPLES OF A GREATER MANCHESTER TCH

The draft Principles of a Greater Manchester TCH is attached (Appendix 1). The model encompasses both residential and nursing, leading and embedding a culture of collaboration for continuous learning and improvement. It is a recognised care home which has been developed to provide an education and learning environment
for all health and social care staff, both internal and external, whether they provide direct care to residents or other services (clinical and non-clinical). It will also become a research and innovation platform and provide student placements, apprenticeships, work experience, etc. and develop a relationship with the community by providing advice, information and changing the perception of a care home. A Greater Manchester TCH is not a medical education centre but a training and development centre for all health and social care staff and future health care professionals, including student nurses, social workers, etc. Therefore, this programme will build on the national Teaching Care Home pilots, training and developing all health and social care staff within a care home setting.

2.1 The programme will work in partnership with key stakeholders, including providers and will focus on:

- Identifying and developing training for all health and social care staff within a care home setting, some of which can be extended to other organisations, families and communities.
- Developing a clear career progression, with clear roles and responsibilities.
- Developing a standardised training and educational passport which can be transferred between organisations.
- Research technology to enable training, on-line consultations and to increase social inclusion.
- Understand how the third sector can contribute to the care homes.
- Develop networks between care homes and commissioners to share best practice, advertise events, ask for advice, etc.
- Identify benefits/incentives.
- Develop a sustainability plan, which includes ongoing quality improvement, continuous monitoring and development.
- Identify best practice and establish evidence of good practice and outcomes in all the above areas.

2.2 The following work streams have been established to develop and co-design the above areas with selected care homes:

- Workforce
- Social and Community Inclusion
- Research, evidence and innovation
- Identification of benefits and incentivisations
- IT Technology and Network Development
- Sustainability

3.0 CURRENT POSITION

The Greater Manchester TCH programme is now in a strong position to shape and model the future of care, education and training delivered in the care home sector. A programme of work has been developed to enhance a career pathway in the social
care sector with strong emphasis on succession planning for the future. We have forged strong relationships with the commissioners, providers, universities, CQC, Skills for Care, HEE, the third sector and others. We continue to develop partnerships including international partnerships (e.g. Schlegel Villages, Research Institute for Ageing and Conestoga College in Canada) and we are applying for funding when the opportunity arises.

3.1 The programme has the backing of all our partners and providers, who, through a rigorous selection process, have been chosen to start the journey of bringing Greater Manchester’s care home sector’s quality provision to great heights. We received expression of interests from care homes from each of the 10 localities and the selection process has been completed.

3.2 It was essential that a robust and transparent process was undertaken and that the right establishments were identified for the test sites. The site visits included a meeting with the key individuals within the care homes and included an environmental audit. These have been undertaken and the care homes are already energised and are positive that the devolution is involving the care homes and coming to fruition.

3.3 The site visits undertaken have already identified best practice care homes are undertaking and could be shared across GM. Also several of the care homes have at least one area rated “Outstanding” and this programme will assist in understanding how a care home can achieve this rating and share the learning with the other test sites and disseminate to other care homes.

3.4 To be able to measure and monitor the success of quality improvement within education, training and development, it has been recognised we need a strong platform of social care settings that specialise in the care of the elderly. This is because other specialities are more complex and therefore require different skill sets. However, one test site does have a blended set of specialities which include a small cohort of residents with learning disabilities and this site will be used to see whether learning from the test sites can be replicated within care homes which specialise in other areas, e.g. LD, mental health. The next phase will include these specialities.

3.5 We have the power to improve change not only in the lived experience of over 750 residents, but also to enhance the blended skill set that already exists in a cohort of over 1,040 employees.

3.6 A launch event is currently being planned for 8 February 2019 and the Greater Manchester TCH Model will be further developed to ensure it is co-designed with the selected care homes and other key stakeholders.

3.7 The Programme Lead and Manager continue to undertake engagement with key stakeholders and are members of the GM Quality Group which feeds into the Care Home Delivery Group. This ensures that the work is aligned with other care home programmes of work and there are no duplications or gaps.
4 RECOMMENDATIONS

4.1 The Greater Manchester Health & Care Board is asked to:

- Endorse the testing of the Greater Manchester Teaching Homes Programme.
- Endorse the progress made to date in taking this work forward.
- Note the current position of the programme.
Appendix 1

Principles of a Greater Manchester Teaching Care Homes Model

“The state of adult social care services 2014 to 2017” state's that the learnings from their findings are as follows:

- All services can learn from other services that give good care.
- Strong managers are important for services in giving good levels of care. They are able to talk to all staff and they are honest about what is happening and what they can do.
- Good staff will have had training, are caring, want to do their jobs well so the people they care for live a happy life.
- Services that give person-centred care will give good care and always find ways to improve. Staff really get to know people for who they are and know what they like and dislike.

This programme strives to achieve the above by enabling the workforce to be upskilled, educated and mentored with strong leadership. This will allow for the raising of the profile and perception of care homes so that they are seen as a positive career choice with career pathways, a place people will want to live and the hub of the community. The care homes will have a learning and improvement environment by developing a culture of continuous learning and improvement, within and across organisations that work together by identifying opportunities to draw on what works and promote good practice. It will also enable the residents to have a voice, to retain the sense of one’s own value and worth as a person, retain their identity and dignity and feel part of the care home and local community.

PRINCIPLES OF A TEACHING CARE HOME

A Teaching Care Home (TCH) encompasses both residential and nursing, leading and embedding a culture of collaboration for continuous learning and improvement. It is a recognised care home which has been developed to provide an education and learning environment for all health and social care staff, both internal and external, whether they provide direct care to residents or other services (clinical and non-clinical). It will also become a research and innovation platform and provide student placements, apprenticeships, work experience, etc. and develop a relationship with the community by providing advice, information and changing the perception of a care home. A GM TCH is not a medical education centre but a training and development centre for all health and social care staff and future health care professionals, including student nurses, social workers, etc. Therefore, this programme will build on the national Teaching Care Home pilots, training and developing all health and social care staff within a care home setting.
A GM TCH will provide learning and education both internally and externally which will include:

- Training, information and advice, on the job learning to all health and social care staff, e.g. healthcare assistants, housekeeping, maintenance, kitchen staff, etc. for both internal health and social care staff and other care homes. This can also be extended to other organisations, e.g. acute trusts, ambulance service, pharmacists, primary care providers, etc. as well as families and communities.
- A TCH will become part of the wider community and will lend itself to form a community hub offering community inclusion and integration with the staff and residents of the establishment.
- The training will also include student nurse placements, working closely with all universities within GM. They will provide mentorship, supervision and assessment of the student nurses. The intention will be to explore the possibility of also including other professions for student placements, e.g. social workers, junior doctors, physio, OT, podiatry, mental health etc.
- The TCH may be identified as an expert in a specialism, e.g. dementia and will be required to support and share knowledge and skill sets with other care homes, organisations, families and communities. The specialism may also include social inclusion, use of technology, advice regarding providing choice to residents, etc.

The GM TCHs will have:

- a CQC rating of Good and working to achieve outstanding
- a Registered Manager with a proven track record
- a sustainable workforce – turnover of staff to a minimum
- nurses that have mentorship training (nursing homes only)
- staff trained and willing to supervise and develop others
- Standard Operating Procedures, with clear understanding of policies and procedures delivery
- Quality surveillance - key quality performance indicators and key improvement matrix and monitoring
- a workforce and owner which is open to change
- an understanding of financial profit and loss
- a facility that offers itself to be a TCH – right environment and culture
- a fully trained and compliant care team
- part of a an innovative improvement community/working group supporting other TCHs/care homes
- welcomes new innovation
- leadership shared across the organisation
- communities of practice
- mentoring and coaching each other
- Research/evidence based improving care
PROGRAMME FOCUS

Testing the GM TCH Model

We will run a test programme of the GM TCH model over a 9-12 month period. This will allow for a solid evaluation and research ensuring that once this is proven to be successful we can roll out across the whole of the care home community in GM. For phase 1 of the testing, expressions of interest will be sought from care homes which have the following minimum requirement:

- a CQC rating of Good and working to achieve outstanding
- a Registered Manager with a proven track record
- a sustainable workforce – turnover of staff to a minimum
- nurses that have undertaken or are working towards mentorship training (nursing homes only)
- staff willing to supervise and develop others
- a workforce and owner that are open to change
- a facility that offers itself to be a TCH – right environment
- a commitment to be part of an innovative improvement community/working group supporting other TCHs/care homes
- welcomes new innovation
- is open to having leadership shared across the organisation

Once the model has been tested and adapted where required, the programme will consider care homes that are rated Requires Improvement and then the remaining ratings.

Initially there will be a requirement to develop a learning and improvement culture within the proposed TCHs. To enable them to do this, key senior leaders will be provided with change management training.

The programme will work in partnership with key stakeholders including providers and will focus on:

- **Identifying and developing training for all health and social care staff within a care home setting, some of which can be extended to other organisations, families and communities.** This will include developing a culture of collaboration for continuous learning and improvement, leadership training, change management training for key senior staff within care homes to enable them to make the necessary changes required to become a TCH. It will also include train the trainer, mentorship training, Care Certificate etc. It will identifying different methods of training, e.g. e-learning, work place training, 1:1 and group learning, web-ex training, mobile training, etc. **Not all training will result in a recognised qualification but would be included on a training passport.**
- **Developing a clear career progression, with clear roles and responsibilities.** This may include reviewing and standardising job titles. This will also include student placement and apprenticeships. Other types of roles/training will be explored.
- **Developing a standardised training and educational passport which can be transferred between organisations** to reduce costs, ensure health and social care
staff are trained to a minimum level and enable new starters to commence in their roles within a shorter period of time.

- **Research technology to enable training, on-line consultations and to increase social inclusion.** This may also encourage community involvement, e.g. internet café, games consoles, Skype, etc.

- **Understand how the third sector can contribute to the care homes**, e.g. involvement of volunteers, enabling choice, reducing social isolation, providing ideas and sign-posting staff to activities, encouraging the community to be involved, etc.

- **Develop networks between care homes and commissioners to share best practice, advertise events, ask for advice, etc.** This will also include access to documents and up to date regulations and information for the residents, families and public. These networks may include face to face meetings or technology.

- **Identify benefits/incentives** for the TCHs and other care homes that aren’t necessarily financial but may reduce costs, e.g. bulk buying of equipment across GM, shared training/train the trainer to reduce costs, etc. Also possible clauses within contracts, e.g. a requirement to be involved and attend networks for a selected number of times per year.

- **Develop a sustainability plan**, which includes ongoing quality improvement, continuous monitoring and development.

- **Identify best practice.** Identify and establish evidence of good practice and outcomes in all the above areas.

The programme will take a phased approach which will be identified within the implementation plan and will be developed in partnership with key stakeholders, including providers.

**PROPOSED WORK STREAMS**

Work streams will be established with key stakeholders, including providers. The proposed work streams are therefore:

- **Workforce**

  **Talent Development & System Leadership**
  - Basic skills training
  - Standardising training – Training Passport
  - Registered Manager Leadership Development
  - Developing a culture of collaboration for continuous learning and improvement
  - Shared leadership
  - Promote asset based models of care
  - Induction
  - Change management
  - Development to support new roles (e.g. tech assisted care)
  - Pre-employment support

  **Employer Brand and Offer**
  - Reviewing job titles / roles
Enabling Trusted Assessments
- Increase perception of care as a career choice
- Pay and conditions
- Flexibility and benefits

Grow Our Own
- Student placements, e.g. nursing, social workers, etc.
- Career progression and development of career pathways
- Apprenticeships and opportunities through the Levy

Filling Difficult Gaps
- Development of new roles
- Reviewing skills mix
- Shared staff resources
- Use of agency review
- Values based recruitment
- Volunteers

- **IT Technology and network development**
  - Website portal – legal requirements, advertise events and training, sharing of best practice, restricted forums for care homes, commissioners
  - Network development – Commissioners network, care homes network
  - Introduction of I.T. technology into the care homes, e.g. Skype, E-consultations, etc. utilising learning from vanguards
  - I.T. training (excluding NHS mail and Information Governance Tool Kit – being led by another programme)

- **Social and community inclusion**
  - Third sector engagement
  - Education engagement, e.g. schools
  - Community engagement
  - Positive promotion
  - Social inclusion – reducing loneliness/social isolation, patient choice, continuing previous activities and keeping mobile/active

- **Sustainability programme**
  - Quality Improvement (gold standard)
  - Monitoring

- **Identification of benefits and incentivisation**
  - Identify benefits and incentivisation – linking into the GMHSC Partnership’s Incentivising Reform work stream.
  - This may include:
    - GM bulk buying, e.g. latex gloves, uniforms, incontinence pads, etc. (pilot being undertaken and outputs will be shared)
    - Solar panels
    - Wi Fi
- Contracts – include requirement to network, ensuring there is a learning culture, having student placements and mentors, etc.

**Research, evidence and Innovation**
- This will include establishing evidence of best practice outcomes and designing and implementing robust evaluation of the feasibility, acceptability and preliminary efficacy of the TCH model. This research/evaluation is essential to identify what are the essential and flexible elements of the TCH model and, consequently, how to roll out the model more widely.

**OUTPUTS FROM THE PROGRAMME**

The outputs from the testing will be:

- Culture will have shifted to an education/learning environment
- Engagement, co-operation and partnership working
- Enhanced training and development including student nurse placement, social work placements, apprenticeships and training passport for all health and care staff
- Third sector engagement
- The communities view of the care home as part of their community
- Support networks including I.T. communications portal
- Adoption of social integration technology, e.g. facetime, internet shopping
- Staff feel they have a voice, have a chance of progression, have support, opportunity for reflection,
- Inter-generational relationship is strong and has been developed/nurtured/is flourishing
- When we meet a resident, they feel that there has been a positive impact on social isolation and loneliness
- Regular evaluation with residents, families and advocates
- Be in receipt of good news stories, testimonials, some ‘positive noise’, changed perceptions of the care home sector
- Quality surveys to evidence the above will have been developed in partnership with staff, residents, families and advocates

**RAISING THE STANDARDS IN OTHER CARE HOMES**

In parallel to the testing of the TCH model, to enable the smooth roll out of the model to other care homes there will be a requirement to raise the standards to meet the criteria and adhering to the Quality Improvement Framework. Therefore, the programme will also focus on quality improvement and the implementation of standards and best practice. There are several different programmes already being undertaken both within GMHSC Partnership and in localities on quality improvement and the TCH programme will link into these to avoid duplication, share good practice and ensure they complement each other. Examples of current work/best practice and innovation being undertaken which we will include are the Red Bags, standard operating procedures, trusted assessor, medicines optimisation, on-line consultations (which are not exhaustive).
All health and social care staff will:
- work as a team with one single set of objectives, values and standards
- have access to ongoing training and development to a set standard for the lifetime of their careers
- receive solid leadership, mentorship and supervision
- have the benefit of partnership working across networks and peer support
- have the knowledge and understanding of the care sector environment, their responsibilities/expectation and what opportunities are available to them to further their careers
- agree to engaging with research and teaching and improving practices etc.

We need to build key partnerships within GM to form an alliance which will drive and lay the foundations for GM ultimately having the ability to utilise skills sets of key professionals to develop and improve the care offering to the most vulnerable/elderly individuals within the care home sector.

**SCOPE OF THE TASK AND FINISH GROUP**

Please refer to Terms of Reference.

_Sandra Malpeli, Head of Quality Improvement (Social Care)_
_Isabella Woodcock, Programme Manager - Operations (Quality)_
1 May 2018
Date: 25 January 2019
Subject: Medicines Excellence
Report of: Dr Richard Preece, Executive Lead for Quality and Medical Director, GMHSC Partnership

SUMMARY OF REPORT:

The Greater Manchester health and care system is confirming its strategy to achieve the “safe, efficient, effective use of and research into medicines to enable the best possible outcomes”.

KEY MESSAGES:

This is how we will deliver medicines excellence across Greater Manchester. It acknowledges the work that needs to be addressed across localities and that this may differ across and within sectors. This first phase of implementation will be reviewed a year after it has been agreed.

The success of reducing variation and improving prescribing, dispensing and administration of medicines will improve outcomes for patients of Greater Manchester. This is one plan where addressing polypharmacy, de-prescribing, medication reviews, diverting patients away from GP practices and A&E would generate the funding to reinvest in future innovations for medicines.

Medicines Excellence calls for a truly integrated and system based approach to medicines with a clear expectation that localities will have the necessary governance mechanisms in place to ensure coordination across the care spectrum of home, primary, community and hospital care settings. All aspects of medicines delivery need to join up so that the organisations involved work collaboratively in pursuit of the strategy for the benefit of the patient and value for money for the tax payer.

Medicines Excellence focuses on the short-term objectives. For each area an overall objective has been compiled at the end of each intervention which will support the
actions that will need to be implemented to achieve this objective. It should be noted that Localities of Greater Manchester will determine which areas they will focus on depending on the needs of their patients and that successes will be shared across Greater Manchester.

PURPOSE OF REPORT:

To update the Board on the progress of the Greater Manchester Medicines Excellence Plan.

RECOMMENDATION:

The Greater Manchester Health & Care Board is asked to:

- Support the implementation of the short-term objectives 2018-2021 set out in the Medicines Excellence plan.

CONTACT OFFICERS:

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Medicines Excellence

Draft v13 Greater Manchester Medicines Strategy Implementation Plan: Short Term Objectives 2018-2021
Introduction

1 Supporting prevention and self-care
1.1 What do we want to achieve
1.2 Short term objectives (2018-2021)
1.2.1 Social Prescribing
1.2.2 The Healthy Living Pharmacy (HLP)
1.2.3 Community Pharmacy being the first port of call for treatment pathways to support self-management.
1.2.3.1 New Urgent Medicines Supply Advance Service (NUMSAS)
1.2.4 Conditions for which over the counter items should not routinely be prescribed in primary care: A consultation on guidance for CCGs

2 Safer use of medicines
2.1 What do we want to achieve
2.2 Short term objectives (2018-2021)
2.2.1 Reduce Prescribing of Antimicrobials
2.2.1.1 Antimicrobial Stewardship Dashboard
2.2.1.2 Examples of innovation in reducing prescribing of antimicrobials from Localities
2.2.2 NHS England Clinical Pharmacists in GP practice pilot
2.2.3 NHS England Medicine Optimisation in Care Homes model
2.2.4 Salford MedicAtion Safety dashboard (SMASH) and PINCER
2.2.5 Develop an open and transparent culture of reporting and learning from medication errors
2.2.6 Clinical handover to community pharmacists (TCAM)
2.2.7 Polypharmacy
2.2.8 Reduce avoidable harm caused by medicine (STOMP)
2.2.9 Medicine related admissions

3 Person centred care and support
3.1 What do we want to achieve
3.2 Short term objectives (2018-2021)
3.2.1 Extend the New Medicines Service (NMS) Advanced Pharmacy Service

4 Standardised, best value, care
4.1 What do we want to achieve
4.2 Short term objectives (2018-2021)
4.2.1 NICE Technology Appraisals
4.2.2 Acceleration of good practice
4.2.2.1 Greater Manchester Primary Care
4.2.2.2 Greater Manchester Hospital Pharmacy Transformation Collaborative
4.2.3 Standardisation of Prescribing in Care Pathways
4.2.4 Standardisation of prescribing for children and young people with long term conditions

5 Innovation and Research
5.1 What do we want to achieve
5.2 Short term objectives (2018-2021)
5.2.1 Single research process, gateway and tariff agreed for Greater Manchester sites.
5.2.2 Collaboration with the Industry
5.2.3 Identification of studies and technologies for adoption
5.2.4 Programme to eradicate Hepatitis C virus

6 Workforce
6.1 What do we want to achieve
6.2 Short term objectives (2018-2021)

7 Conclusion
Introduction

The Greater Manchester Medicine Strategy sets out a five year vision to achieve the “safe, efficient, effective use of and research into medicines to enable the best possible outcomes”.

For the vision to be successful professions across primary, secondary and community care will need to work together and feedback to the economy their successes in the delivery of medicines excellence.

An implementation plan task and finish group drawn from experts in the field of medicines from Greater Manchester was established to review and identify priority areas.

The conclusions of the group were as follows:

- Initially to focus on short term objectives and phase the wider Implementation Plan over the five year period.
- There is a need for a proactive approach to “accelerate implementation of best practice” building on existing evidence based initiatives.
- Target key therapeutic areas such as respiratory, cardiovascular, mental health and diabetes to improve the quality of prescribing and patient outcomes.
- Reduce polypharmacy with a focus on eliminating inappropriate medication for people with learning disabilities and mental health conditions. This requires a collaborative approach to reduce the use of powerful medicines in these patient cohorts.
- Initiatives to be presented in a standardised proforma and agreed through the governance route before implementation.

Leads have been identified for each initiative within the Strategy:

- Clinical Commissioning Groups – Medicine Optimisation teams
- Clinical Standards Board formerly Greater Manchester Medicine Management Group (GMMMG)
- Pharmacy Local Professional Network (PLPN)
- Greater Manchester Health and Social Care Partnership (GMHSCP)
- Health Innovation Manchester (HInM)
- Chief Pharmacists – NHS Acute Trusts and Mental Health Trusts
- Primary Care Advisory Group (PCAG)

This implementation plan highlights initiatives that are to be implemented in the short term, i.e. 2018-2021. There will be two further plans for the medium and long term initiatives. The plan consists of existing initiatives that require accelerated implementation across Greater Manchester and new initiatives to be agreed; enabling commissioning decisions to be agreed by the relevant stakeholders.

A separate piece of work is required to develop a dashboard to monitor the progress of the initiatives both qualitatively and quantitatively. The overall objectives within this document will be captured in addition to quality indicators developed with the Medicine Optimisation
Teams and the Chief Pharmacists within the Localities and progress will be monitored through the quarterly CCG Assurance meetings.

The ambition is to standardise prescribing, dispensing, administration, purchasing and innovation of medicines across Greater Manchester by 2021. This will be achieved through quality improvement methodology and should not be mistaken for a lack of ambition. The outcomes and rewards in the improvement of quality of life, treatment and outcomes to the patient should not be underestimated.

This is a framework of how we can deliver medicines excellence across Greater Manchester. It acknowledges the work that needs to be addressed across localities and that this may differ across and within sectors. This first phase of implementation will be reviewed a year after it has been agreed.

The success of reducing variation and improving prescribing, dispensing and administration of medicines will improve outcomes for patients of Greater Manchester. This is one plan where addressing polypharmacy, de-prescribing, medication reviews, diverting patients away from GP practices and A&E would generate the funding to reinvest in future innovations for medicines.

The Medicines strategy calls for a truly integrated and system based approach to medicines with a clear expectation that localities will have the necessary governance mechanisms in place to ensure coordination across the care spectrum of home, primary, community and hospital care settings. All aspects of medicines delivery need to join up so that the organisations involved work collaboratively in pursuit of the strategy for the benefit of the patient and value for money for the tax payer.

This Medicines Strategy Implementation Plan focuses on the short-term objectives. For each area an overall objective has been compiled at the end of each intervention which will support the actions that will need to be implemented to achieve this objective. It should be noted that Localities of Greater Manchester will determine which areas they will focus on depending on the needs of their patients and that successes will be shared across Greater Manchester.

1  Supporting prevention and self-care

1.1  What do we want to achieve

Encourage and reduce reliance on medicines through promoting and supporting appropriate self-care and prevention.

1.2  Short term objectives (2018-2021)

1.2.1  Social Prescribing

Social Prescribing – is based on link workers, such as care navigators, providing a bridging role between statutory services (such as GP practices) and non-medical community-based support for health and wellbeing (such as exercise or arts on prescription). It is a structured and supported referral and introduction process, rather than simple signposting. There is a clear evidence base that social prescribing improves health and wellbeing outcomes for
people as well as reducing demand for statutory services (by around 25%). By supporting better self-care and resilience, social prescribing can reduce dependency on prescribed medication and enable people to access support and activities in their communities, which in turn can slow the decline of pre-existing conditions and prolong independent living.

Social prescribing connects people with non-medical support in their local community; therefore a strong and vibrant voluntary, community and social enterprise (VCSE) sector is essential. These community-based activities, which promote self-care and improve health and wellbeing, are largely delivered by VCSE organisations and community groups. Many of these will be small, un-constituted groups that do not have the infrastructure to compete for funding through procurement and contracts, so commissioners need a clear medium to longer-term investment strategy, using a combination of grant funding as well as contracts with larger VCSE organisations. This public sector commitment often makes it easier for VCSE organisations and groups to attract funding from other sources. Community assets can also be developed through the social prescribing work itself, for example, GP practices supporting patient groups to set up their own support groups and activities.

The Partnership is committed to a Greater Manchester wide adoption of social prescribing, as a mainstream service offering that is universally available. Social prescribing already exists and provides a valuable service in many parts of Greater Manchester.

A baseline review of the current state of social prescribing across GM has been commissioned from Salford CVS and the University of Salford; a final report has yet to be released.

**Target:** In 2018/19 the Localities will accelerate rolling out social prescribing programmes across Greater Manchester as a consistent feature of integrated neighbourhood models of care and support. Our aim is that all localities have social prescribing programmes fully implemented by the end of 2019/20.

**Lead:** Localities to make commissioning decision

1.2.2 The Healthy Living Pharmacy (HLP)

This programme was launched in GM in 2016/17. This programme includes the inclusion of dementia friends and a practice having a dementia friendly practice environment. The HLP programme centres on population health initiatives such as stop smoking, cancer awareness, alcohol safe limits, physical activity, healthy weight, food and diet, mental wellbeing, support for people with long term conditions and sexual health. Training has been delivered to support the pharmacy teams. Further plans are in progress to embed the training and development into a sustainable programme for the future. The programme has also been developed into a healthy living framework and rolled out to optometry and dental practices to link primary care providers at a locality level.

For people with mental health conditions the Healthy Living Pharmacy model could provide a valuable service as these patients die 15-20 years earlier before a person without a serious mental illness.
Target – Full population coverage by September 2019 for all three professional groups.

Lead: Local Professional Networks

1.2.3 Community Pharmacy being the first port of call for treatment pathways to support self-management.

In Greater Manchester there are 700 Community Pharmacies who all have support for self-care within their ‘core’ contract; this is an essential service. They also have a responsibility for signposting information and linking to the public health campaigns. This service is available to patients, carers as well as the general public. The Community Pharmacy essential service delivery is assured via the Community Pharmacy Assurance Framework (CPAF).

A Quality Payments Scheme, which forms part of the Community Pharmacy Contractual Framework (CPCF), was introduced on 1st December 2016. The original version of the scheme ran until 31st March 2018 and a total of £75 million of national funding was paid to community pharmacies for meeting the specified quality criteria. The extensive work undertaken by GM pharmacies to date has entitled them to receive circa £4m of the national allocation.

In March 2018, it was announced that the scheme would be extended for the first six months of 2018/19, as part of interim arrangements prior to substantive negotiations for 2018/19 being undertaken and confirmation has been received that the scheme is to be extended to March 2019. The extended scheme has a review point in June 2018. The results of the November 2017 submission for Greater Manchester were very encouraging and demonstrate the contribution towards quality and outcomes.

Supporting people, particularly frail, vulnerable and older people to manage medicines, live independently at home and stay out of hospital, are all areas that community pharmacy teams can contribute to and is the key to supporting the future of the NHS, at a time when it is facing ongoing constraints on its funding.

Whilst many of our patients are able to visit the pharmacy to access services there is a growing cohort of patients who cannot. These are often the most vulnerable of our patients who have limited access to services in the community. This service would allow pharmacists to provide a range of agreed commissioned services in patients’ homes to ensure that all have equal access to healthcare services. Currently:

- 3.64 million people in the UK aged 65+ live alone
- Nearly 200,000 older people in the UK do not receive the help they need to get out of their house or flat
- 9% of older people feel trapped in their own homes and 6% of older people (nearly 600,000) leave their house once a week or less
- 52% of older people agree that those who plan services do not pay enough attention to the needs of older people
- An estimated 4 million older people in the UK (36% of people aged 65-74 and 47% of those aged 75+) have a limiting longstanding illness. This equates to 40% of all people aged 65+
- Of the 18.7 million adults admitted to hospital last year, around 7.6 million (41%) were aged 65+
- People aged 65+ make up 42% of elective admissions and 43% of emergency admissions to hospital and up to 23% of all A&E attendances and 47% of admissions to hospital from A&E.

**Action:** This is a short to medium term objective to explore with Commissioners, the Local Medical Committees and Providers how Community Pharmacy can support the Frailty agenda.

**Lead:** Local Pharmaceutical Committees (Greater Manchester & Bolton), Pharmacy Local Professional Network, Direct Commissioning – Pharmacy

**1.2.3.1. New Urgent Medicines Supply Advance Service (NUMSAS)**

Requests for medicines needed urgently account for about 2% of all completed NHS 111 calls. These calls normally default to a GP out of hour’s appointment to arrange an urgent prescription and as a result block access to GP appointments for patients with greater clinical need. The New Urgent Medicines Supply Advance Service (NUMSAS), pharmacy service was introduced as a pilot Advanced Pharmacy Service from 2016 and launched across GM in July 2017. The service is being piloted nationally until 30th September 2018, to evaluate the impact on the urgent care system to inform future commissioning.

The number of community pharmacy providers has risen steadily to a current level of over 50 pharmacies actively providing this service. Every locality across GM has at least one pharmacy providing the service. Between July and December 2017 there were 2417 consultations/interactions with patients, following referral from NHS 111. These patients may have normally been directed to OOH or could have decided to attend at an urgent care setting or A&E department. The service has supported patients to address urgent medication needs, particularly of evenings, weekends and bank holidays and ensures continuity in management of long term conditions.

A national dashboard is being developed to support localities to identify need for the service and where to focus their attention for commissioning of services. A national decision will be made in the autumn whether to continue the service and if so this service will be funded nationally.

**Target:** Utilise the dashboard information to highlight and act on inappropriate supply of medicines until the NHS England announcement in September 2018.

Increase the number of pharmacies providing the NUMSAS service to 15% coverage by December 2018 to ensure full population coverage.

**Lead:** Direct Commissioning Team – Pharmacy
1.2.4 Conditions for which over the counter items should not routinely be prescribed in primary care: A consultation on guidance for CCGs


In the year prior to June 2017, the NHS spent approximately £569 million on prescriptions for medicines which can be purchased over the counter from a pharmacy and other outlets such as supermarkets.

These prescriptions include items for a condition:

- That is considered to be **self-limiting** and so does not need treatment as it will heal of its own accord;
- Which lends itself to **self-care**, i.e. that the person suffering does not normally need to seek medical care but may decide to seek help with symptom relief from a local pharmacy and use an over the counter medicine.
- Vitamins/minerals and probiotics have also been included in the consultation proposals as items of low clinical effectiveness which are of high cost to the NHS.

NHS England has partnered with NHS Clinical Commissioners to carry out the consultation after CCGs asked for a nationally coordinated approach to the development of commissioning guidance in this area to ensure consistency and address unwarranted variation.

The intention is to produce a consistent, national framework for CCGs to use.

Guidance was made available on the 30 April 2018 for CCGs not to prescribe drugs that can be purchased over-the-counter. NHS England has stated that CCGs need to conduct a Local Equality Impact Assessment to assess the impact on their local populations; this will address the Public Health issues raised within the consultation.

1.2.4.1 General Exceptions to the Guidance:

There are however, certain scenarios where patients should continue to have their treatments prescribed and these are outlined below:

- Patients prescribed an over the counter treatment for a long term condition (e.g. regular pain relief for chronic arthritis or treatments for inflammatory bowel disease).
- For the treatment of more complex forms of minor illnesses (e.g. severe migraines that are unresponsive to over the counter medicines).
- For those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms for example indigestion with very bad pain).
- Treatment for complex patients (e.g. immunosuppressed patients).
- Patients on prescription only treatments.
- Patients prescribed over the counter products to treat an adverse effect or symptom of a more complex illness and/or prescription only medications should continue to have these products prescribed on the NHS.
- Circumstances where the product licence doesn’t allow the product to be sold over the counter to certain groups of patients. This may vary by medicine, but could
include babies, children and/or women who are pregnant or breast-feeding. Community pharmacists will be aware of what these are and can advise accordingly.

- Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an over the counter product.
- Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor condition.
- Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
- Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

This guidance should provide capacity within GP practices if patients are self-medicating, however, there is a public health issue where vulnerable patients groups may not be able to afford to purchase treatments over-the-counter. One scenario is that of a family where a child has head lice and infects the family and the school because they cannot afford to purchase the necessary treatment. A Greater Manchester minor ailment service commissioned from community pharmacies provides a mechanism to enable provision of medicines for the most deprived of our communities that have an evidence base demonstrating value for NHS resources.

Ensure the secondary and community care providers are aware of the changes to restrict prescribing of over-the-counter medicines for which they send referrals to GPs to prescribe.

Action: To implement the over-the-counter guidance.

Target: Clinical Standards Board to develop guidance across Greater Manchester by end of 2018.

Lead: Clinical Standards Board, Locality Medicine Optimisation Teams

1.2.5a Minor ailment scheme – Community Pharmacy

Nationally, it is estimated that 57 million GP consultations a year are for minor ailments, costing the NHS a total of £2 billion. The ambition of the Greater Manchester (GM) devolution agenda is to achieve both clinical and financial sustainability. A Pharmacy Minor Ailments Scheme (PMAS), operating consistently on a GM footprint, can make an important contribution to both of these goals. By shifting the relevant care to a pharmacy setting, PMAS can alleviate pressure on GP practices and release time for more suitable conditions.

In Greater Manchester we have a minor ailment scheme in 60% of localities. The scheme diverts activity away from GP practices and A&E to community pharmacy to provide a list of agreed medicines to treat a number of conditions. There has been a cost benefit analysis undertaken modelled on the best available evidence.
The medicines utilised within the scheme are low cost to the NHS and the scheme provides advice and guidance to patients presenting in the community pharmacy. A review of this commissioned service will be undertaken following local Equality Impact Assessment as advised within the over-the-counter prescribing guidance.

The data below is derived from questionnaire responses within the CCG’s currently operating the programme. The findings show that the Greater Manchester scheme over a five year period will save approximately:

- 170,000 GP appointments
- 500 A&E attendances
- 3,500 presentations at Out-of-Hours and Walk-In-Centres

Over a five year period per Clinical Commissioning Group this equates to:

- 14,000 GP appointments
- 350 appointments per practice
- 26,000 hours of GP consultation time.

It is important to acknowledge these findings within the broader financial constraints of the current health and social care system, which means that it is unlikely that these gross savings will result in significant cashable returns. The current GM CBA model assumes that the cashability conversion rate of GP appointments (both short and long term) is 0%. Instead, the purpose of a GM Minor Ailments Scheme is to relieve capacity in primary care, including pressure on GP practices, and to release appointments for more suitable purposes (such as patients with long term conditions).

Action: Localities to review the requirement for a minor ailment scheme following an Equality Impact Assessment.

Target – December 2018 (NB detailed within the GM Business Plan)

Lead: Pharmacy Local Professional Network and Localities

1.2.5b NHS proposal to reduce prescribing over the counter medicines – ‘Optometry First’ Greater Manchester Minor Eye Conditions Service (MECS)

Minor eye conditions are a significant driver of health service demand and cost. It is estimated that 1.5-2% of GP appointments are eye-related; the incidence of presentations to hospital eye casualty services is thought to be 20-30 per 1,000 per year. Ophthalmology is the speciality with the second highest cause of attendance at Greater Manchester (GM) hospitals, with some 390,000 outpatient appointments in 2014/15.

The Greater Manchester Minor Eye Conditions Service (MECS), Optometry First, seeks to divert demand away from GPs and acute settings by making use of the skills of primary care optometrists to assess, manage and prioritise patients presenting with recent onset minor eye conditions. Patients are seen quickly and receive high-quality eye advice and treatment from qualified clinicians in a safe, convenient and appropriate environment. A cost benefit analysis has been completed.
The prescribing of over-the-counter products used for eyes is included in the consultation and there is a section with the Greater Manchester Medicine Management Group Formulary. A review of the formulary section is required, working closely with the Local Professional Network for Eye Health to fully understand how ceasing the prescribing of these medicines by a GP impacts on patient care, especially the use of antibiotic eye drops and for the treatment of dry eyes.

The aspiration is that the Optometry First service and the community pharmacy minor ailment service will improve the appropriate supply of medicines to appropriate patients reducing GP and A&E attendances. Four localities have already implemented MECS.

**Action**- This is part of the roll out of the Primary Eyecare Service Framework, which is scheduled for roll out from April 2019 which includes MECS.

**Lead:** Local Professional Networks and Localities

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**Overall objective for supporting prevention and self-care:**

**Objective:** Increase access to alternative services for patients, public and carers reducing pressure on GP practice appointments and A&E.

**Objective:** Reduce the prescribing of over-the-counter medicines by GPs in line with the NHS England and Clinical Standards Board guidance; target to be set by each Locality – to be monitored through the CCG Medicines Business Intelligence tool.

**Timescale:** 2020

**Lead:** Pharmacy Local Professional Network and Localities

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2 Safer use of medicines

2.1 What do we want to achieve

Reduce the prescribing of antimicrobials and reduce the avoidable harm caused by medicines. Develop an open and transparent culture of reporting and learning from medication errors.

2.2 Short term objectives (2018-2021)

2.2.1 Reduce Prescribing of Antimicrobials

This is an agenda for all localities whether national or local. NHS England has established targets within their Quality Premiums to reduce the prescribing of antibacterial drugs within Clinical Commissioning Groups; the Localities include these targets in their annual plans. The localities all have examples of good practice in the reduction of antimicrobial prescribing. This practice needs to be accelerated across Greater Manchester.

A dashboard has been developed to monitor antimicrobials that have been dispensed, - EPACT2 which is available to all Clinical Commissioning Groups. The NHS England
Antibiotic Quality Premium Monitoring Dashboard has been produced to support monitoring CCG performance in the delivery of the Antibiotic Quality Premium. The EPACT2 dashboard is published monthly and reports on performance with the primary care antibiotic prescribing indicators; these are defined in the Quality Premium Guidance document.

### 2.2.1.1 Antimicrobial Stewardship Dashboard

In collaboration with NHS Improvement, the Antimicrobial Stewardship Dashboard is being developed to support the national Antimicrobial Resistance Strategy. The Government is committed to lead the international fight against AMR, setting out new ambitions to do this. Following the O’Neill Review of AMR, the Government has set the following ambitions:

- 50% reduction of preventable Gram-negative bloodstream infections (GNBSIs) by 2020/21
- 50% reduction of the number of inappropriate antimicrobial prescriptions by 2020

The Antimicrobial Stewardship Dashboard will support delivery of both of these ambitions, providing prescribing data to support local stewardship activity and reporting, and linking to relevant AMR resources such as the PHE AMR Portal and NICE guidelines.

In Greater Manchester there is an annual Antimicrobial Resistance campaign in primary care for each of the four primary care contractors.

Further discussion needs to take place with secondary care around the advice to primary care to prescribe antibiotics.

### 2.2.1.2 Examples of an innovation in reducing prescribing of antimicrobials from Localities

Localities have explored innovative approaches to reducing the prescribing of antimicrobials:

a) Heywood, Middleton and Rochdale Clinical Commissioning Group introduced C-reactive protein (CRP) testing in GP Practices.

This strategy is aiming to reduce antibiotic use in primary care by guiding antibiotic treatment through the use of a point-of-care biomarker. Evidence to support the clinical and cost-effectiveness of C-reactive protein (CRP) testing for the management of lower respiratory tract infections in primary care has been established and in some European countries it is a standard of care. In the UK, the role and use of CRP has yet to be established but the recent NICE clinical guidelines on pneumonia recommended that a CRP test should be considered if, after clinical assessment, it is not clear whether antibiotics should be prescribed. Furthermore, in the updated Public Health England (PHE) Primary Care Guidance (May 2016) for acute cough and bronchitis, CRP testing is recommended.

b) Tameside and Glossop has introduced a practice based model where there has been investment in a specialist pharmacist to work with practices to change prescribing habits of antimicrobials. This has shown excellent outcomes. This has led to a whole team culture change including the receptionists and practice nurses and GPs, as it was noted that
frontline staff may face more challenges than GPs when patients present for repeat antibiotics.

The practice came to realise that although they share management with patients, when it comes to antibiotics, patients do not prescribe – the practice do, and with shared management also comes clinical responsibility.

Although the change has been difficult, to their surprise, the majority of patients have respected their honesty and many seem relieved that antibiotics are not required for their condition. It is possible that this has been helped by media coverage of the issue.

Each of the localities will have different approaches to addressing this agenda across primary, community and secondary care our objective is to address the national targets and supersede them whilst sharing good practice that can be shared and implemented across Greater Manchester

2.2.2 NHS England Clinical Pharmacists in GP practice pilot.

An intervention to support the reduction of avoidable harm caused by medicine has been rolled out across Greater Manchester. The NHS England clinical pharmacists in GP practice pilot is part of the GP Forward View. For Greater Manchester, this programme is linked to the transformation programme through the devolution agreement. The pilot is open to General Medical Service (GMS) providers, noting that this can be through a GP federation or collaborations of individual GP practices. The GMHSCP pilot has several key planned outcomes:

- Addressing potential GP workforce shortages
- Making use of non-medical prescribers
- Increase GP practice clinical service capacity and improving patient access
- Reducing waste medicines
- Improving patient outcomes
- Improved use of additional health professional skills and abilities within the local health economy
- Increasing patient safety.

The agreed GMHSCP funding for the programme is £7.5 million, which includes GMSHCP contribution towards the delivery at each locality, training pathway and independent non-medical prescribing qualification for each pharmacist.

The pilot application process is run in alignment with phase two of the wider NHS England programme across four waves throughout 2017/18. Across the GMHSCP footprint we have approved five locality bids during wave one; one as part of wave two and are currently assessing a bid for wave three. There are also three sites that were successful in bidding for phase one of the wider NHS England programme and have been delivering services since 2015/16.

Currently there are approximately sixty pharmacists in post across GM working as part of the pilot programme and delivering clinical services to patients. The pharmacists will complete GMHSCP funded pathway training (delivered by the Centre for Postgraduate Pharmacy
Education) and an independent non-medical prescribing qualification as part of the programme.

There is an element of medicines cost efficiency and value linked to the activities of the clinical pharmacists. However, this is not the core focus of the programme, which is improving patient outcomes / safety and optimising the use of pharmacists’ skills across the GM health economy.

**Actions:**

- Decision to be made by each locality to continue to bid for monies for clinical pharmacists;
- Long term objective to commission mental health pharmacists to support GP practices.
- Provide evidence at a partnership level for the effectiveness of clinical pharmacists from all localities to prepare for long term investment.

**Target –** full population coverage for clinical pharmacists in localities by June 2019.

**Leads:** Locality Medicine Optimisation Teams and Direct Commissioning - Pharmacy

### 2.2.3 NHS England Medicine Optimisation in Care Homes model (MOCH)

The safer use of medicines within care homes is a priority. A Greater Manchester Medicines policy for care homes will be developed with providers, commissioners and users to improve the safe administration, prescribing, storage and ordering of medication for people within a care home environment. This will form part of a wider programme across Greater Manchester supporting care homes, care providers and carers.

Guidance is available from NICE which will be used as a starting point with the development and implementation of this policy. This is a short term priority which will require the collaborative working of the partnership with minimal cost implications in its development; implementation of the policy will require a business case.

NHS England has introduced the Medicines Optimisation in Care Home component of the Pharmacy Integration Fund. Greater Manchester has been awarded an allocation. The plan is to integrate clinical pharmacists and pharmacy technicians into health and social care settings to improve medicines management within care homes and optimise medicines for their individual residents by undertaking face-to-face medication reviews.

**Actions:**

- Implement the “plan on a page” for the Medicines Optimisation in Care Homes model approved by NHS England by December 2018.
- Develop and implement a care home medicine policy incorporating mental health across Greater Manchester care homes by September 2019

**Leads:** Locality Medicine Optimisation Teams and GMHSCP
2.2.4 Salford MedicAtion Safety dasHboard (SMASH) and Pharmacist-led Information technology iNtervention for reducing Clinically important ERrors in medication management (PINCER)

Salford Clinical Commissioning Group recruited clinical pharmacists to support general practices in identifying patients with complex medication regimens to improve adherence and reduce the use of multiple drugs. In addition to improving the quality and outcomes for patients the cost associated with medication is being reduced.

Salford Clinical Commissioning Group is undertaking research with Manchester University to examine the effectiveness of their clinical pharmacists being supported by a software tool to identify complex medication regimens and record the effectiveness of the intervention. This research initiative is being promoted nationally by Manchester University; hopefully it will be adopted and funded nationally when the evaluation is published later this year. Preliminary findings are very promising; once the final evaluation is presented a decision can be made to look at the possible acceleration of this model / tool for the whole of Greater Manchester.

Evidence has been provided by Health Innovation Manchester which supports this work being undertaken in Salford. There is evidence of reductions in error rates from the pharmacist-led information technology intervention for reducing clinically important errors in general practice prescribing (PINCER). This methodology underpins the tool being used within Salford CCG. Prescribing errors in general practices are not common – but when they happen they can be an expensive cause of safety incidents, illness, hospitalisation and even death.

An economic analysis demonstrated an overall reduction in costs of £2,679 per practice and an increase in quality of life of patients (0.81 Quality Adjusted Life Years per practice). Rolling out to 1,387 GP practices nationwide (by end 2019/20) PINCER will prevent over 46,000 hazardous errors in the first two years of the licence period saving £2M of NHS and £12M social care costs.

The PINCER prison research funded by Greater Manchester Mental Health (GMMH) will deliver by 2020. The PINCER mental health is a longer term objective as a PhD student has been appointed for a 5 year project.

Actions:

- Share evaluation of the Manchester University programme for SMASH across Greater Manchester.
- Implement findings of the PINCER prison research
- Implement PINCER findings for Mental Health

Lead: Health Innovation Manchester, Mental Health Trusts

2.2.5 Develop an open and transparent culture of reporting and learning from medication errors

The evidence base is strong for improving safety by reporting and learning from medication errors. Organisations across Greater Manchester have implemented reporting systems for medication errors. A Greater Manchester innovation has been the development and
implementation of the Controlled Drug reporting system, now adopted across England. This has changed practice across Greater Manchester by encouraging an open culture of reporting; through supporting practitioners rather than censuring them.

Although some localities have reporting systems for medication related issues, there is not one system capturing information about medicine incidents to enable shared learning across Greater Manchester. The system needs to reduce duplication of work, be easily accessible and responsive to organisations to monitor from a central point. We have such a system operational in Greater Manchester which is being adopted by all NHS England teams and is used by most Providers across Greater Manchester; the Controlled Drug reporting system.

**Objective**

- Develop and implement a single reporting system for medication errors by November 2018 to be fully operational by all providers both NHS and Private Health and Social Care by 2020.

**Lead:** GMHSCP in collaboration with all Providers

### 2.2.6 Clinical handover to community pharmacists (TCAM)

Another area where the safety of medicines is compromised for patients is the transfer of information concerning their medication. The continuity of patient care when transitioning from one healthcare setting to another is a national priority. Studies have indicated that the details of changes to patient's medication are not always effectively transferred from the hospital to community setting leading to readmissions and extended hospital stays. An AHSN supported study evaluated an electronic transfer of care initiative and demonstrated significantly lower rates of readmissions and shorter hospital stays. The Transfer of Care around Medicines programme will be rolled out to 40 trusts nationwide with the objective of preventing 6,000 hospital readmissions over two years saving £19 million of NHS costs.

This is another area where we work closely with the AHSN to deliver a crucial agenda. The AHSN role would be to:

- Actively promote and support implementation with trusts
- Project manage dissemination and spread amongst trusts in the region
- Provide analysis of data for evidence and feedback
- Provide opportunities for collaborative working to share best practice.

The benefit assumptions are:

Published longitudinal studies based upon the active referral of patients discharged from hospital to community pharmacy in Newcastle and on the Isle of Wight allowed Pinnacle Health to develop a cost benefit simulation of the programme, which the national rollout simulation has used. NHS benefits accrue from reduced length of stay, which fell from 13 days to a mean of 7.2 days. This difference has been costed at £400 per bed day.

- The review also found 30 day hospital readmission reduced from 16.05% to 5.79% for the cohort. A value of £2,358 has been used following analysis of relevant HRG coding.
Additional readmission benefits for 30-60 days (6.1% reduction) and 60-90 days (5.8% reduction) have not been costed.

The spread assumptions are:

- Within Wessex AHSN, who developed and spread the programme locally, 2,216 patients were affected by the programme. Scaling this to the total England GP register population (QoF, 2017) gives an indicative total affected population of 43,088 patients per year.
- During the first three years of roll out, 25% of trusts have been included in modelling, equating to 9,788 additional patients each year benefiting from the programme.

Data to be collected:

- Patient outcome data over a baseline and intervention period.
- Process implementation data to demonstrate engagement and correlate implementation with outcomes.

The Partnership commissioned a cost benefit analysis by the GMCA Research Unit to examine the feasibility of implementing this service across Greater Manchester before 2020. The CBA concluded that there is a return on investment of 1:25. A business case has been developed to support investment in this programme; however to date the investment has not been realised. It is expected that the programme would take up to two years to rollout across Greater Manchester.

Action: A business case has been compiled. There is a need to ensure the Mental Health Trusts and other providers are included in this programme.

Target – Commence October 2018 with a two year programme to roll out across GM.

Lead: Pharmacy Local Professional Network and Chief Pharmacists

2.2.7 Polypharmacy

Polypharmacy is defined as the use of multiple medications by a patient generally, but not exclusively, older adults aged 65 and over. Polypharmacy is a key issue in health and social care, as evidence suggests that being on multiple medications increases the individuals’ risk of harm and contributes to hospital admissions and poor therapeutic outcomes. Indeed, patients on 10 or more medicines are over 300% more likely to be admitted to hospital.

The List of comparators available on a dashboard is as follows:

- Average number of unique medicines per patient
- Percentage of patients prescribed 8/10/15/20 or more unique medicines
- Percentage of patients with an anticholinergic burden score of 6/9/12 or greater
- Multiple prescribing of anticoagulant and antiplatelet medicines
- Percentage of patients prescribed two or more unique medicines likely to cause kidney injury (DAMN medicines).
Action: This is integral to the workload being undertaken by the Clinical Pharmacists in practice and Care Homes which directly impacts on polypharmacy.

Target: Localities to set a target to show a reduction in the number of polypharmacy medicines prescribed to patients aged 65 and above by 2020 - Monitored through the EPACT2 dashboard.

Lead: Locality Medicine Optimisation teams

2.2.8 Reduce the avoidable harm caused by medicine – STOMP

Stopping Over Medication of People (STOMP) with a learning disability, autism or both with psychotropic medicines is a national project involving many different organisations which are helping to stop the over use of these medicines. STOMP is about helping people to stay well and have a good quality of life the principles of this programme are also applied to patients with dementia.

The aims of STOMP are to:

- encourage people to have regular check-ups about their medicines
- make sure doctors and other health professionals involve people, families and support staff in decisions about medicines
- inform everyone about non-drug therapies and practical ways of supporting people so they are less likely to need as much medicine, if any.

Actions:

- Reduce the inappropriate prescribing of Antipsychotics in patients with a Learning Disability and dementia.

Lead: Localities; Mental Health Trusts

2.2.9 Medicine related hospital admissions

A set of prescribing indicators have been developed as part of a programme of work to reduce medication error and promote safer use of medicines, including prescribing, dispensing, administration and monitoring. The programme of work is in response to the World Health Organisation (WHO) global challenge – Medication without Harm, (https://www.gov.uk/government/publications/medication-errors-short-life-working-group-report).

The NHS BSA has constructed a dashboard as an experimental piece of work. This is the first time prescribing data has been linked to admissions data at a national level; this will continue to evolve.

The purpose of the indicators is to identify hospital admissions that may be associated with prescribing that potentially increases the risk of harm, and to quantify patients at potentially increased risk.

The aim of the indicators is to:
- support local reviews of prescribing, alongside other risk factors for potential harm;
- minimise the use of medicines that are unnecessary and where harm may outweigh benefits
- identify where the risk of harm can be reduced or mitigated including prescribing of alternative medicines or medicines that mitigate risk e.g. gastro-protective agents
- reduce the number of hospital admissions that may be associated with medicines
- reduce the number of patients that are potentially at increased risk of hospital admission that may be associated with medicines.

The analysis only highlights the potential risk of harm and possible association with hospital admission. Any review of benefits and risks of prescribing should be undertaken on an individual patient basis.

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### Overall objectives to ensure safer use of medicines:

**Objective 1:** To deliver the CCG Antibiotic Quality Premium. To be monitored through the NHS England Antibiotic Quality Premium Monitoring Dashboard at the Quarterly CCG Assurance meetings.

**Objective 2:** To reduce the prescribing of unnecessary medicines in patients aged 75 and above by 20% utilising Clinical Pharmacists. To be monitored through the Polypharmacy EPACT 2 dashboard.

**Timescale:** By 2020 / 21

**Lead:** Locality Medicine Optimisation teams and Chief Pharmacists.

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### 3 Person centred care and support

#### 3.1 What do we want to achieve

All prescribing should be a shared decision between the patient and prescriber, to understand the benefits and risk of treatments. Tailoring medicines regimes (targeted, precision medicine) to individuals or cohorts e.g. care home residents to reduce polypharmacy, wasteful or unnecessary treatment and improve outcomes and value is a priority within the medicines strategy.

#### 3.2 Short term objectives (2018-2021)

Implementation of the initiatives in sections one and two of this Implementation Plan will contribute to person centred care and support. There is a suite of resources available on the NICE website to support shared decision making. Expertise and specialist knowledge, practical help and support for implementation is also available from the NICE field team, medicines education team and NICE medicines and prescribing Associates (of which there are two in the GM area).

##### 3.2.1 Extend the New Medicines Service (NMS) Advanced Pharmacy Service
The New Medicines Service is currently funded from a central budget and operational in Greater Manchester as an advanced Community Pharmacy Service. The evidence base for this service has been produced nationally.

There is an opportunity to develop this service to follow up 80% of all newly prescribed medicines by introducing a locally commissioned service through community pharmacy. There is evidence that this service does increase patient medicine adherence by 10% compared with normal practice, which translated into increased health gain at reduced overall cost.

Actions:

- Localities to decide whether to commission a service to follow up 80% of all newly prescribed medicines including patients with mental health issues. This will require a business case and will be decided locally.

Lead: GMHSCP Direct Commissioners and Localities

Overall objective for Person and Centred Care

Objective: To have 100 Clinical Pharmacists embedded in multi-disciplinary teams in GP practices and Care Homes with Independent Prescriber status

Timescale: 2025

Lead: Localities

4 Standardised, best value, care

4.1 What do we want to achieve

Establish a systematic approach to standardising and improving the value and outcomes of care led by the Clinical Standards Board. Ensure where appropriate the Medicine Implementation Plan links to all strategies and policies to ensure medicines are appropriately prescribed with outcomes. Reduce unwarranted variation across Greater Manchester led by the Clinical Commissioning Group Medicine Optimisation teams and the Chief Pharmacists Group to raise the quality of prescribing, dispensing and administration of medicines.

4.2 Short term objectives (2018-2020)

4.2.1 NICE Technology Appraisals

To implement and assess clinical and financial impact of NICE Technology Appraisals. As the majority of NICE Appraisals are relevant to Secondary Care they have established governance processes where all of the NICE technology appraisals are assessed and an action plan to implement would be agreed and shared at Board level. However, there is a need to ensure that uptake is monitored and audited to confirm medicines are used in line with NICE.
In Primary Care there is no process to gain assurance that NICE technology appraisals have been assessed and actioned. A solution is to develop a process to enable (through a template) a primary care contractor to make a declaration to provide assurance that the NICE technology appraisals have been processed within their practice.

NICE has a plethora of tools to support the standardisation agenda which are available and relevant to all the sectors dealing with medicines. A development from NICE is a tool for Integrated Care Organisations / Sustainable and Transformation Partnerships to deliver high quality medicine optimisation to be released later this year.

The Declaration would form part of the incident reporting system and would initially be voluntary with a view to becoming part of any quality initiatives. This piece of work will be led with the NICE field team working closely with the quality function within the partnership.

Actions:

- Develop and implement a web based process for declarations for NICE technologies to be made by primary care contractors linked to the incident reporting system.
- Roll out the NICE Integrated Care Organisations / Sustainable and Transformation Partnerships medicine optimisation tool.

Lead: GMHSCP – Quality team and NICE

4.2.2 Acceleration of good practice

4.2.2.1 Primary care

The majority of prescribing takes place in primary care; there is also a wide variation in prescribing expenditure. Our objective is to standardise prescribing practice across Greater Manchester ensuring that there is high quality prescribing, improve patient outcomes and evidence based, cost-effective prescribing.

In Bury Clinical Commissioning Group there has been a significant amount of work focussing on prescribing quality and evidenced based prescribing which has achieved a prescribing average below the England average. They have shown how standardising prescribing can improve quality, outcomes and provide best value care. This is a goal we should strive to achieve over the next three years recognising that this will occur at differing times across the Greater Manchester Localities. In theory, if all Clinical Commissioning Groups in Greater Manchester reduced unwarranted prescribing spend to the current England average spend – a potential saving of circa £60M could be saved across Greater Manchester. The evidence for this figure is circumstantial and had not be properly evaluated; we do know the variation is considerable across Greater Manchester and England. This objective will yield cost efficiencies whilst ensure evidenced-based prescribing.

This work requires constant communication with patients so an informed decision can be made with the patient to either stop prescribing a drug, change to drug to a more cost-effective drug or request the patient purchases their drug over-the-counter.
There are a plethora of easily accessible data resources available to Medicine Optimisation Teams, Clinical pharmacists and community pharmacists to support prescribers to prescribe the most evidenced based safe and cost effective medicine.

The Greater Manchester CCGs have agreed the following areas to focus on for 2018/19. Note that this is an iterative plan that will be monitored through the quarterly CCG assurance meetings:

- Antibiotics
- Over The Counter (OTC) / Self Care
- Drugs of Limited Clinical Value
- Development of pathways for use across Greater Manchester
  - Frailty
  - Management of Individual Funding Requests
  - Migraine
  - Dermatology
- High Cost Drugs management

**Actions**

- Medicine Optimisation teams have identified the priority areas for their localities; we will ensure that their successes are shared across Greater Manchester to accelerate learning at scale.
- Develop and implement effective GP practice Repeat Prescribing policies.
- Focus, where applicable on “generic prescribing”
- Agree and implement an average prescribing spend for Greater Manchester that localities work towards.

**Lead:** Locality Medicine Optimisation Teams

### 4.2.2.2 GM Hospital Pharmacy Transformation Collaborative

Lord Carter of Coles report, published in February 2016, identified significant variation in operational productivity and efficiency across NHS acute hospitals. A series of hospital pharmacy recommendations were included within the final report; providing a transformational focus, with the underlying message being to enhance medicines optimisation through investment into clinical patient facing activities. The challenge set out by Lord Carter is to position more than 80% of Trusts’ pharmacy resource into delivering direct medicines optimisation activities, medicines governance and safety remits by 2020.

Responsible for delivering Lord Carter’s recommendations across GM is the Hospital Pharmacy Transformation Collaborative (GMHPTC). Established by provider Chief Pharmacists in 2016, GMHPTC is a distinct project within GMHSCP Transformation Theme 4 - Standardising Clinical Support and Corporate Functions. Reviewing the pharmacy services categorised as ‘infrastructure’ by Lord Carter is the priority for GMHPTC and work streams are fully established scoping, supporting and delivering hospital pharmacy transformation across the region as illustrated in the schematic below.
Medicines optimisation, therefore motivates and focuses GMHPTC service reviews as infrastructure collaboration generates operational and workforce efficiencies which locally can be reinvested into clinical patient facing roles. This shift in service delivery for hospital pharmacy ensures clinical outcomes and financial investments into medicines across GM are optimally managed.

Endorsing the introduction and commissioning of Consultant Pharmacist posts across GM is a GMHPTC priority initiative which will deliver effective use of medicines. A Consultant Pharmacist is an experienced pharmacist clinician who has the necessary expertise and clinical leadership to drive improvements in patient care across healthcare boundaries. These clinically innovative posts will therefore ensure optimal pharmaceutical outcomes for patients and will support the wider GM medicines strategy deliver its short, medium and long term ambitions.

The three Greater Manchester Mental Health Trusts are included within the main GMHPTC with a mental health subgroup reporting back as one of a number of commissioned work streams. This ensures the needs of all secondary care pharmacy services are considered across GM. The mental health subgroup is leading the work related to the medicines optimisation needs of acute providers when managing people with a mental illness. This is on behalf of the North of England and agreed through the All England Chief Pharmacists network.

The second Lord Carter of Coles report was published on 24th May 2018 entitled ‘NHS operational productivity: unwarranted variations Mental Health Services and Community Health Services’. This report will be reviewed as part of the GMHPTC programme.
Actions:

- GMHPTC, through its collaborative work plan and shared Hospital Pharmacy Transformation Programmes, will achieve Lord Carter benchmarks by 2020 in agreement with NHS Improvement and NHS England.

- Review the impact and implementation of the second Lord Carter of Coles mental health and community services report. This will require GM wide liaison with community services providers.

- Infrastructure workforce efficiencies will be reinvested into direct medicines optimisation activities, medicines governance and safety remits supporting the wider regional strategy.

- Introduce and test Consultant Pharmacist posts across selected therapeutic areas within GM. Effectiveness and clinical outcomes delivered will build the case for long term investment.

Lead: Greater Manchester Hospital Pharmacy Transformation Collaborative

4.2.3 Standardisation of Prescribing in Care Pathways

The Greater Manchester Clinical Standards Board has the following priority areas identified for implementation in 2018/19. Their plan is iterative and is flexed to meet the priorities for the Greater Manchester population:

Antimicrobial stewardship: GMMMG is to support all CCGs to achieve the required QP target of “Additional reduction in Items per Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PU) equal to or below 0.965 items per STAR-PU”, by identifying areas for improvement and sharing of successful initiatives across GM

Biosimilars: to improve the uptake of biosimilars across GM and manage the effective entry of adalimumab biosimilar across GM. The uptake of biosimilar medicines across GM has been slower than other areas of the UK, with associated savings being lower.

“Adalimumab is the highest spend drug to the NHS, with a CCG commissioned spend of £20m in 2017/18. It is the next biologic to come off patent in October 2018, potentially there could be a saving of between 25 and 50% during the 12 months following launch. The GMMMG biosimilar adalimumab implementation project aims for a coordinated action within the GM health economy, facilitating successful uptake of biosimilar adalimumab and maximising the savings from the very beginning of implementation.”

Drugs of Low Clinical Value: NHS England issued guidance to CCGs listing 18 drugs or drug groups which should not routinely be prescribed in primary care, this work is intended to improve the quality of prescribing by reducing and stopping prescribing of drugs which have little clinical value and in some cases, drugs for which safety concerns exist. Spend on cost ineffective treatment diverts resources form more effective treatment. GMMMG introduced the “Do not prescribe (DNP)” list (and later the Grey list) across GM in 2011, and these lists now include 81 entries. Of the 18 drugs / drug groups listed on the NHSE list, only
six have not already been considered by GMMMG. Spend across GM CCGs for items which are a low priority for funding (November 2016 to October 2017 inclusive) sits at just under £5.2M, with a spend variation of £411k to £1.1M across the CCGs. GMMMG will manage the continued drive to reduce GM prescribing of drugs of low clinical value with the support of AGG in delivering conversion of this guidance to policy.

1. **Ophthalmology:** To explore the opportunity across the GM health economy to commission the use of Avastin (unlicensed for this indication) in macular pathways.

A more detailed work plan incorporating details of the other GMMMG work streams e.g. implementation of the GMMMG COPD pathway, guidance to support the reduction in opioid prescribing is available on the GMMMG website.

As per current GMMMG process there will be an opportunity for GMMMG to scope the topics directed to the Clinical Standards Board in order that the appropriateness and capacity of each topic be determined and scheduled accordingly. Where a topic could be undertaken more effectively by another route or body CSB will direct accordingly.

**Action:** Implement Clinical Standard Board work plan for 2018/19 and thereafter.

**Lead:** Clinical Standards Board, Chief Pharmacists & Localities

The NICE medicines optimisation standards to be implemented as national English evidence-based guidance and, if this is done in line with the recommendations, has benefits such as embedding of shared decision making, learning from medication related incidents, and clinically appropriate medication reviews.

The NICE guidance on Medicine Optimisation provides guidance on:

- Managing medicines for adults receiving social care in the community and the ‘Right’: the person’s right to decline.
- Systems for identifying, reporting and learning from medicines-related patient safety incidents.
- Medicines-related communication systems for when patients move from one care setting to another.
- Medicines reconciliation and medication review.
- Self-management plans.
- Patient decision aids.
- The use of patient decision aids in consultations involving medicines.

4.2.4 **Standardisation of prescribing for children and young people with long term conditions**

Greater Manchester Children’s Health and Wellbeing Strategy 2018 – 2022 has ten objectives; one of which is to reduce unnecessary and inappropriate hospital admissions for children and young people, especially those who have long term conditions such as asthma, diabetes and epilepsy. A gap has been identified; there is no prescribing included in the guidance for asthma for children.

This will be achieved by piloting a community children’s hub, the introduction of a ‘passport’ for children and young people with all types of long term conditions. A framework will be
developed for preventing avoidable admissions including GP / Pediatrician; observation assessment units and Children's Community Nursing teams.

Consistent care pathways for asthma, diabetes and epilepsy including prevention and transition will be implemented. This will require the development and implementation of medicine taking into account and the developments in digital aids to improve outcomes.

Actions:
- Reduce variation and waste, while improving quality and safety through clinical review.
- Ensure Greater Manchester trusts are in the top quartile of the NHS Improvement top ten medicines measures.
- To improve the prescribing of medication in Greater Manchester monitoring through national benchmarking dashboards including the Medicines Optimisation Dashboard, Key therapeutic topics, RightCare, PHE fingertips, Carter.
- Informatics and data is shared openly across Organisations.
- Ensure compliance with NICE guidance.
- Ensure prescribing of medication is embedded in the care pathways for asthma, diabetes and epilepsy for children and young people.

Lead: Clinical Standards Board

<table>
<thead>
<tr>
<th>Overall objectives for standardised, best value, care</th>
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<tbody>
<tr>
<td><strong>Objective 1:</strong> Prescribing of drugs in primary care is 80% for agreed specified chapters within the Clinical Standards Board Medicines Formulary.</td>
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<tr>
<td><strong>Objective 2:</strong> 90% uptake of best value biosimilars within 12 months of launch</td>
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<td><strong>Objective 3:</strong> Achieve Lord Carter benchmarks by 2020 in agreement with NHS Improvement and NHS England</td>
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<td><strong>Timescale:</strong> 2021</td>
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<tr>
<td><strong>Lead:</strong> Clinical Standards Board, Chief Pharmacists, Medicine Optimisation teams</td>
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5  Innovation and research

5.1  What do we want to achieve

That Greater Manchester will be a leader of biomedical research and accelerate adoption of innovation in the United Kingdom.

5.2  Short term objectives (2018-2021)
- Aim that everyone taking medicines can be part of a trial
- Reduce the gap of research for cancer v Mental Health and dementia
5.2.1 Single research process, gateway and tariff agreed for Greater Manchester sites.

A commercial and non-commercial research process has been established via the Greater Manchester Research Hub. Other initiatives include a Greater Manchester route map or initiating clinical trials and education and training days to build capability in research initiation and delivery. The Greater Manchester Research Hub has established a process for costing and contracting commercial and non-commercial research, designed through collaboration with the conurbation’s most research active organisations (via the Academic Health Science centre function).

5.2.2 Collaboration with the Industry

Health Innovation Manchester (HInM) has established a pipeline of innovation projects through a memorandum of understanding with the Association of the British Pharmaceutical Industry (ABPI) and a further memorandum of understanding is in train with the Association of British Healthcare Industries (ABHI). Expertise and process has been established within HInM to accelerate the pace of innovation across Greater Manchester. The HInM Innovation Nexus provides a means of discovering, developing and deploying innovation across the Greater Manchester conurbation and wider through HInM’s connection with the network of AHSNs.

5.2.3 Identification of studies and technologies for adoption

We will identify those studies and technologies that show greatest promise, if adopted, to transform mainstream care and generate clinically and financially sustainable models of care. This will include exploiting world-leading experimental medicine opportunities in respiratory, dermatology, musculoskeletal, audiology and cancer (advance radiotherapy, precision medicine and prevention and early detection) through the NIHR Manchester Biomedical Research Centre and NIHR Manchester Clinical Research Facility (MFT and Christie).

Through HInM, there is access to the NIHR Patient Safety Translational Research Centre (one of only three national centres in the UK) with a focus on medicines safety in primary and transitional care settings. Studies and technologies that show promise will be assessed by the HInM Innovation Prioritisation and Monitoring Committee (IPMC) which has representation from a number of key stakeholders across the GM Health and Social Care Partnership before implementation, which may require services to be commissioned.

Actions:
- Encourage primary care providers to sign up to contribute to research; this could include either as trial sites or data contributors.
- A prioritised programme of research in place with implementation plans and proposals waiting for inclusion.

Lead: Health Innovation Manchester
5.2.4 Programme to eradicate Hepatitis C virus

Hepatitis C virus (Hep C) infection is now curable utilising two to four months of well tolerated oral therapy. This has allowed modelling to demonstrate the feasibility of elimination of this infection as a public health issue at a population level.

Greater Manchester has significant issues with Hep C including a high prevalence and significant impacts on health, healthcare utilisation and social costs. A significant challenge is many of the individuals with this infection are either undiagnosed, or have been diagnosed but are not engaged with specialist services that can provide curative treatment. Therefore the programme is largely based on initiatives to diagnose the undiagnosed and engage the dis-engaged.

The only way the elimination ambition is going to be achieved is by treating more patients. This would not only significantly exceed the current NHS England Cap, but also exceed the numbers proposed by NICE in their financial modelling. This is predicated on an estimated 17,450 patients with Hep C currently living in Greater Manchester and assumes that (a) there is agreement to exceed the NHS England cap (b) the patients can be found to the levels predicted (c) are prepared to be treated and (d) there is aligned investment to match the level of ambition.

**Action:** A business case is being compiled for the commissioning of a community pharmacy service to provide point of care testing and treatment management of Hepatitis C as we have acquired the drug to support the eradication process.

**Lead:** Health Innovation Manchester

5.2.5 COPD programme

The focus of the COPD programme is the improved implementation of the GMMMG guidelines and the adherence to medicines that are recommended in the formulary, launched in October 2017.

This programme will:
- improve appropriate prescribing
- increased uptake of pulmonary rehabilitation
- increase number of COPD patients offered smoking cessation advice without the requirement for direct support
- raised awareness and support for patient support groups
- increase the number of Health Care Professionals completing the online education modules in the COPD learning hub
- increase number of COPD patients having flu vaccination

This will be delivered through the range of support offers such as virtual clinics and digital apps.
Overall objective for Innovation and Research

Objective 1: Develop and implement a programme to eliminate Hepatitis C

Objective 2: Develop and implement a COPD programme to improve outcomes for patients with COPD; to reduce hospital admissions and A&E attendances; with agreed targets across all sectors

Timescale: 2020

Lead: Health Innovation Manchester

6 Workforce

6.1 What do we want to achieve

The Greater Manchester Pharmacy Local Professional Network (LPN) has agreed to form a task and finish group with the aim of developing a strategy or framework and implementation plan for the recruitment, development and retention of pharmacy professionals and their teams.

6.2 Short term objectives (2018-2021)

The Pharmacy LPN Workforce Group (PWG) will inform the development of a GM Primary Care workforce strategy that is being developed as part of the GM Primary Care Strategy. The Pharmacy LPN recognises that, in developing a strategy for pharmacy in primary care, there must be involvement of all sectors of pharmacy to reflect the changing role of pharmacy teams and the need to create a mobile, responsive pharmacy workforce to meet the needs of patients and the public in Greater Manchester.

The key responsibilities of the PWG are to develop:

- A pharmacy workforce strategy to include all sectors of pharmacy and all members of pharmacy teams
- A pharmacy primary care workforce programme to inform the primary care workforce strategy
- Workforce plans that are cognisant of the wider context and aspiration for better population health, wellbeing and medicines use in Greater Manchester
- Reflections on new roles and their implications for the wider pharmacy workforce e.g. in general practice, care homes, integrated urgent care, advanced and consultant practice
- System leadership policy and education strategies for the whole pharmacy workforce
- A rationale for pharmacy professionals to work more effectively and flexibly across sectors
- An implementation plan to deliver the strategy and programme
- A communication plan for stakeholders
• Effective links with the HEE North School of Pharmacy and Medicines Optimisation and education and training providers for pharmacy professionals in Greater Manchester

The membership of the pharmacy workforce group will include representatives from:

• Community pharmacy
• Hospital pharmacy
• Industrial pharmacy
• Academic pharmacy
• General practice pharmacy
• CCG medicines optimisation pharmacy teams
• Mental health
• Pharmacy technician education
• Commissioners of pharmacy services

Meeting Frequency

The Pharmacy Workforce Group will meet face-to-face twice during the period of strategy development. The group will convene virtual meetings at least monthly until the end of December 2018, and will then agree a working plan for implementation through 2019. Between meetings there will be calls for information and requests to comment on iterations of the workforce strategy and implementation documents.

Accountability

The PWG will report progress - through the Pharmacy LPN Chair - to the Primary Care Workforce Reference Group which reports to the GM Workforce Collaborative and ultimately the GM Health and Care Board.

Guidance for the Development of Consultant Pharmacist Posts was published in 2005. There have been many changes in the pharmacy profession and the NHS in the last 13 years.

A draft of updated guidance has been written and aims to create a fresh approach to consultant pharmacist development in line with the current and emerging drivers for change within the NHS, while retaining the emphasis on the four pillars of expert practice, research, leadership and education.

The Consultant Pharmacist Guidance Stakeholder Group and the All England Chief Pharmacists, we are seeking views on the draft; the consultation will be open from 4th to 30th September 2018.

Medicine Optimisation in Care Homes (MOCH)

There are 27 training places available for the MOCH programme. This is will funded by NHS England for programme salary supported pharmacists and pharmacy technicians. CPPE
and HEE have developed a fair process for **allocating** the non-salary supported training places.

**Criteria for allocating non-programme places**

- Pharmacists and pharmacy technicians must be working in a care home setting for at least 2 days per week (0.4WTE). **This ensures the learning is supported by regular practice in the care setting to support trainees.**
- Employing (providing) organisation must commit to the training pathway and release staff for the 28 days of protected learning time over 18 months and provide travelling and other incidental expenses as required.
- Potential non-salary supported learners must be made aware that there is also a similar amount of self-directed learning to do in their own time.
- Employing (providing) organisation must allocate a clinical supervisor (training will be provided by CPPE).

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### Overall objectives for Workforce

**Objective 1:** To have 100 Clinical Pharmacists supporting GP practices across Greater Manchester.

**Objective 2:** To have 27 pharmacists / technicians attend the Medicine Optimisation in Care Home’s training.

**Objective 2:** To have three to five Consultant Pharmacists across Greater Manchester (depending on the outcome of the PWG scoping and strategy).

**Timescale:** 2021

**Lead:** Hospital Pharmacy Transformation Collaborative; Pharmacy Local Professional Network

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### 7 Conclusion

7.1 Medicines Excellence is the aim of the Greater Manchester Medicine Health & Social Care Partnership; this document provides the first stage in its implementation. As a framework we have identified leads for all the areas highlighted in this Implementation Plan:

- Clinical Commissioning Groups – Medicine Optimisation teams
- Clinical Standards Board formerly Greater Manchester Medicine Management Group (GMMMGG)
- Pharmacy Local Professional Network (PLPN)
- Greater Manchester Health and Social Care Partnership (GMHSCP)
- Health Innovation Manchester (HInM)
• Chief Pharmacists – NHS Acute Trusts and Mental Health Trusts
• Primary Care Advisory Group (PCAG)

Many of the initiatives within this plan are currently operational but not across the whole of Greater Manchester. Cost Benefit Analysis has been undertaken on schemes where benefit can be realised from diverting patients away from the GP practice and/or A&E. Reducing variation and improving the prescribing of medication will improve outcomes. This will be achieved by the implementation of medication reviews, improved repeat prescribing policies, addressing polypharmacy and de-prescribing. None of these are quick wins but will provide a sustainable improvement and release funds which will need to be invested in any newly diagnosed patients identified with a long-term condition.

The additional clinical support through NHS England and that invested by the Clinical Commissioning Groups together with the existing Medicine Optimisation teams across Greater Manchester will improve the quality of prescribing whilst utilising a different skill mix both in General Practice and Care Homes.

The Chief Pharmacists have a programme of work to deliver that is both challenging and innovative. There will be improved safety for medicines when the national reporting system is implemented to support our quality agenda.

Innovation will run alongside this programme of standardisation working closely with Health Innovation Manchester and the Pharmaceutical Industry to introduce new medicines and devices to improve patient outcomes.

There will be challenges in how we apply guidance when released; a choice to adopt or adapt or not to follow this will be made in conjunction with all relevant partners across the Partnership.
Date: 25 January 2019

Subject: Winter Pressures Update

Report of: Steve Barnard, Head of Service Improvement, Urgent & Emergency Care

SUMMARY OF REPORT:

The report provides the Board with an update on the progress of how the Greater Manchester system is managing the demand challenges associated with winter. The planning arrangements are an extension of the well-established GM UEC Improvement and Transformation Plan.

KEY MESSAGES:

The paper provides an update on the current winter pressures and progress against the agreed winter plans. The primary focus was on ensuring sufficient operational capacity that is matched to both non-elective and elective demand. While the additional capacity has been created, there have been significant challenges due to a higher number of sicker patients, which has increased their length of stay in hospital. Greater Manchester achieved 83.5% against the accident and emergency four hour standard for quarter 3, which is below the national standard. GMHSCP are working with NHSI/E and the senior leadership across Greater Manchester to better understand the root causes for reduced performance. This will include a review of hospital and community bed, social and primary care capacity this winter compared with similar systems in the North and agreed improvement actions.

Despite the pressures, there is a significant amount of progress being made with delivery of the Greater Manchester UEC Improvement and Transformation plan. A Greater Manchester Acute Frailty model has been agreed with testing being planned for early this year. A specification for a single Greater Manchester Clinical Assessment Service and locality-based Integrated Urgent Care Services has been developed with testing planned to go live at the end of January. A substantial amount of support is currently being provided to localities and organisations in Greater Manchester via the GMHSCP, local service improvement support teams and the national Emergency Care Improvement Support Team. The Greater Manchester flu vaccination campaign has been successful this year with no reported issues on vaccine supplies and some of the highest uptake rates in the country for the majority of at
risk patient groups. The GMHSCP continue to hold weekly winter planning meetings where we review current pressures and performance and agree any required actions.

PURPOSE OF REPORT:

The purpose of the report is to provide the board with an overview of winter pressures and progress against the agreed winter plans and Greater Manchester UEC Improvement and Transformation Plan.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Note the content of the report

CONTACT OFFICERS:

Steve Barnard, Head of Service Improvement, Urgent & Emergency Care
stevebarnard@nhs.net
1.0 WINTER PLANNING APPROACH

1.1. Prior to winter, the GMHSCP worked closely with the GM Chief Operating Officer/Executive Directors of Operations Committee and the GM UEC Improvement and Transformation Board to develop and agree an approach to winter planning, which was focused on developing sufficient levels of bed capacity to match the predicted levels of demand. It was also agreed that the planning would be aligned to the existing GM UEC Improvement and Transformation Plan.

1.2. GMHSCP have also worked in close collaboration with NHSI/E to ensure support alignment of planning and assurance processes to eliminate or reduce the duplication of information requests (particularly during periods of heightened demand or pressure).

1.3. The locality winter planning arrangements are focused on the following areas:
   - hospital attendance and admission avoidance schemes within the community
   - increased bed capacity in the hospital and community
   - increased staffing in the hospital emergency departments and wards
   - increased capacity in social care
   - a continued focus on reducing the number of patients with an extended length of stay in hospital

1.4. Greater Manchester received just over £13 million of the national £240 million Adult Social Care winter funding allocation. Each of the Greater Manchester Localities agreed through their Urgent and Emergency Care Delivery Boards what their funding allocations would be used for. Appendix 1 provides a summary of how the funding was used across both health and social care for each locality.

2.0 CURRENT PERFORMANCE

2.1. December was a very challenging month for Greater Manchester, achieving 83.52% for performance against the Accident and Emergency four hour standard. This was a deterioration of 2.29% compared with November performance. Levels of demand were marginally lower when compared to the same period last year but, remain significantly higher than the same period in 2017.

2.2. There has been a continued increase in the proportion of higher acuity patients being admitted, which is extending their length of stay in hospital. As a result, we are seeing higher levels of bed occupancy in systems. The number of patients with an extended length of stay of 7 days and 21 days or more remains high.

2.3. A number of localities have been affected by outbreaks of flu and norovirus, which has resulted in the closure of beds in the hospital and community settings.
2.4. The reduced capacity, despite additional hospital and community beds being made available, is continuing to create a significant challenge for localities to maintain patient flow across the urgent and emergency care pathway.

2.5. In November, the average daily number of Delayed Transfers of Care for Greater Manchester was 219. This is a reduction of 17 from the October position. The Greater Manchester ambition is a daily average of 200.

2.6. All localities are running regular length of stay reviews and participating in the agreed Greater Manchester-wide monthly review process. These reviews help systems to understand what individual patients are waiting for and to identify and resolve any delays in progressing a patient’s care or discharge. The results of the reviews are being used to support local improvement work, and are now a standing agenda item on Locality Urgent and Emergency Care Delivery Boards.

2.7. A formal meeting between NHSI/E, Greater Manchester Urgent and Emergency Care Delivery Board Chairs and provider organisation Chief Executive Officers is being planned for early February to review the root causes of the recent challenges and issues and to agree improvement actions. This will include a joint analysis between NHSI and the partnership to look at areas such as bed capacity and to benchmark against similar systems across the North region.

2.8. Appendix 2 provides a summary of the published performance against the four hour accident and emergency standard. Tameside and Glossop are the only locality that have achieved 90% or greater for each quarter this financial year.

2.9. There have been improvements with North West Ambulance Service response times despite anticipated seasonal increases in 999 calls. Greater Manchester has the highest rates of non-conveyance in the North West, achieved through either telephone or face to face assessment.

2.10. NWAS have also delivered improved performance for the NHS 111 service. Greater Manchester implemented NHS 111 online in the summer last year and uptake of the service continues to grow. Greater Manchester has seen the largest uptake in the country for 111 online (26% uptake) and has been referenced as a best practice site for implementation process. As a result, the GMHSCP Urgent and Emergency Care team have been asked to provide support to other systems in England.

3.0 GREATER MANCHESTER IMPROVEMENT AND TRANSFORMATION PLAN

3.1. As stated earlier, the Greater Manchester Improvement and Transformation Plan has remained central to winter planning and delivery. Significant progress has been made with the reform of urgent and emergency care despite the significant operational challenges that localities have faced.

3.2. A Greater Manchester Acute Frailty Model has been developed and approved. This model complements GM Framework for Resilience and Independent Living (FRAIL) and focuses on the acute management and care for patients with urgent and
emergency care needs in the community or hospital. Its aim is to support patients to continue to live well through increased delivery of same day emergency care, reduced length of stay in hospital and the safe provision of care and support as close to home as possible. Early adopter sites are now being finalised with a plan to begin testing in late March/early April.

3.3. Greater Manchester Discharge and Recovery standards have also been drafted and are currently out for consultation with localities and stakeholder groups. These will support earlier discharge planning, improve patient flow and help resolve many of the current delays or issues experienced due to geographical boundaries between Local Authorities or CCGs. The standards will also help to provide patients with improved information on choice around ongoing care requirements. At a locality level this work is helping to drive local improvements. For example, Stockport has recently commissioned an external review of therapy in Stockport (jointly delivered by the GMHSCP UEC team and the Emergency Care Improvement Support Team) which will be used to develop a test of change.

3.4. NHS Elect who run the national Ambulatory Care Network are currently carrying out analysis of ambulatory care data from each acute trust in GM. Ambulatory care enables patients, who would have normally been admitted, to be treated and discharged on the same day. Data has now been submitted from most acute trusts. The outputs of the GM analysis should be available by the end of January 2019, which will inform the 19/20 operational planning guidance and improvement plans across GM to develop ambulatory care in line with national guidance including same day emergency care for older people.

3.5. Greater Manchester has produced a specification for a single GM Clinical Assessment Service and locality-based Integrated Urgent Care Services. These services will enable Greater Manchester to manage lower acuity 111 and 999 calls much earlier in the call. This will reduce variation in care, enable patients to be connected with local services much more quickly and safely reduce the number who attend or admitted to hospital. A test of change is currently being agreed with localities and GM Directors of Commissioners. It is planned to mobilise and go live with the test of change before the end of January. This test is also a critical part of the GM winter plan. The GMHSCP have agreed to design and implement a single GM UEC web page for the public to use. The web page will provide an indication of current ED pressures and help people to find a range of local services such as; pharmacy, GP appointment or walk in centre/urgent treatment centre. The web page will also offer a direct link to NHS 111 online for patients who want to check their symptoms or are unsure of the service they require. The web page is planned to be operational by the end of January.

3.6. The Greater Manchester UEC Hub has worked with systems and the GMHSCP Business Intelligence Team to develop a single live dashboard which will show the individual Operational Pressure & Escalation Levels (OPEL). This system, once finalised, will also provide a suite of actions for each level (initially set against the national guidance but can be tailored to suit localities). The system is currently being tested with two sites and it is envisaged this new development will be
finalised once we are through the peak of the current winter pressures and it will allow greater transparency for all stakeholders on the pressures across Greater Manchester.

3.7. In addition, the UEC Hub has been liaising closely with Greater Manchester systems and NWAS and using the live system data to prioritise support to those systems under the greatest pressure. This has enabled more focused support on demand management and deflection where appropriate. The hub has also continued to provide support to GM systems with the repatriation and out of area transfer of patients. The hub has been able to help move 95 patients between November 2018 and January 9th.

4.0 FLU UPDATE

4.1. Uptake of the flu vaccine in primary care across Greater Manchester is above the national and regional reported average in all the target groups with the exception of all 2 and 3 year olds. However, the overall uptake is lower than the same reporting period from 2017 but mirrors the national trend.

4.2. Greater Manchester is ranked as one of the highest achieving areas in the country in those aged, 65 years and older, 6 months to under 65 years in a clinical at risk group and all pregnant women. It is ranked as one of the lowest performing areas in the country in all 2 and 3 year olds. The reported uptake of the flu vaccine at GM level is above the England average and has improved in all year groups when compared to the same reporting period last year, with the exception of year group 5.

4.3. The GM provider of the schools flu vaccination programme have now completed the programme across all schools in GM. Targeted catch up sessions are now underway. Additionally this year the provider also offered the flu vaccine in special schools to those outside the national schools programme.

4.4. The GM Screening and Immunisation Team (SIT) are working in collaboration with Trusts to maximize uptake of the vaccine to support the achievement of the challenging target. The Christie FT are the highest achieving Trust in GM and Manchester University Foundation NHS Trust is the largest in the country and have administered over 10,000 flu vaccines to their eligible Health Care Workers.

4.5. All the Greater Manchester localities have reported that they have access to flu vaccine as nationally directed at the present time.

4.6. The SIT are reviewing the GM flu vaccination uptake data in all the eligible cohorts and are proactively working with localities, GP practices and trusts with low flu vaccine uptake.

4.7. The SIT has held meetings this week with Salford, Manchester and Oldham CCGs who have the lowest uptake of flu vaccine in those aged 2 and 3 years of age in Greater Manchester. Local action plans have been agreed in an attempt to improve uptake of the vaccine. These include:
• a revised communications plan supported by the GM communications team

• GMHSCP have commissioned a private provider to visit identified practices and hold flu clinics for all 2 and 3 year olds before the end of January 2019.

• Oldham CCG have commissioned a private provider to go into some of their local nurseries to offer flu vaccine sessions.

4.8. The GMHSCP communications are continuing to promote the flu vaccination programme across all eligible groups including, targeted messages to Health Care Workers and further work with Astra Zeneca with a focus on the children’s programme. A letter requesting nursery’s to encourage all 2 and 3 year olds to have the flu vaccine is going to be sent this week signed by Dr Richard Preece.

4.9. In the North West, influenza activity is at similar or slightly higher level than last week. Syndromic surveillance indicators continue to rise and are now exceeding seasonal thresholds where defined. 16 respiratory outbreaks were reported last week, all from care homes, of which 7 were confirmed as flu-related (largely influenza A, un-typed).

4.10. Nationally, community activity is described as low, while flu-related hospitalisation remains at moderate levels. Flu-related Intensive Care Unit/High Dependency Unit admissions are approaching the high level.

5.0 SYSTEM SUPPORT

5.1. The GMHSCP UEC Team has been working with systems to agree packages of service improvement support to improve the UEC pathway.

5.2. NHS Utilisation Management (UM) Unit are currently providing a programme of on-site urgent and emergency care support for Stockport NHS Foundation Trust (FT) over Q4 18/19.

5.3. ECIST are supporting to Manchester Foundation Trust and Pennine Acute Hospitals Trust on reducing long stay patients.

5.4. All GM trusts have been offered the opportunity to join the national ECIST programme for eradicating corridor care and reducing minors breaches.

5.5. The GMHSCP team are working with the NHS Utilisation Management Team to develop a single source and repository for UEC data that is easily accessible by all parts of the GM system. It is planned to share the new report and predictive modelling at the next GM UEC Improvement and Transformation Board to agree next steps.

5.6. The GMHSCP continue to hold weekly winter planning meetings where we review current pressures and performance and agree any required actions. The partnership have held a number of calls with systems to provide support in the
resolution of any issues or to identify if any further support is required within the system.

6.0 RECOMMENDATIONS

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

- Note the content of the report
Appendix 1

Adult Social Care Winter Funding 2018 / 2019

What has the additional social care winter funding been used for?

**Bury**
- Additional discharge to assess capacity, to address the shortfall in SRG funding and to double run a D2A community provision along with a proposed Acute ward allocated for D2A purposes.
- GP cover for the D2A beds
- 1 x Trusted Assessor to increase flow from the hospital
- Increased Social Work support to the D2A hospital team
- To purchase additional Agency staff to be able to flex staffing requirement in the initial "hot spots" service

**Rochdale**
- Staffing and bed capacity increases
- Discharge to assess capability
- Care Home stock contract for Christmas period
- Market stabilisation for care home setting (not one-off allied issues)

**Stockport**
- Social care commission 10 beds to support discharge from acute and intermediate care beds when families are unable to identify a home of choice with available beds.
- Increase through right support to avoid admissions
- Commission 15 extra care packages (4x site or equivalent)
- Facilitate the trusted assessor process across care homes
- Increase social worker capacity
- Increase case manager support for patients who are a pressure
- Potential early implementation of the 19/20 fees uplift for the residential/nursing market
- Work with the third sector to implement preventative support within the community.

**Wigan**
- Re-placemen staff work all year covering 7 days and bank holidays.
- Social workers - 2 additional posts to support the winter schemes and community task fully implemented.
- Local Authority have also used their Winter funding for additional support

**Tameside**
- Replacemnt Staff to work all year
- Social workers - 2 additional posts to support the winter schemes and community task fully implemented
- Local authority have also used their winter funding for additional support

**Manchester**
- Priority discharge programme
- Mental Health bed bureau, Mental Health housing support worker, MHTOC team
- Homecare bridging capacity and transitional arrangements
- Bed based transitional care
- Care home support (North and South)
- Readiness and complex Readiness
- Crisis Clean
- Social/PAI Capacity
- Advocacy
- Neighbourhood apartments
- Homelessness

**Warrington**
- Discharge to assess bed capacity.
- Mental health expertise in Integrated Discharge team at Wythenshawe hospital.
- Staffing capacity to support hospital assessment and flow.
- Further expansion of Urgent Care control room
- Residential and nursing homes capacity for mental health and dementia care

**Bolton**
- A large part will be used to purchase existing services and mitigate the extent of overspend
- Home care will be bought in a block for the winter period
- Timetline reviews to reduce service users escalating into crisis, where packages of care breakdown and or hospital admission results
- Community investment programme to be distributed across neighbourhoods for a 2 year programme of targeted services that reduce demand

**Oldham**
- Additional community equipment
- Additional respite beds
- Extension of D2A beds
- Incentive payments for care homes / care providers during Christmas/New Year period
- Clinical support to care homes
- Clinical input to residential rehabilitation
- Additional social work capacity
- Additional capacity to support hospital discharge
- Increase in availability of rehabilitation
- Additional funding for short stay residential placements

**Trafford**
- Home from hospital home care service
- Discharge to assess beds

**Salford**
- Priority discharge programme
- Mental Health bed bureau, Mental Health housing support worker, MHTOC team
- Homecare bridging capacity and transitional arrangements
- Bed based transitional care
- Care home support (North and South)
- Readiness and complex Readiness
- Crisis Clean
- Social/PAI Capacity
- Advocacy
- Neighbourhood apartments
- Homelessness
### 4hr Performance Monthly Ranking by Trust

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### 4hr Performance Quarterly Ranking by Trust

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