Chair: Ms J Crombleholme
Enquiries to: Laura Latham
07827 239332
Laura.latham1@nhs.net

NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group Governing Body
Part 1

A G E N D A

The next meeting of the NHS Stockport Clinical Commissioning Group Governing Body will be held at Regent House, Stockport at 10am on 27 April 2016

	Agenda item	Report	Action	Indicative Timings	Lead
1	Apologies	Verbal	To receive and note	10.00	J Crombleholme
2	Declarations of Interest	Verbal	To receive and note		
3	Approval of the draft Minutes of the meeting held on 30 March 2016	Attached	To receive and approve		J Crombleholme
4	Actions Arising	Attached	To comment and note		J Crombleholme
5	Notification of Items for Any Other Business	Verbal	To note and consider		J Crombleholme
6	Patient Story	Video		10.15	J Crombleholme
7.	Corporate Performance Reports a) Strategic Impact Report b) Finance Report c) Performance Report d) Quality Report	Written Reports	To receive, assure and note.	10.30	 T Ryley M Chidgey G Mullins M Chidgey
8.	Locality Chairs' Update	Verbal Report	To receive and note	11.00	Locality Chairs
9.	Report of the Chair	Verbal Report	To receive and note	11.15	J Crombleholme
10.	Report of the Chief Operating Officer to include the following: • Update on Integrated Commissioning	Written Report	To discuss and approve	11.20	G Mullins

	• Stockport Together Update • Update on prioritising and resourcing Operational Plan projects				
11.	Report of the Chief Clinical Officer to include the following: • Greater Manchester Commissioning for Reform Strategy • Delegation Agreement • Healthier Together Implementation Planning	Written Report	To discuss and review	11.45	R Gill
12.	Procurement of the MCP	Written Report (to follow)	To approve	12:05	Mark Chidgey
13.	Response to Public Health Annual Report	Written Report	To note and approve	12:20	V Owen Smith
14.	Reports from Committees • Primary Care Commissioning Committee • Remuneration Committee	Written reports	To note and approve recommendations	12:35	J Crombleholme J Greenough
15	Any Other Business	Verbal		12:50	J Crombleholme
	Date, Time and Venue of Next meeting The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 25 May 2016 at Regent House, Stockport. Potential agenda items should be notified to stoccg.gb@nhs.net by 1 February 2016.				

NHS
Stockport
Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
MINUTES OF THE GOVERNING BODY MEETING
HELD AT REGENT HOUSE, STOCKPORT
ON WEDNESDAY 30 MARCH 2016
PART 1

PRESENT

Ms J Crombleholme	Lay Member (Chair)
Mrs G Mullins	Chief Operating Officer
Dr J Higgins	Locality Chair: Heatons and Tame Valley
Mr J Greenough	Lay Member
Mr M Chidgey	Interim Chief Finance Officer
Dr A Johnson	Locality Chair: Marpeth and Werneth (Vice-Chair)
Dr R Gill	Chief Clinical Officer
Dr L Hardern	Locality Chair: Stepping Hill and Victoria
Dr A Firth	Locality Vice-Chair : Stepping Hill and Victoria
Dr V Owen Smith	Clinical Director for Public Health
Mrs K Richardson	Nurse Member

IN ATTENDANCE

Mr R Roberts	Director for General Practice Development
Mr T Ryley	Director of Strategic Planning and Performance
Mrs L Latham	Board Secretary and Head of Governance
Cllr J Pantall	Stockport Metropolitan Borough Council
Dr D Jones	Director of Service Reform
Mr M Cullen	Stockport Metropolitan Borough Council

APOLOGIES

Dr C Briggs	Clinical Director for Quality and Provider Management
Dr V Mehta	Clinical Director for General Practice Development
Dr D Kendall	Consultant member
Dr P Carne	Locality Chair: Cheadle and Bramhall

192/15 APOLOGIES

Apologies were received from Dr C Briggs, Dr V Mehta, Dr D Kendall and Dr P Carne.

193/15 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

194/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 9 MARCH 2016

The minutes of the meeting held on 9 March 2016 were approved as a correct record.

195/15 ACTIONS ARISING

The Chair noted that the completion date for the actions listed was April and updates would be sought at the next meeting of the Governing Body.

196/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were none on this occasion.

197/15 PATIENT STORY

The Governing Body heard from a patient who had delayed responding to requests from her GP to attend an appointment for a cervical smear test. She explained that she had always found reasons not to make the appointment. The Nurse Practitioner noted as part of another appointment that a smear had not been carried out and strongly persuaded the lady to make an appointment for the test. The results had indicated high grade abnormalities and a referral to the hospital had been made. Following initial investigations the patient had been diagnosed with cervical cancer in the early stages which was noted to be treatable. She explained that all the practitioners involved in her care had shown great empathy, support and made time for her to discuss her diagnosis and the treatment. To conclude the story, she highlighted the incredibly positive experience about all aspects of the service she had received in particular the speed with which the stages had progressed. She urged all women to act promptly on requests from their GP for cervical smear tests and not ignore them as in her case, the actions of the Nurse Practitioner in ensuring an appointment was made had proved life-saving.

J Higgins noted the powerful message portrayed in the patient story and the importance of ensuring as GPs that patients understood the importance of cervical smear testing and the potential impact of abnormal results. A Johnson supported this view and highlighted the crucial role of wider primary care practitioners in influencing patient behaviour. M Chidgey noted that in addition to the regular communication of reasons for regular cervical screening to patients, it had to be supported by the whole system and all practitioners.

R Gill highlighted the numbers of women within Stockport who had never accessed the cervical screening programme and the importance of the role of the commissioner in planning to ensure that Practices worked with the information available to them to target communications. V Owen Smith noted that where practices were not meeting the 80% QOFF targets for this area of work, there could be a number of potential reasons, in many cases linked to practice nurse capacity.

The Governing Body considered the role of early education for young women. V Owen Smith noted that the immunisation rates for the cervical cancer vaccine were available and there were some ongoing issues highlighted in data capture between the Child Health Information System and Practice systems. Some data reconciliation had been undertaken but capacity did not exist locally to continue to do this work. Emis Web was noted to offer some functionality which could be of value. She explained that following a recent procurement exercise across Greater Manchester no bidder for the Child Health Information System had been secured but that a further exercise was being planned.

Resolved: That the Governing Body:

1. Notes the content of the patient story and requests that thanks be passed on to the patient for sharing their views.
2. Requests that the patient story be shared with Practice Nurses in particular and more widely through the Communications Team subject to patient consent.

198/15 MONTH 11 FINANCIAL POSITION

The Governing Body considered the current financial and forecast positions of the CCG as a month 11 of the 2015/16 financial year. M Chidgey highlighted that the CCG was on track to deliver the end of year planned surplus of £1.75m but this would include a recurrent deficit brought forward into the 2016/17 financial year. He noted that the continued achievement of planned CIP would remain challenging for the CCG.

J Greenough requested that information be provided on the achievement of planned CIP in previous financial years.

Resolved: That the Governing Body:

1. Notes the year-to-date surplus of £1,604kk which is line with plan.
2. Notes that the CCG is forecasting to deliver the planned surplus of £1.75m which has only been achieved through in-year non-recurrent benefits.
3. Notes as a result of the CCG is carrying forward a deficit of £8.7m, delivery against all NHS England business rules in 2016/17 will be extremely challenging.
4. Notes that there are no significant risks which would prevent delivery of the CCG's planned surplus of £1.75m

199/15 CCG FINANCIAL AND OPERATIONAL PLANS

M Chidgey provided an overview of the CCG's financial and operational plans for the 2016/17 year and explained that the proposed plans fell within year 3 of a longer term 5 year strategy. He highlighted a number of key areas which the Governing Body needed to consider which included:

1. The trajectory for emergency department performance outlined within the plan not meeting the NHS Constitutional target of 95%
2. The growth monies being received by the CCG on 1 April 2016 being used to move from a position of recurrent deficit to one of surplus and thereby the growth monies are unavailable for other investments.
3. The challenge in achieving the CIP as outlined in the Plan
4. The negotiated position of 0.5% surplus
5. The requirement in the Business Rules for CCGs to keep 1% of their total budget uncommitted which would be managed as unidentified CIP in line with the approach being taken by CCGs across Greater Manchester.

He highlighted the risk ratings for the delivery of the CCG's CIP plans and noted the particular challenges around the delivery of Stockport Together and Prescribing elements. He outlined the required investment in the NHS 'Must do' areas and noted that the GP Development Scheme had proven benefit following the initial evaluation and it was hoped the return on investment would continue to increase in the coming year.

V Owen Smith highlighted that the plan did not capacity for research and that a recent offer to the CCG had been declined due to lack of capacity. M Chidgey noted that work would be undertaken to prioritise the projects and programmes as outlined in the plan to maximise the effective use of the CCG's capacity. He explained that where innovation would impact on achievement of CIP and transformation objectives it would likely to be prioritised. V Owen Smith requested to be involved in the prioritisation work. T Ryley also noted that as part of the Vanguard Programme evaluation would be undertaken on

the care model development with a view to ensuring the delivery of the predicted benefits. D Jones commented on the CCG's appetite for research and innovation and the opportunities to scale up the work at Greater Manchester level, in particular around new models of care.

There was a discussion around the assessment framework and diabetes and benchmarking within this area. M Chidgey provided an update in response to questions on the Contract Negotiations with Providers, including with NHS Stockport Foundation Trust. He indicated that the move to Commissioning for Outcomes and Provider collaboration was key to delivering the best patient outcomes and the Neighbourhood Model was essential to progressing that work. R Gill noted that the focus of the contract negotiations had presumed no growth and that the system needed to work to manage that as part of its daily operations.

A Johnson requested that consideration be given to the performance management and outcomes of investment in community services. T Ryley noted that part of the Stockport Together work in developing the neighbourhoods, responsibility for considering the totality of available spend to deliver the best outcomes for patients would in time be managed at that level. It would be supported by continued innovation through the use of electronic patient records and IM&T initiatives overall to create increased capacity. The Governing Body supported the view that clinical commissioners should take a strong lead in developing the neighbourhoods through innovation and in reviewing and scrutinising the designs. R Gill highlighted that the opportunities for efficiencies across the entire model of care were significant and acknowledged the importance of the leadership of the design of the new primary care focussed models of care to come from general practice.

In responding to questions, T Ryley highlighted the challenges in developing the neighbourhood model through a partnership based approach and the need to focus on the entire population as part of the design process. He noted that a continued challenge was balancing collaboration and pace of complex transformation, particularly in light of some of the known issues around workforce development. He highlighted the positive work currently underway within neighbourhoods relating to aligned social care and district nursing staff and Multi-Disciplinary Team meetings. R Gill highlighted the progress made by the Stockport Together Programme in bringing together the Leaders across the partner organisations to develop the transformation approach.

J Greenough sought confirmation about how the CCG would manage the £4.2m outlined in the financial plan for the unidentified 1% surplus. M Chidgey outlined the Greater Manchester planning footprint which had been assumed for 16/17 and the need to deliver across the region. He noted that he would continue to present the Stockport position at Greater Manchester Level to ensure that the level of financial risk being carried by the CCG.

Resolved: That the Governing Body:

1. Approves the Operational Plan for 2016/17.
2. Approves the Financial Plan for 2016/17 (appendices 1-3 of the report)
3. Note that as a result of the above there will be additional scrutiny from Greater Manchester and NHSE on the Stockport economy due to:-

    • A forecast surplus of 0.5%.
    • An ED 4 hour trajectory which is below the national constitution standard.

4. Delegate to the CFO in consultation with Chair, GM and RG the ability to vary this plan resulting from:-
    • Final contract negotiation outcome.

- Revised national guidance.
- Changes to agreements between Greater Manchester CCGs.

Any changes to the plan to be supported by both the Chief Operating Officer and Chief Clinical Officer and subsequently reported to the next meeting of the Governing Body.

5. Support the management team in:-
   - Prioritising the early delivery of the existing CIP projects.
   - Rapidly expanding this to address the remaining unidentified CIP.
   - Reviewing objectives for teams and individuals and

200/15 INTEGRATED COMMISSIONING

G Mullins provided an overview of the development of a new integrated commissioning approach with Stockport Metropolitan Borough Council, underpinned by a new Section 75 Agreement. The Council had reviewed the approach via a Joint Overview and Scrutiny Committee and approved the arrangements at its Executive meeting in March 2016.

The Governing Body was advised of the existing pooled budget with the Council and the proposal to move to a more place based integrated commissioning approach, supported by the development of a Multi-Speciality Community Provider focussed on a neighbourhood approach. The integrated approach to commissioning through a pooled budget would blend both budgets and provide opportunities to align commissioner resource, capacity and expertise.

She explained the purpose of the S75 document and the joint decision making power which would be carried out by both parties through the Heath and Care Integrated Commissioning Board (HCICB). J Crombleholme, R Gill and A Johnson had been nominated as the CCG's representatives on the Board. The Joint Commissioning Board would act as an operational management arrangement to oversee the pooled budget and integrated commissioning function and support the operation of the (HCICB.) The Governing Body noted the receipt of legal advice by the CCG which had highlighted some technical amendments required, some areas where greater clarity could be received regarding roles and responsibilities of the key components and the need to exclude spend on surgery which was prohibited under the S75 arrangements. The anticipated financial impact of excluding surgical specialties was approximately £30m which would be treated as an aligned budget within the view of the HCICB. M Chidgey indicated that the agreement also included an approach to the risk share arrangements between both organisations.

Members considered the update on the integration of providers as they began to work towards the establishment of a new organisational form through the Multi-Speciality Community Provider. G Mullins explained that the CCG would not be a formal signatory to the Memorandum of Understanding being proposed by the Provider Board but would endorse the approach taken and seek assurance that the Provider Board under the Leadership of a new Chief Officer post would possess the appropriate clinical and financial leadership required.

M Cullen explained that the pooled fund as outlined in the Section 75 Agreement was a concept which provided a mechanism for a joint and integrated view of the totality of resource across health and care which would be allocated through joint decision making by both partners. Councillor Pantall highlighted the role of the Health and Wellbeing Board in governing the Better Care Fund arrangements.

A Johnson requested a highlights paper be prepared to share with GP Members to explain the aims and objectives of the pooling of financial resource and integrated approach to commissioning. R Gill acknowledged the importance of the CCG in representing its Members maintaining a clear line of sight over the development of the Multi-Speciality Community Provider and focussing on the improved outcomes for patients.

G Mullins concluded by outlining the proposal for integrated commissioning within the wider context of the Stockport Together Programme ambition and the process of learning and dissemination of best practice which would take place in the early stages of the S75 Agreement period.

Resolved: That the Governing Body:

1. Approves the approach to the Integrated Commissioning of health and social care set out in the report and, subject to any further changes that may be made in discussions with health partners, the following :
   • The CCGs contribution to the pooled budget with the Council for 2016/17 as set out in Appendix Two;
   • The revised Section 75 Partnership Agreement with the Council (Appendix Four)
   • The establishment and operation of the Health and Care Integrated Commissioning Board (HCICB) as set out in Appendix Three
   • The Integrated Commissioning arrangements described in paragraphs 3.13-3.16

2. Delegates authority to the Chief Operating Officer in consultation with the Chief Clinical Officer to make any changes that are necessary to enable the above arrangements / documents to be implemented as a result of further discussions and negotiations with Council partners.

201/15 ANY OTHER BUSINESS

J Crombleholme expressed thanks on behalf of the Governing Body to K Richardson for her contribution to the development of the CCG and her continued commitment to putting forward a strong voice on behalf of the nursing profession.

R Gill expressed congratulations to Marple Cottage Practice on its recent Outstanding Care Quality Commission inspection. He requested that consideration be given to how the CCG shares success and good work within general practice.

(The meeting ended at 10.04am)

Questions from Members of the Public

1. Clarity was sought regarding the arrangements for the progression of Healthier Together within the context of the ongoing contractual negotiations with Providers.

   R Gill noted that Healthier Together was a programme at the start of the implementation phase and regular updates would be provided to the Governing Body on progress in the coming months.

   A number of other questions had been submitted in writing which would be responded to in due course.

NHS Stockport Clinical Commissioning Group
30 March 2016

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
09 03 2016 (1)	Patient Story To link prescribing of antibiotics into the proposed GP led campaign on patient behaviour change. To align any local messages to relevant Public Health England Campaigns in due course.	180/15	April 2016	V Owen Smith V Owen Smith
09 03 2016 (2)	Strategic Impact Report To include in the next version of the report narrative around the performance of the provider for urology and dermatology treatments. To investigate the potential impact of dietician prescribing rights coming into force from 1 April 2016.	181/15	April 2016	M Chidgey R Roberts

09 03 2016 (3)	Chief Operating Officer's Report To review the processes for keeping the Governing Body appraised of procurement activity planned and underway and informing them of the outcome.	186/15	April 2016	G Mullins
09 03 2016 (4)	Chief Clinical Officer's Report To seek clarification about the strategic public health support available as part of the Greater Manchester approach to specialist commissioning.	187/15	April 216	R Gill
09 03 2016 (5)	Public Questions A briefing note to the provided on the outcome of the changes to the community mental health team structure undertaken by Pennine Care to be appended to a future set of minutes.	N/A	April 2016	M Chidgey
30 03 2016 (1)	Patient Story That the Story be shared with Practice Nurses and thanks be expressed to the patient for sharing her story.	197/15	April 2016	L Latham
30 03 2016 (2)	Integrated Commissioning That a highlight report on the approach to integrated commissioning and the Section 75 Agreement as an enabling document be drafted and shared with the GP Membership.	200/15	April 2016	G Mullins

30 03 2016 (3)	Any Other Business That consideration be given to the organisational sharing of success and good work within general practices including areas such as Care Quality Commission Inspections	201/15	April 2016	L Hayes / L Latham
30 03 2016 (4)	Financial Position Month 11 Information regarding achievement of Cost Improvement Plans (CIP) in previous years be collated and shared with Governing Body Members	198/15	April 2016	M Chidgey

NHS
Stockport
Clinical Commissioning Group

Strategic Impact Report

Performance against key indicators in operational plan

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 **Fax:** 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What decisions do you require of the Governing Body?
The Governing Body are not being asked to make any specific decisions but should note the content of this report when considering the finance report and CCg Strategy and plans.
Please detail the key points of this report
Emergency and non-elective performance is broadly in line with plan and better than national trends Planned activity and prescribing are worse than plan Variation between localities is marked with a degree of consistency across all key indicators within certain localities. Causal factors are unclear or difficult to prove but the GP Development scheme is a strong likely factor and moving forward the focus on neighbourhoods within development of an MCP will need to address variation.
What are the likely impacts and/or implications?
There needs to be a strong focus on getting the benefits of recent changes such as *consultant-connect*, work on *dermatology* and *integrated teams* during 2017-18.
How does this link to the Annual Business Plan?
It describes success or otherwise of delivering plan
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors meeting
Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 26th April 2016
Agenda item:

1. Introduction

The report summarises the position across the year 2015-16 of our key set of strategic measures. The data is to month 11 (end Feb 15) except for prescribing and occupied bed days which is to month 10 (End Jan 16). The report is against plan rather than actual, though these in most cases are the same.

The report also includes a comparison of performance across the four neighbourhoods. Given we now have 10-11months of data the level of statistical reliability at neighbourhood level is sufficiently robust to discuss at this level.

Members should remember performance *indicators* are *indicative.*

2. Summary of Overall Position

We have made good progress against our plans for emergency and non-elective care. Against a background of growth in this area nationally our lower than 1% non-elective admission and A&E attendance increase in actual terms and our variance against plan of less than 1% is good performance. In two areas performance has been exceptional with an 11-12% reduction in people admitted for long-term condition or from a care home. These are two areas the GP Development scheme focused on.

In the planned arena performance against plan has been weaker. We have seen a 4.4% underachievement against plan (3.7% real growth) in GP referred 1st outpatient activity and a 1.4% growth in elective activity (1.3% actual). Prescribing activity has also grown 2.8% above plan but has improved from earlier in the year.

3. Locality Comparison

The charts on the following pages compare the performance against plan of the four localities. It will be noticed that there is marked variation in performance. This variation is not obviously driven by deprivation and affluence. The two localities with the highest level of deprivation (Heaton& Tame Valley, and Stepping Hill & Victoria) both have a mixed set of similar results. The two more affluent localities have both seen the biggest increases (Cheadle & Bramhall biggest % increase on 6/9 indicators), and the lowest growth or indeed reduction (Marple & Werneth best on 6/9 indicators).

Exceptional performance on A&E attendance and non-elective admission reduction is evident in Marple & Werneth and in Stepping Hill & Victoria. Stepping Hill & Victoria have reduced admissions for a long-term condition by nearly 20%, and similarly Marple & Werneth have reduced Care Home admissions by nearly 20%. Only Marple & Werneth have reduced GP referred 1st Outpatients (one practice by 17%). Only Stepping Hill and Victoria have reduced prescribing activity.

Areas of particular concern are the 10% increase in GP referred 1st Outpatients in Cheadle & Bramhall and 7.3% increase in prescribing activity in Heaton and Tame Valley.

Comparison against plan

	Cheadle& Bramhall	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria
A&E Attendances	-1.4%	-1.1%	-4.6%	-3.9%
All Non-Elective Admissions	+1.5%	+0.3%	-5.6%	-4.3%
Occ Bed Days per 100,000 [1]	+8.5%	+0.2%	-0.4%	+2.3%
LTC Admissions	-10.4%	-12%	-10.6%	--19.2%
Care Home Admissions	+1.0%	-14.7%	-19.6%	-13.1%
GP Referred 1st OPA	+10.1%	+3.6%	-2.5%	+2.5%
Other Referred 1st OPA	-3.7%	-2.0%	-8.0%	+0.4%
Elective Admissions	+3.0%	-1.0%	-0.2%	-0.5%
Prescribing [1]	+2.2%	+7.3%	+2.1%	-2.8%

Rank

	Cheadle& Bramhall	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria
A&E Attendances	3rd	4th	1st	2nd
All Non-Elective Admissions	4th	3rd	1st	2nd
Occ Bed Days per 100,000 [1]	4th	2nd	1st	3rd
LTC Admissions	4th	2nd	3rd	1st
Care Home Admissions	4th	2nd	1st	3rd
GP Referred 1st OPA	4th	3rd	1st	2nd
Other Referred 1st OPA	2nd	3rd	1st	4th
Elective Admissions	4th	1st	3nd	2nd
Prescribing [1]	3rd	4th	2nd	1st

1 - For Occupied Bed Days per 100,000 and prescribing items there is no plan data so it is always compared with 2014/15 actual

4. Explanation

The direct causal link between changes under taken on the ground and results of this type are difficult to prove. However, it should be noticed that the GP Development scheme focused on four areas:

- Increasing GP access (no half day closing)
- Care Home alignment and weekly ward rounds
- Long-term condition management
- Prescribing.

In all but the last of these there appears to be a noticeable positive impact.

Work emerging from Stockport Together and Referral Programmes of work such as multi-disciplinary teams, consultant-connect and work in dermatology will be too recent to have a marked impact on this data.

The Governing body should note that expecting improvements in one year is unlikely. Where we have seen improvements tis often reflects years of work.

At this time there is not a clear rationale for the variation in performance between localities. However, the development of neighbourhood based healthcare through Stockport Together as part of creating an MCP including pushing responsibility for budgets down to this level over the next few years should strengthen neighbourhood focus on addressing these issues.

5. Neurology Variation

There is an increase in GP referred 1st OP of 44% compared to last year. This activity is almost entirely at Salford and the variance was even higher earlier in the year.
An analysis of the activity suggests that there is an increase in multiple attendances, all being classified as firsts, compared to previous years. This issue was first raised with Salford FT in August and followed up in October. We have again requested further clarification this month.

The lack of resolution is down as far as we can tell to two reasons. Firstly, this issue was raised in the content of a number of data quality problems at Salford, particularly around Dermatology, and was probably a lower priority than the Dermatology problems, certainly when it was first raised. Secondly, Salford themselves have suggested a couple of possibilities which have been subsequently discounted. When the issue was first raised, the initial response from Salford was that it might be to do with a new triage service. Subsequent responses have focussed on Salford's handling of issues of commissioning responsibility for this activity i.e. whether it is commissioned by Stockport CCG or NHS England. Our understanding is that GP referrals to Neurology (almost 99% of the total) are CCG commissioned in 2015/16 – therefore, this activity is being correctly reported so we don't believe this is the issue. The latest response from Salford FT is again about commissioning responsibility, which they now think is resolved, but clearly the issue is unresolved.

We intend to follow up with a clear statement of the problem and ask for an urgent resolution, given that it is now eight months since the issue was first raised. One possibility is that OPFUs are being incorrectly coded as firsts. If this is the case then we are potentially also being charged incorrectly as well. However, that has not yet been tested.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	Stkpt	Stkpt	
Practice Name	All Stockport		
GP Partnership			
Prescribing Name		Map:	
		Tel reception:	

List Size	
Mar 2015	304218
Mar 2014	298743
Mar 2013	296314
Weighted list 31/10/14	297723

Select comparison yr: Actual 2014-15

		2014-15 YTD Apr-Feb	2015-16 YTD Apr-Feb	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		85588	86169	581	0.7%		**0.7%**	**0.7%**
Ambulance Conveyance Rate		81.9%	79.9%					
Non-Elective Admissions								
All Non-Elective Admissions		35125	35461	336	1.0%		**1.0%**	**1.0%**
Occ Bed Days per 100,000 [1]		56758	55204	-1554	-2.7%		**-2.7%**	**-2.7%**
GP Direct Admissions		5731	6093	362	6.3%		**6.3%**	**6.3%**
LTC	**Register**							
CHD Admissions	11741	857	734	-123	-14.4%		**-14.4%**	**-14.4%**
HF Admissions	2728	442	492	50	11.3%		**11.3%**	**11.3%**
COPD Admissions	6711	527	362	-165	-31.3%		**-31.3%**	**-31.3%**
Asthma Admissions	19770	186	215	29	15.6%		**15.6%**	**15.6%**
Diabetes Admissions	14575	117	115	-2	-1.7%		**-1.7%**	**-1.7%**
LTC Admissions	55525	2129	1918	-211	-9.9%		**-9.9%**	**-9.9%**
AF Admissions	5732	486	432	-54	-11.1%		**-11.1%**	**-11.1%**
Care Home Admissions		1857	1680	-177	-9.5%		**-9.5%**	**-9.5%**
Referrals								
GP Referred 1st OPA		50596	52486	1890	3.7%		**3.7%**	**3.7%**
Dermatology		5082	5288	206	4.1%		**4.1%**	**4.1%**
ENT		5640	5965	325	5.8%		**5.8%**	**5.8%**
General Medicine		7968	8571	603	7.6%		**7.6%**	**7.6%**
General Surgery		9433	9811	378	4.0%		**4.0%**	**4.0%**
Obstetrics & Gynaecology		3588	3736	148	4.1%		**4.1%**	**4.1%**
Opthalmology		3745	3278	-467	-12.5%		**-12.5%**	**-12.5%**
Paediatrics		2462	2591	129	5.2%		**5.2%**	**5.2%**
Rheumatology		1097	1126	29	2.6%		**2.6%**	**2.6%**
Trauma & Orthopaedics		6810	7374	564	8.3%		**8.3%**	**8.3%**
Urology		2812	2789	-23	-0.8%		**-0.8%**	**-0.8%**
Other Specialist Medicine		220	184	-36	-16.4%		**-16.4%**	**-16.4%**
Other Specialties		1739	1773	34	2.0%		**2.0%**	**2.0%**
Other Referred 1st OPA		32775	32259	-516	-1.6%		**-1.6%**	**-1.6%**
GP Referred 1st OPA								
Neurology [2]		1864	2684	820	44.0%		**44.0%**	**44.0%**
Planned								
Elective Admissions		34747	35189	442	1.3%		**1.3%**	**1.3%**
Prescribing [1 3]		5389329	5540079	150750	2.8%		**2.8%**	**2.8%**

NHS
Stockport
Clinical Commissioning Group

Finance Report March 2016 – Month 12 (Draft) and 2016/17 plan update.

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900
Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
• To note that the planned surplus for 2016/17 has been increased to £2.75m (0.63%) but remains below the required 1% level.
Please detail the key points of this report
• The 2015/16 planned surplus of £1.75m has been achieved. This is a draft positon within the 2015/16 annual accounts and is subject to external audit. • The CCG is carrying forward a deficit of £8.7m, therefore delivery against NHS England business rules in 2016/17 will be extremely challenging. • Achievement of the £1.75m planned surplus has been achieved through non-recurrent measures which do not address the underlying recurrent pressures carried forward into 2016-17. • The main 2016/17 healthcare contracts have been agreed and signed.
What are the likely impacts and/or implications?
Delivery against statutory financial duties and financial performance targets.
How does this link to the Annual Business Plan?
As per 2015/16 Financial Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Governing Body only
Clinical Executive Sponsor: Ranjit Gill
Presented by: Mark Chidgey
Meeting Date: 27th April 2016
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Report of the Chief Finance Officer
for the financial year ended 31st March 2016

1. Introduction

Members should note that the financial position being reported is a draft position which is subject to external audit. The external audit will commence on the 22 April 2016 and will be completed by the 25 May 2016, this being the date that the Governing Body will meet to approve the 2015-16 Annual Report and Accounts. Grant Thornton who are the CCGs external auditors will present their independent auditors report to governing body members at the 25 May meeting.

2. Statutory Financial Duties and Performance Targets

NHS England requires the CCG to deliver its statutory duties and financial performance targets. The CCG's financial performance against its financial duties and performance targets for the year ended 31 March 2016 are detailed in Table 1 below:

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty	Performance
Revenue (Appendix 1 Table 1)	Not to exceed revenue resource allocation	✓
Running Costs (Appendix 1 Table 1)	Not to exceed running cost allocation	✓
Capital – *(Note: The CCG has not received a capital allocation in 2015/16)*	Not to exceed capital resource allocation	**N/A**

Area	Performance Target	Performance
Revenue (Appendix 1 Table 1)	Deliver a Recurrent Surplus	✗
Revenue (Appendix 1 Table 1)	Deliver a 0.5% in-year surplus	✓
Cash (Appendix 1 Table 9)	Operate within the maximum drawdown limit	✓

Business Conduct (Appendix 1 Table 8)	Comply with Better Payment Practices Code	
QIPP (Appendix 1 Table 10)	Fully deliver planned QIPP saving	

3. Financial Performance for the year ended 31st March 2016

The CCG has delivered its planned surplus of £1.75m. However, members should note that this has only been achieved through in-year non-recurrent benefits and as a result the CCG is carrying forward a **c£8.7m** deficit into 2016-17.

The current deficit is a result of:

- Non delivery of recurrent CIP (mainly elective activity and prescribing) **£6.5m**
- Impact of ETO partially funded non recurrently **£1.4m**
- Full Year Effect (FYE) of charging for Allied Health Professions (AHP's) **£0.8m**
- Prescribing over performance **£0.6m**
- Other over/(under) performance (**£0.6m).**

The main areas of over performance are acute elective (Trauma & Orthopaedics and Ophthalmology) and outpatient activity (Dermatology, Trauma & Orthopaedics and Cardiology General Medicine) as well as prescribing.

The CCG's forecasted recurrent position has **deteriorated by £0.7m** since month 9 (December 15). The forecasted recurrent position as at month 9 is the month on which the CCG's 16/17 financial plan is based, therefore any recurrent deterioration in the CCG's financial position against this baseline will be a call against the contingency set aside in 2016-17.

4. 2016/17 Financial Plan and Contract Agreement

In March the Governing Body agreed the 2016/17 planned surplus of £2m (0.5%) but also gave delegated authority to the interim CFO to vary this if appropriate. Following review and clarification of the contributions and reimbursement to the GM risk share it is confirmed that in the plan submitted to NHSE on 18th April, the planned surplus has been increased by £0.75m to £2.75m (0.63%). This change has been notified to and endorsed by the Chief Operating Officer, Chief Clinical Officer and Chair.

A key part of the planning process is agreement of contracts with providers. The two most material contracts with Stockport NHS FT and Pennine Care NHS FT have both been agreed and signed. This is despite significant financial challenges across the system and has been

achieved significantly earlier than in previous years. Of the remaining contracts there are no material issues in dispute that will prevent us progressing quickly to sign off.

5. Recommendations

The Governing Body is asked to:-

I. **Note** that the 2015/16 planned surplus target of £1.75m has been achieved.

II. **Note** that as a result of the CCG carrying forward a deficit of £8.7m, delivery against all NHS England business rules in 2016/17 will be extremely challenging

III. **Note** that the planned surplus for 2016/17 has been increased to £2.75m (0.63%) but remains below the required 1% level.

Mark Chidgey
Interim Chief Finance Officer and
Director of Provider Management

14th April 2016

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	Y
Page numbers	N	Service Changes: Public Consultation Completed and Reported in Document	n/a
Paragraph numbers in place	Y	Service Changes: Approved Equality Impact Assessment Included as Appendix	n/a
2 Page Executive summary in place (Docs 6 pages or more in length)	n/a	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	n/a
All text single space Arial 12. Headings Arial Bold 12 or above, no underlining	Y	Change in Service Supplier: Procurement & Tendering Rationale approved and Included	n/a
		Any form of change: Risk Assessment Completed and included	n/a
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	n/a

Appendix 1

DRAFT MONTH 12 FINANCIAL DASHBOARD

Appendix 1

TABLE 1

RAG Rating Key:

G	Potential risk of overspend: less than or equal to £0
A	Potential risk of overspend: between £0 and £250k
R	Potential risk of overspend: Over £250k

Draft Month 12 Financial Position - as at 31st March 2016

	YTD (Mth 12) Plan £000s	YTD (Mth 12) Actual £000s	Var £000s	Var %	RAG RATING	Recurrent Budget £000s	Recurrent Commitment £000s	Recurrent Variance (Favourable) / Adverse £000s
Revenue Resource Limit (RRL)								
Confirmed	(378,328)	(378,328)	0	0.0%	G	(374,047)	(374,047)	0
In Year	(8,438)	(8,438)	0	0.0%	G	(1,348)	(1,348)	0
Total RRL	**(386,766)**	**(386,766)**	**0**	**0.0%**	G	**(375,395)**	**(375,395)**	**0**
Net Expenditure								
Acute	223,708	227,491	3,783	1.7%	R	221,804	227,634	5,830
Mental Health	32,295	31,944	(351)	(1.1%)	G	31,103	30,879	(224)
Community Health	35,786	35,787	1	0.0%	G	35,711	35,721	10
Continuing Care	17,126	16,378	(748)	(4.4%)	G	15,009	15,009	0
Primary Care	12,628	12,057	(571)	(4.5%)	G	10,073	9,973	(100)
Other	8,001	5,253	(2,748)	(34.3%)	G	2,636	3,398	762
Sub Total Healthcare Contracts	**329,544**	**328,910**	**(634)**	**(0.2%)**	G	**316,336**	**322,614**	**6,278**
Prescribing	48,651	50,178	1,527	3.1%	R	48,643	50,178	1,535
Running Costs (Corporate)	6,750	5,927	(823)	(12.2%)	G	6,424	6,424	0
Reserves (Ref: Reserves Summary)	71	0	(71)	(100.0%)	G	2,769	4,897	2,128
Total Net Expenditure and Reserves	**385,016**	**385,015**	**(1)**	**(0.0%)**	G	**57,836**	**61,499**	**3,663**
TOTAL (SURPLUS) / DEFICIT	**(1,750)**	**(1,751)**	**(1)**	**0.1%**	G	**(1,223)**	**8,718**	**9,941**

ACUTE

PRESCRIBING

TABLE 2

Acute Contract Performance		Year to Date		
Top 6 Acute Commissioning contracts & AQP/IS	Annual Budget	Budget	Actual	YTD Variance - Overspend / (Underspend)
	£'000	£'000	£'000	£'000
Stockport FT	144,302	144,302	143,625	(677)
University Hospitals of South Manchester FT	25,490	25,490	25,598	108
Central Manchester University Hospitals FT	18,706	18,706	19,074	368
Salford Royal FT	5,670	5,670	6,098	428
East Cheshire NHS Trust	2,259	2,259	2,269	10
Tameside Hospital FT	1,084	1,084	1,256	172
AQPs/IS	11,328	11,328	14,606	3,278
Other	14,869	14,869	14,965	96
Total Acute	**223,708**	**223,708**	**227,491**	**3,783**

PoD

TABLE 3

Forecast variance to plan at Mth 12 based on Mth 11 Activity Data (SLAM) (£000)	Top 6 Acute Commissioning Contracts & AQP/IS								
PoD	SFT (£000)	UHSM (£000)	CMFT (£000)	Salford Royal (£000)	East Cheshire (£000)	Tameside (£000)	AQP / IS (£000)	Other Providers (£000)	Total (£000)
Elective	(377)	49	104	(51)	(55)	31	2,949	124	2,774
Drugs & Devices	619		260	(55)	19	0	0	(6)	837
Outpatients	107	31	(53)	591	(42)	(9)	329	18	972
Non Elective	892	269	(331)	(2)	(11)	43	0	(47)	813
Non Elective (Excess bed days)	(786)	111	42	0	(13)	23	0	(14)	(637)
Macular	243	0	0	0	0	0	0	0	243
Fertility	0	0	70	0	0	0	0	3	73
Maternity	(133)	3	138	(33)	(8)	2	0	(8)	(39)
A&E	222	63	(4)	25	(2)	10	0	(9)	305
Critical Care	(474)	(206)	123	(137)	(28)	50	0	(62)	(734)
Other PoDs	(1,009)	(212)	19	90	150	22	0	116	(824)
Total Mth 11 Forecast Variance	(696)	108	368	428	10	172	3,278	115	3,783

TABLE 4

Month 12 - as at 31st March 2016

Forecast Reserves Summary

Amounts Held in CCG Reserves	Reserves Held Mth 12 £000s	Commits Mth 12 onwards £000s	Forecast Bals Year End £000s
Investments - National	1,267	0	(1,267)
Investments - Greater Manchester	1,144	0	(1,144)
Contingency	313	0	(313)
In-Year Allocations	561	0	(561)
CIP - Not embedded in budgets	(3,214)	0	3,214
Total Reserves	71	0	(71)

TABLE 5

Forecast spend against in year allocation (NHS Eng Requirement)	£000s
2015-16 Allocation	(386,766)
Less: Brought forward 2014-15 Surplus	4,281
2015-16 Expenditure	385,015
Forecast (under)/over-spend against in year allocation	2,530

TABLE 6

Top Five Increases in Prescribing Spend by Drug Type	Feb 14 - Jan 15 (£000s)	Feb 15 - Jan 16 (£000s)	Change (£000s)	Change in Spend (%)	Change in No. Items (%)
Endocrine System	6,243	6,884	641	10.3%	4.4%
Cardiovascular System	5,996	6,519	523	8.7%	1.6%
Central Nervous System	10,306	10,681	375	3.6%	4.0%
Nutrition And Blood	2,602	2,945	344	13.2%	2.9%
Appliances	1,285	1,423	138	10.7%	12.5%

TABLE 10

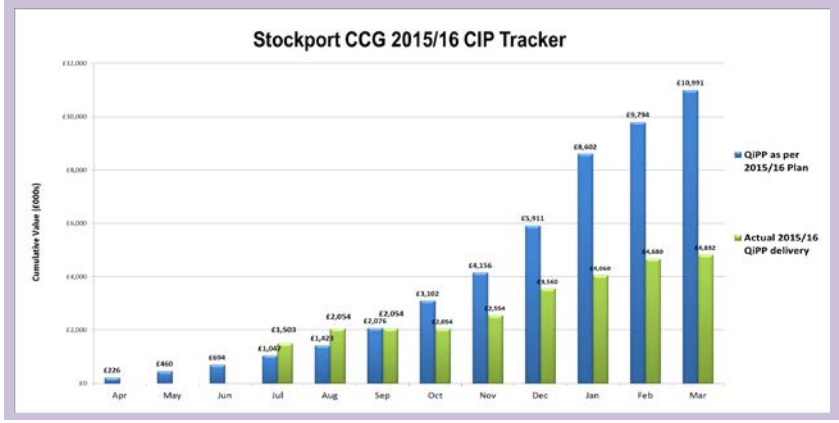


TABLE 7

Risks not in the financial position

There are no significant risks to the delivery of the draft financial position

TABLE 8

Public Sector Payment Policy (PSPP) - Measure of Compliance

The Public Sector Payment Policy target requires CCG's to aim to pay **95%** of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.	MARCH YTD Number	MARCH YTD £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	10,819	67,949
Total Non-NHS Trade Invoices Paid Within Target	10,574	66,360
Percentage of Non-NHS Trade Invoices Paid Within Target	97.74	97.66
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,718	263,960
Total NHS Trade Invoices Paid Within Target	2,621	263,485
Percentage of NHS Trade Invoices Paid Within Target	96.43	99.82
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	13,537	331,909
Total NHS Trade Invoices Paid Within Target	13,195	329,845
Percentage of NHS Trade Invoices Paid Within Target	97.47	99.38

We will continue to monitor our performance against the 95% 'Public Sector Payment Policy' (PSPP) target of invoices paid within 30 days of invoice. Performance is measured based on both numbers of invoices and £ value.

TABLE 9

Cashflow Summary - Month 12	£000s
Cash Limit for the Year	385,406
Cash drawn down YTD	384,135
Remaining cash	1,271
Actual cash drawn down (%)	99.7%
Expected cash drawn down (%)	100.0%

Appendix 2

NHS STOCKPORT CCG BALANCE SHEET as at 31st March 2016 (Month 12)

	Opening Balances 1.4.15 £000s	Closing Balances 31.03.16 £000s	Movement in Balances £000s
Non-current assets:			
Property, plant and equipment	14	9	(5)
Intangible assets	0	0	0
Trade and other receivables	0	0	0
Total non-current assets	**14**	**9**	**(5)**
Current assets:			
Cash and cash equivalents	43	76	33
Trade and other receivables	1,363	1,757	394
Inventories	0	0	0
	1,406	**1,833**	**427**
Non-current assets classified "Held for Sale"	0	0	0
Total current assets	**1,406**	**1,833**	**427**
Total assets	**1,420**	**1,842**	**422**
Current liabilities			
Trade and other payables	(20,923)	(22,638)	(1,715)
Provisions	(883)	(470)	413
Borrowings	0	0	0
Total current liabilities	**(21,806)**	**(23,108)**	**(1,302)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(21,266)**	**(880)**
Non-current liabilities			
Trade and other payables	0	0	0
Provisions	0	0	0
Borrowings	0	0	0
Total non-current liabilities	**0**	**0**	**0**
Total Assets Employed:	**(20,386)**	**(21,266)**	**(880)**
FINANCED BY:			
TAXPAYERS' EQUITY			
General fund	(20,386)	(21,266)	(880)
Revaluation reserve	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(21,266)**	**(880)**

NHS
Stockport
Clinical Commissioning Group

Resilience and Compliance Report - April 2016

Report to Governing Body on NHS Stockport CCG's performance, including NHS Constitution indicators and Legal Compliance indicators.

NHS Stockport Clinicial Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives

Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
Note the report.
Please detail the key points of this report
Performance on NHS Constitutional targets and legal compliance indicators
What are the likely impacts and /or implications?
Continue to monitor measures and compliance, especially ED, RTT, Cancer (62 days) and ambulance response times.
How does this link to the Annual Business Plan?
Updates Governing Body on performance on the measures laid out in our annual business plan.
What are the potential conflicts of interest?
N/A
Where has this report been previously discussed?
Directors Meeting
Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Gaynor Mullins
Meeting date: 27th April 2016
Agenda item: 7A
Reason for being in Part 2 (if applicable)
N/A

Chief Operating Officer's Report

This report covers data to February 2016 for both NHS constitution targets and for statutory duty and compliance indicators.

Additional information is provided below for:-

- Planned care, including the 18 week and 52 week standards.
- Urgent care, including; the 4 Hour ED waiting times standard and 12 hour standard.

Planned Care

The main target, that 92% of patients should have been waiting no longer than 18 weeks, has been failed in February. This is because there were two of our main providers, UHSM and East Cheshire NHS Trust where for Stockport patients the standard was not met. Whilst Stockport FT have achieved the standard it is clear from the increase in the number of patients waiting more than 18 weeks that risk is significantly increasing. The issue has been considered by the quality committee and because of the absence of a clear recovery plan and Quality Impact Assessment this has been categorised as a “red” issue.

This issue is also in sight of the SRG and a recovery plan has been requested through this forum. As the SRG meets on the day prior to the Governing Body meeting then a verbal update will be provided to the GB by the SRG chair on progress and any further escalation decisions.

The 3 52 week waits originate from UHSM as the external validation work continues. Breaches are clinically reviewed and appointments offered within 3 weeks once identified.

Urgent Care

The Governing Body have been kept informed of the significant reduction in performance since the beginning of November. The SRG co-ordinated response is yet to result in improvement to flow and performance sufficient to regain the standard. Whilst it is confirmed that no 12 hour breaches have occurred it is known that patients will have waited for excessive periods of time to access care.

The core SRG membership of Stockport CCG, Stockport NHS FT and SMBC attended a tripartite meeting with NHS England and NHS Improvement. At this meeting the 16/17 ED trajectory was discussed as were the improvement plans to achieve this. The plans are built upon a system wide RCA and fall into three categories:-

- Short term – a series of rapid improvement projects that are focussed on acute provision and processes.
- Medium term – implementation of the ECIST high impact changes to improve flow and reduce DTOC.
- Longer term – transformation of the urgent care system both indirectly through proactive care and directly by implementation of the proposed new urgent care system models.

Cancer standard reporting

Governing Body members are advised that an error has been identified within the procedure that has been previously reported for three of the cancer wait measures:

- EB.09 Maximum 31-day wait for subsequent treatment where that treatment is surgery
- EB.10 Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen
- E.B11 Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy

This has now been corrected and all of the figures in the SPR have now been retrospectively updated. The error did not have a material impact with the only significant change being that the radiotherapy standard was reported as having failed in Q1 15/16 whereas corrected performance shows it to be 100%.

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters									Last Three Months						Details		
NHS Constitutional Compliance Indicator	Q4		Q1		Q2		Q3		Dec 2015		Jan 2016		Feb 2016		Operational Standard	Collection Frequency	Status / Commentary
Patients on incomplete non-emergency pathways (yet to start treatment) should have waited no more than 18 weeks from referral	93.3	★	93.2	★	93.4	★	91.9	▲	91.6	▲	91.8	▲	91.5	▲	92%	Monthly	See commentary.
Number of patients waiting more than 52 weeks	0	★	1	▲	1	▲	3	▲	3	▲	2	▲	3	▲	0	Monthly	See commentary.
Urgent operations cancelled for a second time	0	★	0	★	0	★	0	★	0	★	0	★	0	★	0	Daily during Winter (Nov-Mar)	There is no significant risk identified to threaten future performance.
Number of patients not treated within 28 days of last minute elective cancellation	5	▲	2	▲	2	▲	1	▲							0	Quarterly	There is no significant risk identified to threaten future performance.

Diagnostics - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q4		Q1		Q2		Q3		Dec 2015		Jan 2016		Feb 2016		Operational Standard	Collection Frequency	Status / Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	97.2	▲	98.6	▲	98.1	▲	97.6	▲	98.0	▲	98.0	▲	99.0	★	99%	Monthly	Improved performance at UHSM means that this standard has been met in he current month. As CMFT are not yet achieving then this target will remain at risk.

A&E waits - Last Four Full Quarters									Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4		Q1		Q2		Q3		Dec 2015	Jan 2016	Feb 2016	Operational Standard	Collection Frequency	Status / Commentary
Patients should be admitted, transferred or discharged within 4 hours	86.0	▲	93.4	▲	92.1	▲	82.1	▲	76.4 ▲	75.3 ▲	75.4 ▲	95%	Weekly	See commentary.
12 Hour waits from decision to admit until being admitted	0.0	★	0.0	★	0.0	★	0.0	★	0 ★	0 ★	0 ★	0	Quarterly	See commentary.

Cancer waits - 2 week wait - Last Four Full Quarters									Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4		Q1		Q2		Q3		Dec 2015	Jan 2016	Feb 2016	Operational Standard	Collection Frequency	Status Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	95.7	★	96.0	★	95.8	★	97.0	★	97.7 ★	96.6 ★	97.8 ★	93%	Monthly	There is no significant risk identified to threaten future performance.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	98.0	★	95.5	★	97.2	★	94.9	★	96.7 ★	96.0 ★	99.4 ★	93%	Monthly	There is no significant risk identified to threaten future performance.

Cancer waits - 31 days wait - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q4		Q1		Q2		Q3		Dec 2015		Jan 2016		Feb 2016		Operational Standard	Collection Frequency	Status / Commentary
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	97.6	★	98.3	★	98.9	★	98.6	★	96.3	★	97.6	★	99.1	★	96%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is surgery	97.2	★	98.2	★	98.2	★	100.0	★	100.0	★	100.0	★	100.0	★	94%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	100.0	★	100.0	★	100.0	★	100.0	★	100.0	★	96.6	▲	100.0	★	98%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	100.0	★	90.0	▲	100.0	★	100.0	★	100.0	★	100.0	★	100.0	★	94%	Monthly	There is no significant risk identified to threaten future performance.

Cancer waits - 62 days wait - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q4		Q1		Q2		Q3		Dec 2015		Jan 2016		Feb 2016		Operational Standard	Collection Frequency	Status / Commentary
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85.5	★	88.3	★	88.2	★	87.4	★	94.4	★	89.2	★	82.7	▲	85%	Monthly	This is a quarterly standard which it is anticipated will be achieved.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	91.9	★	96.9	★	85.2	▲	100.0	★	100.0	★	100.0	★	100.0	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	72.7	n/a	79.5	n/a	72.1	n/a	72.1	n/a	72.7	n/a	66.7	n/a	93.8	n/a	No National Standard	Monthly	There is no National Standard for this measure.

Category A ambulance calls - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4	Q1	Q2	Q3	Dec 2015	Jan 2016	Feb 2016	Operational Standard	Collection Frequency	Status / Commentary
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	67.0 ▲	77.5 ★	78.5 ★	74.7 ▲	74.9 ▲	69.3 ▲	70.5 ▲	75%	Monthly	See commentary.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	65.8 ▲	76.6 ★	75.4 ★	70.1 ▲	69.5 ▲	63.5 ▲	61.1 ▲	75%	Monthly	See commentary.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	91.1 ▲	95.2 ★	94.8 ▲	92.9 ▲	92.7 ▲	89.8 ▲	88.1 ▲	95%	Monthly	See commentary.

Mixed Sex Accomodation Breaches - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4	Q1	Q2	Q3	Dec 2015	Jan 2016	Feb 2016	Operational Standard	Collection Frequency	Status / Commentary
Minimise breaches	0 ★	0 ★	0 ★	0 ★	0 ★	0 ★	0 ★	0	Monthly	There is no significant risk identified to threaten future performance.

Mental Health - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4	Q1	Q2	Q3	Dec 2015	Jan 2016	Feb 2016	Operational Standard	Collection Frequency	Status / Commentary
Care Programme Approach (CPA) : the proportion of people under adult mental illness specialities on CPA who were followed up within seven days of discharge from psychiatric inpatient care during the period	100.0 ★	100.0 ★	96.1 ★	96.5 ★	100.0 ★	100.0 ★	94.7 ▲	95%	Monthly	This is a quarterly standard which it is still anticipated will be achieved.

Healthcare associated infection (HCAI) - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q4		Q1		Q2		Q3		Dec 2015		Jan 2016		Feb 2016		Operational Standard	Collection Frequency	Status / Commentary
Incidence of healthcare associated infection (HCAI) i) MRSA	0	★	0	★	0	★	3	▲	1	▲	0	★	0	★	0	Monthly	There will continue to be risk of MRSA incidence.
Incidence of healthcare associated infection (HCAI) ii) C. Difficile	22	★	34	▲	30	▲	30	▲	7	★	3	★	7	★	7.4	Monthly	Reduction back within target range in recent months is welcomed but we are not yet assured that this will be sustained.

Key

Indicator RAG rating

★ Green - Performance at or above the standard

▲ Red - Performance below the standard

Statutory Duty & Resilience Compliance

Statutory Duty and Resilience - Last Four Full Quarters								Last Three Months						Details		
Statutory Duty or Resilience Measure	Q4		Q1		Q2		Q3	Dec 2015		Jan 2016		Feb 2016		Operational Standard	Collection Frequency	Status / Commentary
Percentage of FoIs handled within the legal timeframe	100.0	★	100.0	★	98.3	★	100.0	100.0	★	94.1	★	100.0	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Number of limited assurance reports received from auditors	1	▲	0	★	0	★	0	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Number of statutory Governing Body roles vacant	0	★	0	★	0	★	0	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Percentage of complaints responded to within 25 working days	77.8	▲	84.6	★	90.9	★	75.0	70.0	▲	100.0	★	100.0	★	80%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of days lost to sickness in the last 12 months	2.23	★	2.01	★	1.89	★	2.35	2.52	▲	2.93	▲			2.5%	Monthly	Whilst sickness levels have increased in the last two periods monitored, they remain significantly below the national average. Trends are reviewed regularly and proactive work between managers and the HR Shared Services continues to be carried out across the organisation.
Percentage of staff contracts which are substantive.	85.6	★	80.7	★	78.9	▲	81.7	82.1	★	82.4	★	81.6	★	80%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of staff working with vulnerable people who have a confirmed up to date DBS check	100.0	★	100.0	★	100.0	★	100.0							100%	Quarterly	There is no significant risk identified to threaten future performance.

NHS
Stockport
Clinical Commissioning Group

Quality Report

Report of the Quality Committee

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 **Fax:** 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

The Governing Body is requested to consider whether any of the issues raised in this report require a higher level of escalation.
Please detail the key points of this report
Summary • This report summarises the key decisions of the April Quality Committee 2016. **Decisions** • None **Attachments** • Quality & Provider Management April Issues Log
How does this link to the Annual Business Plan?
Improving the quality of commissioned services is a key strategic aim within the CCG Annual Operational Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Quality Committee
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Mark Chidgey
Meeting Date:
Agenda item:
Reason for being in Part 2 (if applicable)
Not applicable

1.0 Decisions of the Quality & Provider Management Committee

1.1 Issues Log:

- The issue regarding safeguarding practices within Maternity services has been removed following further significant assurance that issues had been addressed and actions implemented.

- St Anne's hospice safeguarding standards issue moved to green following significant progress. Removal to be considered at the next meeting in June.

- Gastroenterology follow up delays were revised to red as the CCG has not received full assurance regarding the risk assessment of patients, nor has the CCG received a clear recovery plan to improve performance and address validation.

- The RTT backlog position was added as a red because the admitted backlog position has significantly deteriorated and the CCG has not received either a clear recovery plan or a quality impact assessment.

2.0 Issues highlighted to the Governing Body

2.1 It was agreed that the following issues should be highlighted to the Governing Body:-

- The contract query associated with TIA will be removed imminently.

- Having confirmed funding SFT are in the process of recruiting tto additional posts within the Looked After Children service.

- The first Quality review meeting has been completed and focused on Stroke services. Members agreed that the meeting had been a success with good membership and engagement and a clear collaborative approach. The review has made clear recommendations regarding integrated community rehabilitation services and prevention strategies.

- Care Homes The CCG and local authority are working together to proactively support specific care homes with quality issues to ensure that they are able to re-open to admission.

- The local paediatric ophthalmology services will be provided by CMFT from June. The service will remain at Stockport and be provided by the same consultant.

- The quality committee supported the implementation of the final model for Stockport Adult Community Mental Health transformation after a comprehensive presentation on the process.

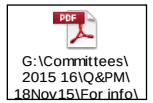
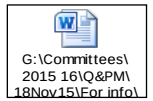
3.0 Decisions for the Governing Body

- None

Compliance Checklist:

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	N/A
Page numbers	Y	Service Changes: Public Consultation Completed and Reported in Document	N/A
Paragraph numbers in place	Y	Service Changes: Approved Equality Impact Assessment Included as Appendix	N/A
2 Page Executive summary in place (Docs 6 pages or more in length)	N/A	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	N/A
All text single space Arial 12. Headings Arial Bold 12 or above, no underlining	Y	Change in Service Supplier: Procurement & Tendering Rationale approved and Included	N/A
		Any form of change: Risk Assessment Completed and included	N/A
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	N/A

Quality Committee Issues Log
(Following Quality Committee of 13 April 2016)

Issue	Date added	Description	Action / Progress	Owner	Expected date of removal	Q&PM RAG rating	Last Updated	Context (papers)
1	20/05/2015	There is an issue with St Ann's Hospice non-compliance with Safeguarding standards which may put patient safety at risk.	Escalated to NHS England. Action Plan received from St Ann's. Reviewed and monitored by SG and currently on trajectory. Reviewed at April committee, voluntary staff training has commenced, for review at next committee and removal if progress continues.	SG	Jun-16		Apr-16	St Ann's Action Plan.
2	19/11/2014	There is an issue that the District Nurse service staffing levels are not at a level to meet patient needs. Stockport GPs are reporting a need to provide additional care to patients. This is not sustainable.	SFT trajectory to achieve compliance with staffing establishment is monitored at community contract meeting. However, post acuity review the Trust have supplied a report with a revised shortfall, this is being progressed through seperate meetings and will have further resource implications.	CB	Jun-16		Apr-16	Trajectory & SFT Risk rating 
3	20/11/2013	There is an issue with patients receiving timely follow-up in gastroenterology.	Number passed due date has risen partly due to elective capacity over the winter months. The CCG have reviewed the Trusts validation process and did not gain full assurance that all patients were subject to risk assesment. CCG have not yet received a plan to address backlog and risk review of waiting list.	CB	Jul-16		Apr-16	
4	18/11/2015	There is an issue that front-line staff at SFT have not received PREVENT training and this may not be rectified until 2018.	Compliance with PREVENT training has been tracked through a KPI since April 2015. The Trust has made progress but has not fully met the trajectory. There has also been a national delay regarding registration that has affected trajectory.	SG	Mar-16		Apr-16	
5	13/04/2016	The admitted RTT backlog continues to increase.	RTT admitted backlog continues to increase and is currently over 800. The CCG have not yet received a recovery plan or analysis of the issues, nor have we received a risk assesment of patients waiting on the list.	CB	01 July 2016		Apr-16	

Locality Chairs report for Governing Body

The Chairs felt that the Primary Care Development Scheme report was extremely positive. At recent Locality meetings members were provided with feedback. This was well received as it was felt it was the first time they had been provided with feedback on something that they are involved in. In view of this Chairs were keen to push the investment in primary care.

Chairs felt that it was important working with hospital as Commissioners that we include primary care capacity in these discussions.

Workforce continues to be a major issue. There are problems recruiting clinicians both GPs and practice nurses. There are less GPs coming into primary care, wanting to work less hours and many aren't interested in partnerships. Many of the practice nurse population are due for retirement in the next 5 years. This all needs to be considered when moving services from the acute sector into primary care.

There continue to be concerns expressed by members about the service provided by NHS 111. Patients are reporting dissatisfaction with the service with long waits for calls to be answered. This in turn is leading to patients abandoning the call and seeking other solutions which may include ED attendance. Clinicians are reporting the forms that they need to complete when they feel inappropriate advice has been provided to patients are lengthy and cumbersome. This in turn is leading to them not bothering to complete these forms so the true scale of the problem cannot be ascertained. It has been agreed that a questionnaire around NHS 111 will be available for GPs to complete at their Start of Year conference in May. Feedback can then be given to Blackpool as lead commissioner.

NHS
Stockport
Clinical Commissioning Group

Chief Operating Officer's update

Chief Operating Officer's update to the April 2016 meeting of the Governing Body

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 **Fax:** 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
This report provides an update on a number of issues.
Please detail the key points of this report
Provides an update on: 1. 2016/17 Plan Prioritisation 2. Stockport Together 3. Integrated Commissioning 4. Procurement
What are the likely impacts and/or implications?
The priorities will underpin the CCGs delivery plan.
How does this link to the Annual Business Plan?
Supports delivery.
What are the potential conflicts of interest?
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 27th April 2016
Agenda item: 10

Chief Operating Officer Update

1.0 Purpose

1.1 This is the report of the Chief Operating Officer to the Governing Body for April 2016.

2.0 2016/17 Plan prioritisation

2.1 Governing Body Members received and approved the 2016/17 Operational Plan at the Governing Body. At that meeting it was agreed that the areas identified within the plan would need to be reviewed and prioritized to ensure that there are sufficient resources identified for those areas that are identified as being the most significant.

2.2 Directors have reviewed the Operational Plan together with the Stockport Together Plans and other national and local plans and guidance (such as the CCG Assurance Framework). We have identified the priority areas and are in the process of setting these as objectives at team and individual level. We will provide a more detailed update to the CCG Governing Body when this work is finalised, but the areas are:

- Stockport Together
    - Governance
    - Programme Delivery
    - MCP Development/procurement
    - Primary Care development and development of GP Federation
    - Integrated Commissioning
- Healthier Together Implementation
- Specific identified quality improvements
- Introduction of delegated commissioning
- Implementation of mental health investments
- Delivery of constitutional standards
- CCG Assurance
- CIP

3.0 Stockport Together

3.1 The Stockport Together Programme continues to develop. The priority areas for quarter one of 2016/17 are:

1. To review the governance arrangements and ensure that they are clear, link to partners' organisational governance and are communicated across the programme/partners. Tim Ryley as Programme Director is leading the work
2. Undertake intensive design work for all programme areas over a 14 week period which will confirm priorities, models, deliverables and timescales for each area. Again, Tim Ryley is leading this piece of work but many CCG staff (including clinicians) are being identified to take forward this important piece of work. This links to the item

above as this work will very much shape the Stockport Together priority areas for the rest of 2016/17 and beyond.

3.2 Governing Body members will be aware that the Vanguard fund now sits within the GM Transformation Fund and approval is now via a GM process. We are in discussion with the GM Devolution Team to discuss this. At present we are continuing to progress the Stockport Together programme at risk in the absence of confirmed funds, but will need to confirm funding. We will be meeting with GM Devolution Team again to discuss this and an update will be provided at the meeting.

4. Integrated Commissioning

4.1 The CCG and Stockport Council have developed a significant section 75 Agreement. As part of this we have agreed to develop an Integrated Commissioning Function. Progress has been made in:

- A Director of Integrated Commissioning has been identified as a joint appointment between ourselves and the Council (The CCG COO is undertaking that role.)
- A draft reporting process and format has been developed for agreement by the Health and Care Integrated Commissioning Board
- A plan to develop an integrated commissioning function is being finalised which will support the development of integrated arrangements which will be put in place during 2016/17.

5.0 Procurement of specialist consultancy support for the development of the Market Segmentation and Outcomes Framework for the MCP Contract

Stockport Together requires specialist consultancy support to develop a Market Segmentation Model and an Outcomes Based Framework from existing prototypes, as well as related ICT Platform. This is a time critical programme of work required for the new MCP service proposition and MCP contract due to come into effect on 1st April 2017. The requirement for this piece of work has been included within our Value Proposition.

The estimated value of this consultancy support exceeds the EU procurement. A full options appraisal supported by legal advice has been undertaken. The outcome of this appraisal is that the CCG should procure from an Existing Compliant Framework Agreement. This will ensure a compliant procurement process that ensures the process is initiated within required timescales.

The Governing Body is requested to approve the initiation of the procurement but with final contract award subject to confirmation of the Value Proposition.

6.0 Action requested of the Governing Body

1. To note the update
2. Approve the initiation of the procurement of specialist consultancy support for the development of market segmentation and outcomes framework for the MCP contract on behalf of the Stockport Together partnership, noting the financial risk outlined in 5.

NHS
Stockport
Clinical Commissioning Group

Chief Clinical Officer's update

Chief Clinical Officer's update to the April 2016 meeting of the Governing Body

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 **Fax:** 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
The Governing Body is required to note the updates on the Greater Manchester Commissioning for Reform Strategy, South East Sector Implementation Planning and Greater Manchester Delegation Agreement.
Please detail the key points of this report
This report provides an update on the following matters: (a) Greater Manchester Commissioning for Reform Strategy (b) South East Sector Implementation Planning (c) Greater Manchester Devolution Delegation Agreement.
What are the likely impacts and/or implications?
The implications and impact of each of the reports is outlined within each of the additional appendices.
How does this link to the Annual Business Plan?
Regional and sector based work forms a key part of the delivery of the Stockport Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
The individual reports have been discussed at their development bodies.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Ranjit Gill
Meeting Date: 27 April 2016
Agenda item: 11

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

4Bii

GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

Date: 18 March 2016

Subject: GM Commissioning for Reform Strategy

Report of: Steven Pleasant – Chief Executive – Tameside Council
Dr Hamish Stedman – Chair – Salford CCG

PURPOSE OF REPORT:
At its February meeting, the Strategic Partnership Board received an update on Commissioning for Reform in GM, which included a commitment to bring forward a Commissioning Strategy for approval at the March meeting. This Strategy is attached here for member's consideration.

The Strategy has been developed under the direction of the Joint Commissioning Board (JCB), working with its Executive and Working Group. During the course of the process, input has been gained from a series of leadership groups, including the Strategic Partnership Board and its Executive, the Association of GM CCGs, and AGMA Wider Leadership Team.

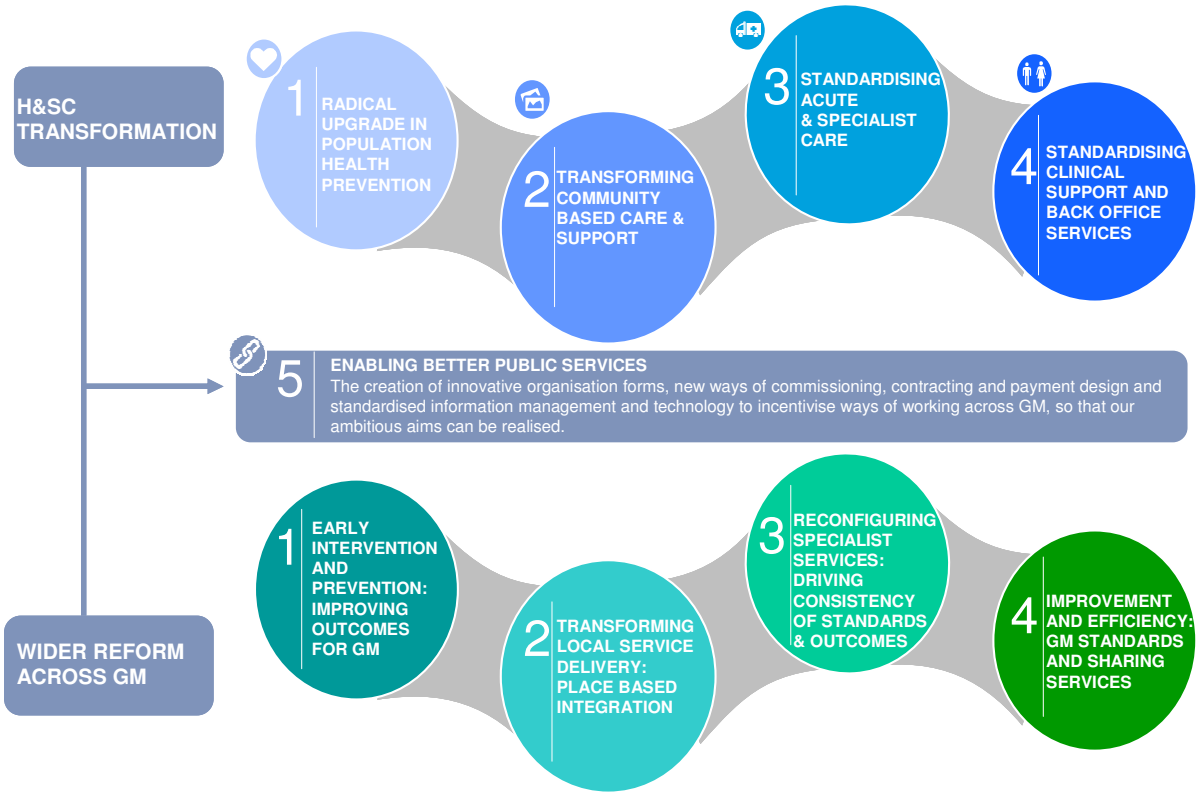
From an early stage of the process, it has been clear that the strategy needs to be ambitious in its scope, becoming a driver for public service reform in its widest sense. The attached document seeks to meet this requirement, setting out an ambitious five year vision and associated implementation plan to deliver improvement and reform across Greater Manchester.

The document describes how, from 1 April 2016, the JCB will:

- Become the lead body for the commissioning of over £800m of activity currently commissioned directly by NHS England. We anticipate that this day one budget will increase significantly over time as the portfolio of the board expands in line with the ambition described in the strategy.
- Develop integrated commissioning approaches for an initial list of priority areas, including Adult Social Care, Children's Services, Learning Disability, Mental Health and our programme for Population Health Improvement.
- Drive forward the progression of developments in areas which underpin all of the work programmes, such as reforming our urgent and unscheduled care system and the key agenda relating to Ageing Well and support for people and families living with dementia.
- Work closely with the GM Reform Board to support our moving further and faster on key public service reform priorities. This JCB will take a lead responsibility in driving forward the improvement in outcomes which this integrated way of working offers, for example in making the connection between work and health outcomes or in appreciating the multiple inputs which impact on the improvements needed with regard to the school readiness of Greater Manchester's children. The attached strategy contains two example areas relating to skills and work and to substance misuse.

The diagram below attempts to illustrate the scope of the ambition set out in our strategy, showing the five implementation priorities described in the GM Health and Social Care Strategic

Plan, “Taking Charge” and complementing these with further themes relating directly to the wider public service reform programme. As described in our strategy, our ambition is that this work will become a driver for the delivery of “Stronger Together”, our GM Strategy for growth and reform, as well as “Taking Charge”.



The strategy contains many examples of planned developments covering all of these thematic areas, with the following attempting to provide a sense of the scale and range of work we plan to do:

- Conduct significant work at a GM level during 2016/17 with regard to the development and sustainability of the market for home and residential care, linked to the wider programme of review and reform in Adult Social Care.
- Children’s services and mental health colleagues working together to design, commission and implement new models of care for Child and Adolescent Mental Health, (CAMHS). This forms part of the overall programme for Integrated Healthcare for Children, with a focus on early intervention and prevention.
- Delivering on our objectives to support people with Learning Disabilities, including our objective that all people with learning disabilities and/ or autism will be supported within the community wherever possible.
- Development of a multi agency pathway for Mental Health, as part of a delivery plan which describes our plans to ensure parity of esteem with physical health issues, facilitating delivery of the Mental Health strategy approved at the February Strategic Partnership Board
- Development and implementation of a programme to find and treat the “missing thousands”, people who may have or be at risk of developing conditions which are preventable, undiagnosed or untreated, through initiatives such as health checks and better or by better targeting existing screening and immunisation programmes. Commission a bespoke integrated intervention for the 10% most deprived communities, connecting prevention support with broader support, eg work and skills.

- Supporting the programme to deliver primary care at scale, covering neighbourhoods of 30-50 thousand people, as part of a drive towards the implementation of fully integrated public services in local areas.
- Focussing on ensuring we achieve compliance with relevant national and locally defined standards, ie using commissioning as a driver to address unwarranted variation in services and outcomes. A current example is the work currently being taken forward with regard to services relating to Urology and Oesophago-Gastric (OG) Cancers.
- Co-sponsoring a development with the Employment and Skills Executive during 2016/17 on the Health and Work programme in GM, recognising the key linkages between employment and health outcomes.
- Development of a set of shared principles for substance misuse commissioning during 2016/17.

The above list is presented as a representative series of examples, rather than a complete list of initiatives. Equally, it should be noted that we anticipate the current list of thematic areas growing over the coming months, as the extent of the opportunities further emerges.

In commending the Strategy to the Board and in summary, we believe that we have created a document which sets out a vision which is ambitious in its scope but grounded in an achievable implementation plan, which sees:

- The creation of an integrated commissioning system to secure integrated service delivery, at both a GM and locality level
- The establishment of a governance system, designed to support the effective stewardship of public funds, to drive forward broad ranging and connected programmes of work and to accelerate innovation into practice.
- A revised commissioning cycle, based on the Public Service Reform principles, focussing on identification and implementation of new delivery models and associated disinvestment in previous paradigms
- A wide ranging approach to the scope and opportunities presented by this new commissioning vehicle, linked to our strategic priorities. Initial thematic areas are identified with potential and scope for further elements to be included
- A commitment to co-production between commissioners, providers and citizens, recognising the need for joint working across all areas, whilst maintaining necessary separation at appropriate decision making points in the commissioning process
- A Strategy grounded in a delivery plan with a focus on significant process being made during year one of its implementation
- Explicit links to the wider programme of Public Service Reform with opportunities already emerging for the JCB to work in partnership with other parts of the PSR programme, eg with the Employment and Skills Board on the Health and Work Programme.

In similar vein to the approval process for the GM Strategic Plan in December 2015, it is proposed that the Commissioning Strategy is approved as a final draft, with a three month process which will incorporate:

- Further stakeholder engagement
- The completion of an Equality Impact Assessment (EIA)
- Further work on the implementation plan, ensuring alignment with the processes surrounding the implementation of the GM Strategic Plan and the 10 Locality Plans
- Conducting further assessment of candidate schemes for investment, to ensure compliance with and alignment to, the GM investment process

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

1. Consider the attached Commissioning for Reform Strategy for approval as a final draft
2. Agree the process for the next three months as described immediately above

CONTACT OFFICERS:

Rob Bellingham
robbellingham@nhs.net

Tim Griffiths
Tim.griffiths@agma.gov.uk

Rachel Pykett
r.pykett@manchester.gov.uk

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

COMMISSIONING FOR REFORM

The Greater Manchester Commissioning Strategy

FINAL DRAFT – MARCH 2016

CONTENTS

COMMISSIONING FOR REFORM: THE GM COMMISSIONING STRATEGY

1. THE GREATER MANCHESTER AMBITION

In Greater Manchester (GM) we want to enable a truly placed based approach to public service reform, transforming the way all public services work together in a place. This approach will enable GM organisations to make real changes to the lives of residents, in ways relevant to them, free from the restriction and fragmentation created by organisational boundaries. To deliver this ambition GM requires a single commissioning strategy that encompasses all public services. This document describes how we will transform our commissioning approach in GM.

The Greater Manchester Strategy, '*Stronger Together'*, placed public service reform at the heart of our strategic ambition. The subsequent Growth and Reform Plan, devolution agreements, and the Health and Social Care Strategic Plan '*Taking Charge'* have restated that commitment to reshaping our services, supporting as many people as possible to contribute to and benefit from the opportunities brings.

With local services working together, focused on people and place, we want to transform the role of public services and take a more proactive approach rather than responding to crises. We want to transform the way we use information, empowering our frontline workforce to make more informed decisions about how and when they work with individuals and families. Building on the principles of early intervention and prevention, GM aims to deliver the appropriate services at the right time, supporting people to become healthier, resilient and empowered.

Delivering on our ambitions will also contribute to meeting the financial challenge facing our public services - for Health and Social Care we are faced with a financial challenge in excess of £2bn by 2021 - reducing demand on expensive, reactive public services through greater integration, prevention and early intervention. Underpinning the delivery of this ambition will be a new approach to commissioning services that focuses on delivering outcomes for residents, putting artificial boundaries to one side. Our new approach will help us to deliver our strategic objectives of supporting GM residents to 'start well, live well, age well', whilst commissioning a financially and clinically sustainable health and social care economy.

A new approach to commissioning will underpin and support our capacity to bring together the breadth of reform activity being implemented across GM. A radical approach to commissioning will be needed to deliver on the GM transformation programmes associated with our Health and Social Care reforms, our wider GM Reform Programme and the local implementation of reform.

As well as a developing a radical approach to commissioning, GM will need to develop innovative ways of decommissioning. The commissioning cycle that we will adopt embeds decommissioning and disinvestment within it. Our commissioning aspirations must be complemented by the strength of our decommissioning intentions.

Delivering transformational change in GM will require public services to work together in different ways. A key component in supporting this will be the creation of mechanisms that support these new conversations, recognising the interdependencies between a range of service areas in achieving improved outcomes for GM residents. We know that delivering the

objectives of the Health and Social Care Strategic Plan will rely on services that have traditionally sat beyond the remit of Health and Social Care providers and commissioners. Transforming our commissioning is not about reassigning responsibility but enabling the breadth of integration we need to bring together decision making across areas that have historically been fragmented.

The Commissioning Strategy will be a key enabler to deliver both ‘Stronger Together’ and ‘Taking Charge’, and the core objectives that sit across them:

- Improving health and wellbeing and life chances of residents.
- Improving quality of public services and outcomes for GM residents.
- Reducing inequalities that exist both within GM, and between GM and the rest of the country.
- Ensuring services are clinically and financially sustainable and creating a sustainable public service economy.
- Unlocking devolution dividends to support public service reform.

2. OUR VISION: A RADICAL APPROACH TO COMMISSIONING

The opportunity of devolution

GM is in a unique position to maximise a number of once in a generation opportunities:

- The agreements that GM has made with Government and national bodies will provide influence/powers and scale to commission for reform.

- The five year Health and Social Care settlement, and potential four year settlements for local authorities provide relative certainty of funding, enabling the development of longer term strategies and more effective commissioning for truly transformational change. Our ability to move away from short term financial planning will allow us to invest in early prevention and intervention, particularly as we know that the return on investments that reduce demand fall beyond normal budgeting rounds.

- Devolution to the Combined Authority for a range of public service reform priorities, and Health and Social Care devolution now includes the Health and Social Care Transformation Fund and Life Chances Investment Fund (and potentially a range of innovative funding streams). These are real opportunities to transform both the £6bn Health and Social Care budget, and the broader £22bn GM public spending, improving outcomes for GM residents and ensuring public money spent in GM is used as efficiently as possible.

- The governance that we have developed and our increased commitment to integration significantly reduce the incidence of silo working, and placement of organisational priority before that of place and person. With this, devolution has provide significant incentives to invest in transformational reform, removing those barriers that precluded investment in preventive approaches, particularly those where investments provided benefit to other agencies in the form of reduced demand etc.

We are now in a position to overcome the barriers of fragmented decision making, overlapping or duplicated investment, and reconciling the longstanding challenge of co-investment.

Integrated planning and decision making

Devolution and reform provides a number of opportunities to transform the current approach to commissioning, including:

From	To
• Focus on organisations and separate areas of spend	• Focus on place and population health needs
• Fragmented view of health, social care and other public services	• Holistic approach and view of health, care and wider public sector reform
• Bound by annual planning horizons	• Multi-year investment programmes
• Plethora of relatively small initiatives	• Comprehensive view across GM
• Lack of flexibility of GM commissioning or lack of efficiency	• Economies of scale combined with integrated delivery around

of local commissioning	individuals and families at neighbourhood level
• Change initiatives which sit on top of but do not fundamentally change the mainstream	• Creating robust evidence for decommissioning existing models of care shown to be of lesser value compared to new models
• Single service planning	• Integrated strategic planning focused on cumulative impact and outcomes

Effective integrated commissioning can act as a catalyst for the implementation of new delivery models, such as moving to outcome based, multi-year capitation models, supporting implementation of new models of provider collaboration and innovation. We are able to take an overall approach that facilitates more effective and rapid change to new ways of working. In doing so it will be important to assess and prioritise areas with the ability to make the most significant steps towards the delivery of local implementation plans and GM strategies.

Developing our approach: building on firm foundations

Devolution gives us the freedom to develop a new way of working together that can bring these opportunities to fruition. We have swiftly developed an infrastructure and process to support joint commissioning decisions, enabling us to take on key decisions from 1 April 2016. Supporting our commitment to joint commissioning across GM services we have:

- Agreed a set of principles that will underpin our approach to reform and commissioning (as outlined at Section 4).
- Developed an investment focused commissioning approach to support our aspiration to commission for reform.
- Identified an initial set of key commissioning workstreams – with an ability to map against our transformation themes and reform priorities.
- Identified key priorities for implementation of the new approach to commissioning, including:
    - Learning from the initial workstreams.
    - Broadening joint commissioning workstreams to cover wider reform activity.
    - Strengthening governance to current GM and district level commissioning, and connect health and social care with wider public service reform.
    - Reviewing leadership, capacity and skills for commissioning.
    - Co-production of services with commissioners, providers and residents.

Throughout 2016/17 we will refine our plans, ensuring we are operating flexibly as reform implementation plans emerge, and ensure the breadth of potential joint commissioning decisions are considered. In all decisions we take, we will ensure we focus on innovation, financial and clinical sustainability, and improved outcomes for GM residents.

A phased approach to change

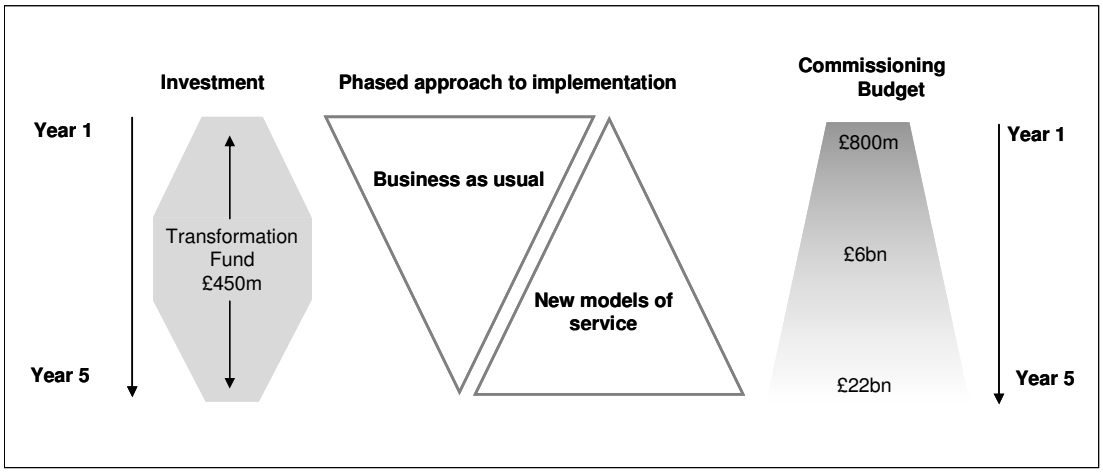
To ensure that we are able to maintain a clear focus on current system performance, we will need to adopt a phased approach to our commissioning transition. Whilst our immediate focus for jointly commissioned services in 2016-17 will be specialised health services and primary care (the total value of these services amounts to c£800m) , we will make significant progress on jointly commissioning other areas of activity.

As we move through 2016/17, and into future years the scope, scale, ambition, and ultimately financial envelope of our joint commissioning activity will broaden significantly.

It is neither practical nor sensible to make the significant transition required in a short period of time. Supporting a phased approach to reform, we will be scaling up the level of investments in our new delivery models, whilst decommissioning and disinvesting in those existing models that are shown not to deliver the outcomes that are required or that fail to meet minimum GM and national standards. Through this approach, we will deliver a managed transition from current business as usual to new models of delivery.

This phased approach to implementation new commissioning models is outlined at Figure 1.

Figure 1: Phased approach to implementation



3. OUR PRIORITY: AN INVESTMENT LED APPROACH TO COMMISSIONING

Investing for improved outcomes: early intervention and prevention

One of the most important changes we need to make in our approach to commissioning is to shift from a transactional and linear approach to an investment led approach. Shifting activity must lead to resources being freed up in one part of the GM public service economy to be reinvested in another part. In developing an approach to joint commissioning we therefore need to think beyond organisational boundaries, and consider how we invest collaboratively to achieve the outcomes we have committed to achieving. This is key to the way we will apply the Health and Social Care Transformation Fund and Life Chances Investment Fund.

Through our broader approach to public service reform, we are supporting residents to become increasingly independent, resilient, and better connected to the opportunities of economic growth. These are outcomes that will also support our capacity to achieve improved health outcomes. For example, we know that being out of work can have a significant impact on mental and physical health. Investing in employment support (particularly for those who have identified health related barriers to employment) can deliver longer-term, sustainable savings for the health system: ensuring access to the right support to get someone into work (or staying in work) potentially saves significant health related spending in the future.

At the heart of our Health and Social Care reform ambitions is the recognition that we need to see a significant shift in activity; shifting the balance from reactive, crisis services to preventative services that help reduce escalation of need (for example, shifting from inappropriate use of in-hospital acute settings to out-of-hospital and community care). Our approach will be underpinned by a need to make significant investments in prevention.

Investability

As we have identified, GM cannot simply move from one model of commissioning to another overnight. Our transition has to be managed. In support of this our commissioning activity will need to satisfy clear criteria. Our investment propositions need to look beyond purely the delivery of value for money, they will need to:

- **Clearly contribute to the delivery of GM priorities (including those set out in Taking Charge and Stronger Together)** - we cannot commission services that do not deliver our strategic priorities.
- **Have synergy with the implementation plans of our reform and transformation strategies** – our commissioning activity has to deliver our reform and transformation agenda.
- **Meet agreed GM and national standards** – we cannot commission services that fail to meet minimum service requirements. By working collectively we can identify what best practice looks like, and more importantly commission to ensure we provide services that deliver that practice.

- **Be supported by a robust evidence base** – our investments and interventions have to be supported by an evidence base that demonstrates they will deliver improved outcomes and efficiencies.
- **Meet the GM criteria for investment** - these criteria have been developed and agreed by GM organisations.
- **Value for money** – our investments will need to deliver value for money.

Supporting innovation, generating evidence and enabling decommissioning

We must collaborate to commission the correct activity, in the correct place, at the correct time, ensuring our residents stay healthy, reach their potential, and are able to contribute to and benefit from growth in GM. Through the development of the GM Reform programme, an approach to commissioning innovative models focused on improving outcomes has been established. This model, set out below, supports an approach to commissioning that:

- **Enables innovation -** supporting capacity to test new public service models based on a robust case for change, understanding of costs and benefits, and understanding of the potential scale of impact of reform.

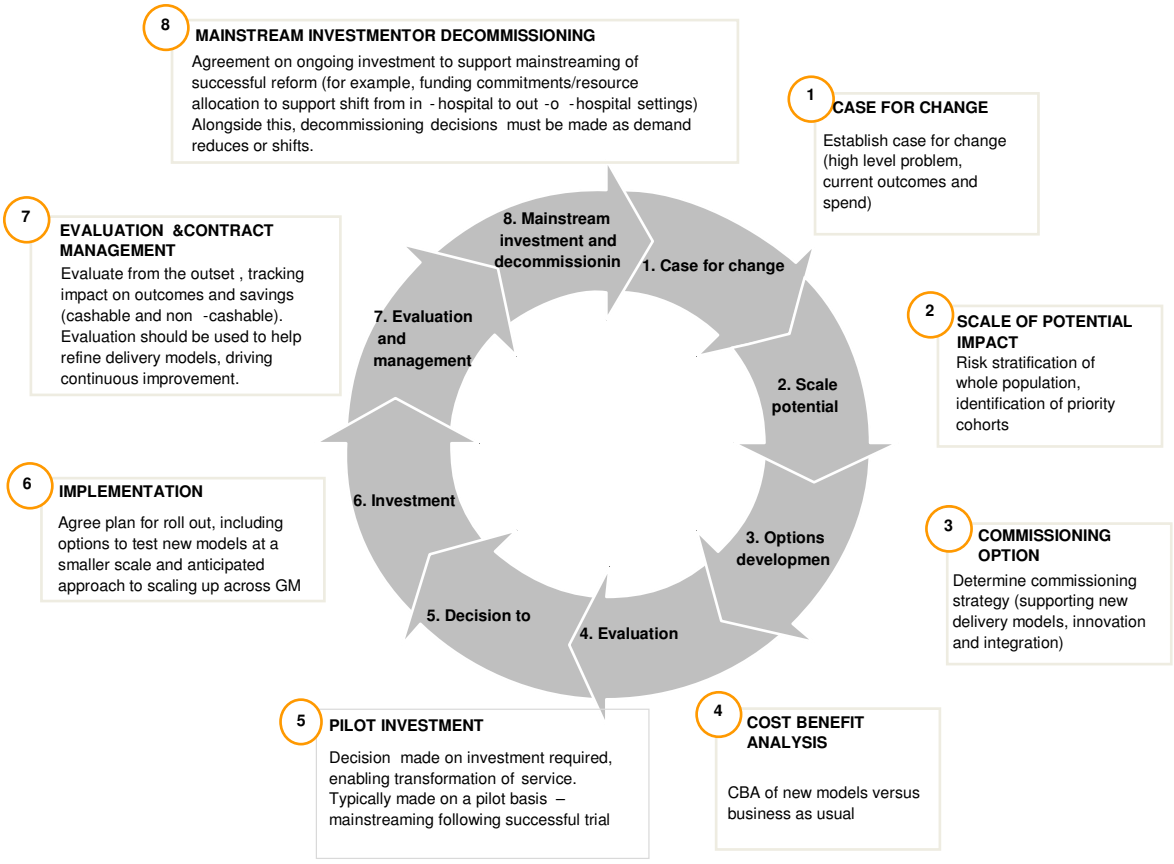
- **Enables the scaling up of reform models -** based on robust evidence and evaluation, GM is able to take commissioning decisions that if shown to have impact can be scaled to support broader groups of residents or wider geographies, ensuring flexible approaches that support and reinforce place-based models of delivery. In this stage, commissioning decisions will increasingly move from a 'reform' focus to embedding new service models as business as usual.

- **Enables decommissioning decisions -** in the process of mainstreaming and embedding reform programmes in mainstream investment planning, decommissioning options and their implications can be considered.

Through this process, financial efficiencies, generated through service improvement, efficiencies and demand reduction should be identified to support decommissioning and reinvestment decisions.

We need to take a longer term view that examines the entirety of our expenditure on an individual and constantly evaluates how it can best be spent. Figure 2 below summarises this new approach.

Figure 2: A new approach to the commissioning cycle



4. OUR PRINCIPLES: COMMISSIONING IMPROVED OUTCOMES FOR GM

Building on our reform principles

We already know that our commissioning needs to look beyond our traditional boundaries. To enable place based whole system reform, we need to embed a new approach, ensuring our reform principles are drivers of our commissioning activity. The principles that underpin our approach to reform are:

- A **new relationship** between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services.
- **A place-based approach** that redefines services and places individuals, families, communities at the heart
- **Asset conscious**, recognising and building on the strengths of individuals, families and our communities rather than focussing on the deficits.
- **Collaboration at the heart**, with providers and commissioners working together to develop solutions that bring benefits to both
- **Focus on driving behaviour change** in our communities that builds independence and supports residents to be in control
- A stronger **prioritisation of well being, prevention and early intervention**
- **Evidence led** understanding of risk and impact to ensure the right intervention at the right time
- An approach that supports the **development of new investment and resourcing models, and the decommissioning of failing approaches**.

Our commissioning principles

Drawing on the principles outlined above, we will look to embed five core principles specific to the commissioning for the residents of GM:

1. People and Place

For all the bureaucracy and complexity of commissioning and whatever the scale of commissioning in the end, what matters is that our decisions help the people and places of GM achieve their own visions of their futures.

Our commissioning ambition has to drive significant behaviour change across our residents, organisations and workforce. Our residents need to be less reliant on public services and be pro-active in their lifestyle choices. Our organisations need to think beyond their organisational boundaries, and think towards person and place. Our workforce needs to think differently in order to commission for outcomes, and outwith the boundaries of their own organisation.

2. Co-design

Commissioners, providers and residents working together will create better proposals and a quicker route to successful change.

3. Decommissioning

Our success will be defined as much by our decommissioning decisions as it will be by our commissioning ones. Across Health and Social Care, we have a £2bn financial challenge to address. This will not be achieved by commissioning more of the same activity; we need to commission new models of care. This will mean decommissioning existing models of care that do not meet minimum standard requirements, or deliver appropriate outcomes.

4. Commissioning at the right level; connecting scale with integration

To be successful we need commission services at the most appropriate spatial level. However, in doing so we need to ensure that commissioning activity across those levels is cognisant of the activity undertaken at differing spatial levels. These will, wherever possible, be complementary.

We need to be able to connect our commissioning, whether it be a those services that are commissioned at a macro level (GM and locality) or those commissioned at the micro level. To deliver our asset based approach we need to make best use of our voluntary and community organisations,

5. Be Bold. Commission differently

We know we cannot commission the same activity, in the same way, but just change the spatial level we commission at. To deliver improved outcomes and achieve financial sustainability we will need to embrace new commissioning models, such as outcome based commissioning. Being bold and commissioning differently means adopting best practice not just from within GM but from around the world.

Underpinning our approach to commissioning and our adoption of the five principles set out, we are committed to commissioning services that meet GM and national agreed standards. The adoption of our commissioning strategy and the approaches outlined within will ensure that research and innovation are embedded at the heart of our commission activity and decisions.

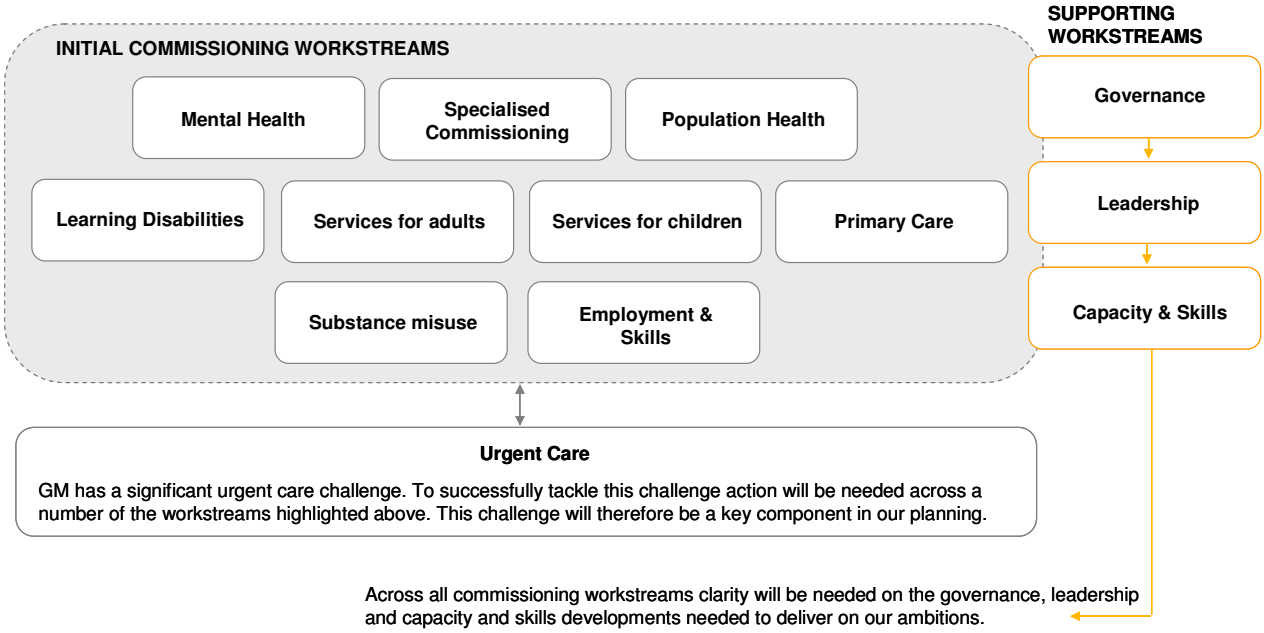
5. OUR INITIAL JOINT COMMISSIONING WORKSTREAMS

Supporting the delivery of our Health and Social Care plans

Our new commissioning framework forms a core part of our Health and Social Care Devolution programme; it is one of our key enablers. It complements the other Enabling Better Care workstreams such as Information Management and Technology, Workforce, Estates, and Contracting and Payment Mechanisms.

There are nine initial commissioning workstreams and three supporting workstreams. Figure 3 illustrates these workstreams and shows that whilst our initial focus is on the commissioning of health and social care services, these services form only a part of our commissioning intentions. Indeed the supporting workstreams already look beyond health and social care, and have an increased focus on the commissioning of the wider public services.

Figure 3 – Initial Commissioning Workstreams



Action plans have been developed for 2016/17 across those initial commissioning workstreams that have been identified.

The initiatives that form part of these plans will be aligned to both the emerging Locality and Implementation Plans; demonstrating how they are delivering against the wider goals of both 'Taking Charge' and 'Stronger Together'.

As part of our approach to commissioning new delivery models for Adult Social Care, we will need to think very differently, be bold in our ambition, and work in an integrated way. This provides GM with a significant opportunity to commission services differently, we cannot commission more of the same activity and hope to see demand change across the health and social care system. We need to invest in new models of care that reduce demand in the acute sector, that support transition from hospitals into community based settings, and that

provide significant opportunities for those residents that are employed in delivery of care services.

Our key priorities for commissioning new models of care will include commissioning for a rapid and real improvement in intermediate and homecare. We know that across GM we need to undertake a review of the domiciliary/homecare market, and that by working at a GM level we are able to address the fundamental challenges that exist within those markets.

As a result of the Winterbourne View we know that our commissioning approach for services that support those with Learning Disabilities have to deliver fundamentally different outcomes; we need to deliver care and services closer to home and in the community. Our commissioning approach will need to ensure those with learning disabilities are supported to fulfil their potential and make a significant contribution to the GM.

Our new commissioning approach cannot be confined to macro commissioners, whether they operate at locality or GM level. To deliver new models of care we need to drive demand reduction through a programme of behaviour change – the role and behaviour of the micro commissioner will be integral to delivering integrated care closer to home. We need to support micro commissioners to embrace new models of care, and to challenge existing activity.

Appendix 1 shows milestones for each of the initial workstreams for 2016/17.

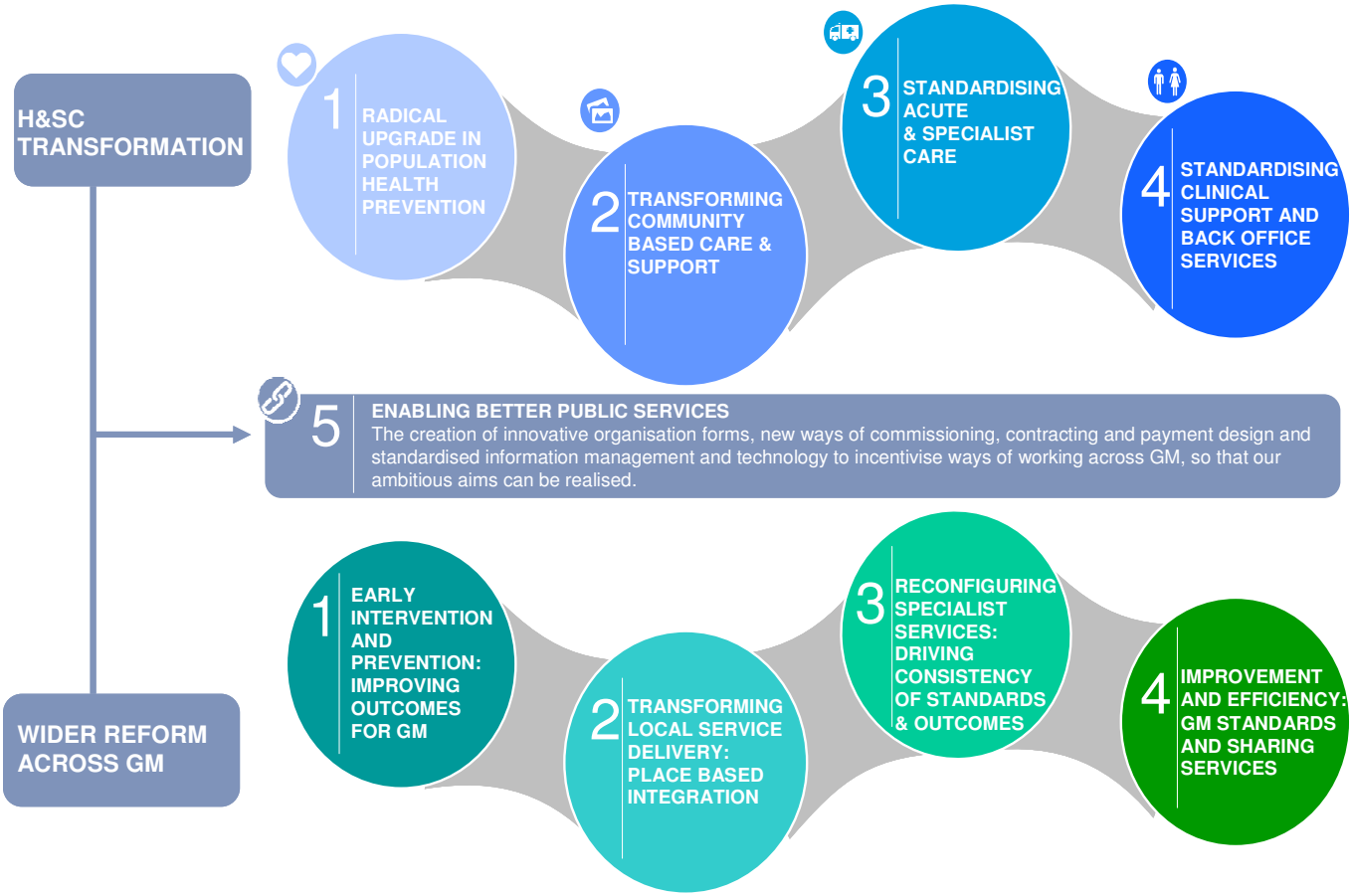
Appendix 2 provides more detail for each of the commissioning workstreams showing: clarity of outcome objectives and phases; 16/17 action plans with key milestones; further work is in progress to provide greater clarity of outcomes required; and identified contribution to financial and clinical sustainability.

Broadening our joint commissioning strategy

Our initial focus has been on ensuring plans are in place to support Health and Social Care reforms that go live in GM on 1 April 2016.

As we move into 2016/17 and beyond, all of our commissioning activity must deliver against or across our broader Health and Social Care Transformation Themes and GM reform agenda. As Figure 4 demonstrates, to capitalise on the opportunities that devolution opens to GM we must align activity. During 2016/17, new joint commissioning workstreams will be identified, driving our ability to deliver on the priorities set out below.

Figure 4 – GM Transformation Themes



As an early priority, employment and skills and substance misuse are two areas that can swiftly be added as joint commissioning workstreams. Initial draft action plans covering these areas are set out at Appendix 3. These action plans highlight the interdependencies between health and social care commissioning decisions and those across broader public services. To achieve the outcomes GM aspires to, we must create a more integrated public service landscape. Integrating our approach to commissioning will be a key component in delivering reform.

6. IMPLEMENTATION OF OUR STRATEGY

There are four implementation priorities for our strategy:

- Learning from the initial commissioning workstreams and swiftly developing a broader set of workstreams
- Engaging our partners in the development and delivery of the strategy
- Strengthening governance
- Developing the leadership, and skills and capacity, for the new approaches to commissioning

Learning from the initial seven commissioning workstreams

We will identify lead commissioners for each of our priority commissioning workstreams. All of our lead commissioners will be brought together through the JCB Working Group to facilitate learning from the application of the principles that are set out in this document.

As we move through 2016/17 and beyond, other commissioning workstreams will be identified. New workstreams will only be formally adopted following approval by the JCB. As the joint commissioning strategy is refined, clear criteria will be developed to support the identification of those new workstreams. These criteria may include:

- Services where there are a small number of high cost placements, where provision could be more efficiently and effectively delivered through a single GM service.
- Services that are more specialist in nature and provided from a very small number of centres.
- Services that are more generic in nature and would have significant delivery commonalities and characteristics across each locality. This may include service areas where there is potential for common service specifications collectively commissioned as a conurbation.
- Services that have a very limited number of potential providers or have significant ongoing workforce challenges meaning providers need to collaborate to ensure stability of the service.
- Services with significant performance and outcome concerns and where major transformation at a is required at a macro level to bring service up to standard.
- Services where major transformation is needed to co-design and implement a radically different model.
- Services where evidence suggests it would be more economical and efficient to commission and deliver on a GM footprint.
- Services for which there is significant cross border activity that could benefit from a pooled commissioning budget with disbursements based on activity.

In developing the forward programme of JCB commissioning decisions, an early area of work should be the development of an overview of key decisions anticipated for public service reform in the medium term. As the GM approach to place-based integration is refined (through existing pilot activity), it is anticipated that further joint commissioning recommendations will emerge.

We know our commissioning reform must extend beyond those services commissioned at a GM level. Reform is needed within localities, including the development of integrated commissioning functions. GM is committed to standardisation and reducing variation, this will be achieved, in part, by GM adopting standards frameworks that are used to guide commissioning at a local level.

Governance

The signing of the Health Social Care Memorandum of Understanding, and the subsequent devolution of the Health and Social Care budgets provides a unique opportunity for organisations across GM to address the challenges of: poor population health, high levels of non elective provider activity, capacity constrained social care, wide variability in outcomes and patient experience; a forecast £2 billion financial challenge by 2021; and, significant health inequalities.

To enable GM to effectively and efficiently address these challenges, new governance was required; this included the creation of the Joint Commissioning Board (JCB).

A shadow Joint Commissioning Board (JCB) is already in place, and brings together the 23 commissioning organisations across GM. Work is now underway to ensure that the JCB is utilised as the vehicle to consider a wider range of commissioning activity and associated decisions we may want to take as GM. For example, to deliver our employment and skills ambition there are decisions we will need to take that cut across health and social care commissioning, employment support provision and commissioning of skills provision. Over time, the remit of the JCB is expected to develop to aligning and integrating strategic commissioning in GM.

To support our ambitions to broaden our joint commissioning activity beyond health and social care, and to integrate our transformation initiatives with those required to deliver a comprehensive programme of public service reform, Greater Manchester has amalgamated the governance structures that have supported our prevention and public service reform agendas, creating a GM Reform Board.

We believe that aligning our governance at a GM level will create stronger structures to commission system wide reform. At a local level the production of Locality Plans have paved the way for stronger integrated commissioning at locality level.

To drive forward the delivery of this strategy at pace, we have identified the need to build upon the foundations provided by the Joint Commissioning Board. Therefore will we adopt a multi platform supporting structure, which will include:

- A JCB - maintaining strategic oversight, a high level overview, and ownership and integrated leadership of our commissioning across GM.

- A JCB Executive - providing detailed oversight of the process and key workstreams. This group will act as the conduit between the Working Group and the Board, and affords the Board opportunity to look in depth at key policy areas.

- A JCB Working Group – providing the engine and capacity to drive workstreams forward.

Our commissioning ambition is bold and complex, it brings organisations together in a way we have not seen before. To support the delivery of our strategy we will need to develop robust supporting architecture. We need to be able to bring the right people together, at the right time. As we develop new structures, we need to identify those that are no longer fit for purpose.

Leadership, Capacity and Skills

Securing integrated delivery will require integrated commissioning at both locality and GM level. Each of the ten localities will be encouraged to review their own arrangements for integrated commissioning across CCGs and local authorities and how this links to the wider reform of public services within their locality. At a district level, single integrated commissioning functions will provide a catalyst for commissioning reform.

Collectively across GM, local authorities and CCGs are intending to pool funding to support the delivery of the health and social care strategic plan.

GM will undertake a review of skills and capacity for integrated commissioning.
This will include:

- A review of capacity within GM Health and Social Care Devolution team once NHS England staff are assigned.

- Links with GM PSR team, New Economy and other CA bodies.

- Clinical engagement and integration across core functions of finance, research and intelligence.

- Support to localities to develop their capability for integrated commissioning. The task of bringing together the relevant skills for the approach to commissioning outlining this strategy will have implications for the future shape and organisation of both councils and CCGs. We should therefore support and learn from the development of integrated commissioning across all districts.

The outcome of skills and capacity review will feed into the development of the GM Commissioning Academy for high quality development of commissioning professionals and related core functions. This development could not be better timed, with the first two cohorts commencing in April 2016. The Academy will provide an opportunity for all commissioning professionals from health, social care and related fields to access a development programme and ongoing support which will model the skills, behaviours and values required by our new integrated commissioning system and as described in this strategy.

7. COMMISSIONING FOR REFORM

On 1 April 2016 a new era in GM's history begins when it becomes the first region in the country to have devolved control over integrated health and social care budgets, a combined sum of more than £6 billion. For the first time, Health and Social Cre will become integrated and local people will be taking charge of decisions on the health and care services for GM.

But GM is not just taking charge of health and social care provision. Fundamental to the success of the ground-breaking agreement between the Government and GM will be our ability to draw together a much wider range of services that contribute to the health and wellbeing of GM people.

The impact of air quality, housing, employment, early years, education and skills on health and wellbeing is well understood. In GM, General Practitioners (GPs) spend around 40 per cent of their time dealing with non-medical issues. Therefore GM is embarking on a large scale programme of whole-system public service reform, bringing together decision making, budgets and frontline professionals to shape services in ways that better support local people and communities.

With local services working together, focussed on people and place, we want to transform the role of public services and take a more proactive approach rather than responding to crises. We want to transform the way we use information, empowering our frontline workforce to make more informed decisions about how and when they work with individuals and families. Building on the principles of early intervention and prevention, GM aims to deliver the appropriate services at the right time, supporting people to become healthier, resilient and empowered.

Our approach to commissioning must support this new era of GM public services: we must commission services at the right spatial level, in collaboration with one another, and with a focus on the outcomes we are seeking to achieve for GM.

This strategy shows that GM has seized this unique opportunity to shape its future, looking beyond organisational boundaries and moving away from single service planning to consider the cumulative impact we can achieve by working together in new ways. We are taking charge of our future, working together to help GM thrive.

Appendix 1 - Milestones for each of the seven initial commissioning workstreams for 16/17.

Commissioning Area	Milestone	Quarter in which milestone is completed			
		Q1	Q2	Q3	Q4
		01/04/2016 - 30/06/2016	01/07/2016 - 30/09/2016	01/10/2016 - 31/12/2016	01/01/2016 - 31/03/2016
Adult social care	Scoping and delivery planning				
	1. Development of a common ethical commissioning framework for GM				
	2. Identification of exemplar care models for upscaling and implementation across GM				
	3. Integrated commissioning functions, working closely with CCGs and well connected with partners such as housing and VCS				
	4. GM Discharge Framework agreed and established				
	5. Telemedicine and assistive technology opportunities pursued				
	6. Workforce reform opportunities developed, eg in blending health and social care roles				
Children's services	Scoping and delivery planning				
	1. Positioning the Director of Children's Services for the Integrated Health Commissioning Children's Workstream on the Joint Commissioning Board.				
	2. Ensuring programme teams supporting the Children's Review and Health & Social Care are meeting regularly to align activity and that appropriate Health and Local Authority representatives are involved in the different				
	3. The Service Director for Children's Safeguarding & Prevention at Stockport Council spending two sessions per week working with the Health and Social Care Programme Team to help ensure that there is alignment across the Integrated Health Commissioning and Delivery workstream and related areas of work.				
Learning Disability Services	Scoping and delivery planning				
	1. GM Extended Collaborative Commissioning				
	2. GM Extended Case Management and Pre-CTR AT Risk and Discharge Coordination Team - and support for extended Panels				
	3. Calderstones – Mersey Care Forensic Care Pathway Development and Transition Stabilisation Programme				
Mental Health	Scoping and delivery planning				
	1. Development of a stepped care multi agency pathway that describes the offer across the whole system based on presenting need				
	2. Development of a GM Transformation plan for CAMHS				
	3. Scope opportunities across GM for commissioning highly specialist elements of the pathway as a collective to improve consistency, equity and efficiency				
	4. Establish GM wide information sharing				
Specialised Commisioning	Scoping and delivery planning				
	1. Complete the process to ensure we address long standing non–compliant cancer pathways in upper GI and urology				
	2. Implement outcomes from prioritisation matrix, which has been developed with providers to support identification of the next services for transformation				
	3. Specialist cancer services are to be reviewed within the work of the GM cancer vanguard schemes The model of care is to consider whole pathway re-design which will incorporate all specialist cancer services into the re-design process				

Commissioning Area	Milestone	Quarter in which milestone is completed			
		Q1 01/04/2016 - 30/06/2016	Q2 01/07/2016 - 30/09/2016	Q3 01/10/2016 - 31/12/2016	Q4 01/01/2016 - 31/03/2016
Population Health Improvement	Scoping and delivery planning				
	1. Develop specific proposals for GM level PH commissioning, including Sexual Health services, drugs and alcohol services and EY health services				
	2. Screening and Immunisation: whole pathway approach as part of the Cancer Vanguard arrangements; Local Care Organisations and their new contractual forms and wider PSR developments such as the expansion of Working Well and the Early Years NDM				
	3. Integration of information systems including Child Health Information Systems, (CHIS)				
	4. Integration of commissioning such as for sexual Assault Services, which could be linked more strongly to local safeguarding and complex dependency arrangements.				
	5. Health and Justice: Liaison and Diversion services and opportunities to develop a unique integrated commissioning and delivery model with police custody healthcare.				
	6. Find and Treat Programme: GM commissioning of NHS Health Checks programme to address variation in price and outcomes and drive up standards; Commissioning a bespoke integrated intervention for the 10% most deprived communities with the poorest health to provide an enhanced service with broader support packages including social support and access to work				
	7. Cancer Vanguard: Delivery of year one commissioning intentions: to include commissioning behavioural insights work to support key elements of programme e.g. improving screening attendance				
	8. Radical upgrade in lifestyle behaviour change support: Commissioning a GM lifestyle and wellness hub to provide a single access point/portal for behaviour change advice and support including triage into 10 placed based locality lifestyle and wellness service offers.				
	9. Early Years NDM: Commission at GM level bringing together the commissioning of HV, FNP related maternity services, perinatal MH services, children centre and early education offers and other targeted support.				
	10. Digital Strategy: The development of a digital health commissioning strategy aligned across three specific areas: digital innovation, empowered citizens and communities and digital navigation to underpin a radical upgrade in prevention and population health.				
Primary Care	Scoping and delivery planning				
	1. Primary care at scale: Development, implementation and commissioning of 'early adopter sites' – delivering primary care at scale. Early adopter sites have been identified in at least 4 localities.				
	2. Population health and wellbeing:				
	GM wide roll out of Healthy Living Pharmacy Framework to all community pharmacies				
	Delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities				
	Healthy Living Dental Framework pilot in Wigan.				
	Mainstreaming 'Healthy gums DO matter' across GM and periodontal care following recent pilot				
	Eye Care pilot for people with learning disabilities				
	Pilot asset based training for front line staff.				
	3. Improving access and responsiveness:				
	7 day services to primary care, hubs operational in all parts of GM				
	GM wide roll out of Minor Ailments Scheme to all community pharmacies				
	Implementation of emergency and urgent repeat medication provision to all CCG localities				
	Implementation of single Minor Eye Conditions Service across GM				
	Extend access to dental health services 'Baby Teeth DO matter' and 'Buddy Practice'				
	Pride in practice pilot launched – improving access for LGBT population				
	Asylum Seeker Pilot launched				

Appendix 2: Summary of each of the workstream's action plans

1. Commissioning Adult Social Care Differently

Summary:

Five year vision, outcome objectives and phases
• Rapid improvement in intermediate care, discharge to assess facilities and home care capacity to improve resilience and reduce non-elective (1). • The work from the Early Accelerator to support the transition from Winterbourne View and better planning for transition services for people with Learning Difficulties (2). • Investment in scaling up the innovation and demand reduction work through a programme of behaviour change/ workforce reform that alters the mindset of individual practitioners. This changes 'micro-commissioning' behaviour and if wrapped around reformed primary care with community health partners, it will make a significant contribution to improved outcomes, reduced prescribing and acute spend (3).
16/17 action plans with key milestones
Quarter 1 • Embed asset based working and micro commissioning as key driver for reform, building on existing exemplars (across all quarters). This will include rite of passage training for workforce. • Map providers across GM footprint. • Undertake quality appraisal of shared providers. • Deliver three market engagement events. • Deliver a GM ethical service specification for reformed home care. • Develop a GM job description for integrated care worker. • Launch of GM Commissioning Academy. • Scope and develop appropriate infrastructure to deliver at scale and pace, including alignment with CCG Heads of Commissioning Group. • Deliver cost benefit analysis for the key areas of asset based model, home care, residential and nursing care and learning disabilities. This will clearly identify system wide payback and return on investment. • Deliver a series of market events with technology providers to articulate the contribution of technology to our reform programme. • 2016/17Development of a common ethical commissioning framework for GM – standardise process across GM under a core specification for procurement of individual placements. • Identification of exemplar care models for upscaling and implementation across GM. • Integrated commissioning functions, working closely with CCGs and well connected with partners such as housing and VCS. • GM Discharge Framework agreed and established. • Telemedicine and assistive technology opportunities pursued • Workforce reform opportunities developed, eg in blending health and social care roles. • Development of the Strategic Plan for Services for Adults.
Clarity of outcomes required and contribution to financial and clinical sustainability and PSR

1. Rapid improvement in intermediate care, discharge to assess facilities and home care capacity

- Delivery of flexible support for home care (time banding visits). Use of PDA/smart phone technology to monitor compliance and facilitate time banking.
- Provision fits around the person. Move away from time/task oriented provision to meeting the needs of individuals and recognising that they will differ.
- Promotes independence - not bound by assessment as per the current model and enshrines reablement principles.
- Bespoke solutions based on need – professionals to triage needs considering the wider offer including community assets to ensure value for money.
- Proactive provision – cares encouraged to be intuitive and do what is required not what is on their task sheet.
- Career of choice for care staff – pathway into health provision. Commissioners and providers to champion the profession. Caseloads rather than task/time sheets.
- Reducing social isolation and connecting people – carers actively encouraged to link people to community assets not just leaving it to other professionals.
- Up skill staff to carry out lower level medical tasks. Reduce duplication and better use of telemedicine and District Nurses to focus on priority patients.
- Revised Regulatory Framework through CQC to facilitate a blending of health and social care roles.
- Standardised commissioning framework in place, based on common values, to improve the market offer in each locality through collective market management once at GM
- Sufficiency and stability ensured in the market.
- All patients have clear and communicated discharge plan and point of contact.

2. The work from the Early Accelerator

- For LA`s and CCG`s to have commissioned joined up clinical and social care responses to proactive, all age care planning and where unsuccessful crisis interventions.
- Movement of activity and resource from acute based services into the community, and improved transition between these.
- Integrated services throughout the life course (ie commissioning strategy outlines transitional arrangements for young people and links with Education / CCG / CHC arrangements).
- Closer integration of mental and physical health and care offer (in localities).
- Reduced incidence of fragmentation, variation and silo working.
- Increased community based offer with principle of positive behaviour support.
- Expansion of community based accommodation.
- Greater Manchester recognised as Age Friendly City Region.

3. Investment in scaling up the innovation and demand reduction work

- Behaviour change embedded across all health and care practitioners, with a common culture/ethos.

2. Children's Services

Summary:

Five year vision, outcome objectives and phases
The ambition for the review is to deliver improved outcomes for children across GM by: • Improving outcomes for children and families; supporting parents and carers to be the best they can be. • Reducing, appropriately, the number of Looked after Children – setting a high level ambition, e.g. 20% reduction in spend on LAC. • Reducing, appropriately, the number of Children in Need and children with Child Protection Plans. • Developing a safe system that is financially sustainable within 5 years through joint investment of resources to reduce future demand. • Supporting more asset based interventions to promote resilience, confidence and wellbeing in families and local communities. • Applying a more effective organisational system in order to make best use of resources and expertise. • Increasing social worker capability and capacity, as part of wider workforce reform and development. • Reduction of caseload so more time can be spent with the families. Less sickness time and fewer agency staff. • Deepening commissioning arrangements and stimulating new models of early intervention, prevention and provision. • Learning from best practice and building on existing innovation.
16/17 action plans with key milestones
A number of steps are being undertaken that it is proposed will help ensure the alignment of proposals in the Services for Children Review and Health & Social Care Strategic Plan. These include: • Agree consistent GM appproach to Early Years baseline methodology (Education) • Planning for accelerated delivery of EY delivery model where gaps exist (integrated health). • Agree GM EH model, standards and joint outcomes framework(EH/Complex Dependency). • Establish EH leadership teams (EH/Complex Dependency). • Agree EH core minimum offer that must be available across all boroughs (EH/Complex Dependency). • Establish role for full time safeguarding officer in Wetherby (youth Offending). • Establish GM Youth Offending commissioning framework and develop single GM courts team. (youth Offending). • Increase understanding of CS through RIP (complex safeguarding). • All GM local authorities will be active members of Fostering Front Door and Adopt North West (LAC). • All LAC children will have an exit plan (LAC). • No LAC (over 2 years) will be cared for at home (LAC). • Extensive engagement of national, regional and local stakeholders in the co-design of a new GM QA vehicle (QA). • Joint development work regarding GM's pathfinder status as part of the national LSCB review (QA). • Innovation fund investment in a joint DfE, Cafcass and Ofted analytical team to

undertake robust technical support during the design and negotiation of the new GM QA framework (QA).
- Commissioning of robust, independent, longitudinal evaluation of the newly launched GM QA framework in practice to inform national policy making (QA).
- Design of a workforce, culture and leadership programme (QA).

Clarity of outcomes required and contribution to financial and clinical sustainability and PSR

There is significant overlap and potential dependency between the proposals identified thus far through Services for Children Review and the ambitions in the Health and Social Care Strategic Plan:

- Commissioning of Mental Health provision – The ambition to develop simpler models for commissioning and service provision of Child & Adolescent Mental Health Services (CAMHS) including early help, plus explore how Perinatal Mental Health services could be improved through greater co-ordination. A focus on early intervention and prevention is also key priority in the Integrated Health Services for Children workstream and is fundamentally intertwined with delivery of an all age mental health strategy for GM which has strategic initiatives that focus on children and young people.
- Early Years – The GM early years new delivery model already has the full engagement of all authorities. There is however an ambition in the Services for Children work to build on this to develop a truly integrated, multi-agency approach to 'Early Years' (0-5 years) and Early Help (0-18) to help secure positive health, wellbeing and educational outcomes, plus the potential to develop a model where primary schools take a lead role in progressing the learning and educational development of children from the age of two linked to the early years pathway. This will require joint planning, commissioning and delivery linked to the Health & Social Care Strategy, including defining health visiting, midwifery, pre/post-natal and primary care alongside the role of schools. Ensuring that more children are reaching good level of development cognitively, socially and emotionally (as cited in the Devolution Agreement) should act as a shared outcome for targeted improvement alongside the ambition for fewer babies with low birth weight.
- Quality Assurance – This workstream includes an aspiration for a single GM outcomes and quality assurance framework in statutory children's services which involves the impact of the work of all partners with children in this cohort In addition, there exists the opportunity to develop a pilot model of a GM LSCB linked to modified local arrangements and such an arrangement would need the commitment of all partners with regard to revised information sharing and governance arrangements.
- Complex Dependency & Early Help – The Services for Children Review advocates the development of systematic prevention system for children and families (start well) that needs to be a fully integrated part of the whole life course (with live well and age well), placed based prevention system in order to reduce demand on acute and specialist services. A 'whole system' approach which can articulate how health services can best integrate with services for children in a place is a key area of work linked to the Locality Plan implementation. It is based firmly on the development of resilient and healthy communities and in particular the Health and Social Care focus on 7 day GP access and community health care will support the Complex Dependency and Early Help priorities of the children's work.
- Targeted and specialist support – Being able to target particularly vulnerable

groups of young people more effectively including Looked After Children, those that are vulnerable to Complex Safeguarding issues, young people with Special Education Needs or Disabilities (including linking into the development of a Learning Disability Fast LD Fast Track)and those transitioning from children to adult care requires a better understanding of the needs of these groups if we are to ensure that they receive the 'wrap around' support needed. This may include different commissioning and delivery models to support improved access rates for vulnerable children, looking at options for 24/7 crisis care support and the better integration of children to adult care.

- Integrated Commissioning – Aligning the proposals within the Services for Children Review with the Health and Social Care Strategic Plan will offer the opportunity for integrated commissioning of specific services or interventions for children and parents at a GM level. The Joint Commissioning Board will have a key role to play in understanding where maximum value and impact can be achieved through an integrated approach to commissioning.
- Workforce Development – A common set of values, behaviours a more flexible workforce will be vital for both programmes areas work. There is opportunity to develop these jointly and consider how workforce development activity can be jointly commissioned/delivered using pooled resources.
- Data sharing and analytics capability – The need to understand the needs of our populations better and understand/predict demand is a vital element of the Services for Children Review. This will require new approached to how we jointly tackle barriers around data sharing (GM Connect) but also how we maximise the information we hold and the analytical resources we have at our disposal. There is an opportunity to explore how we can develop better integrated needs assessments for GM that will support more effective commissioning / provision / monitoring.

3. Learning Disability Services

Summary:

• **Five year vision, outcome objectives and phases**
• Greater Manchester has developed 7 principles within which service delivery models will be developed and delivered. These are based on recognised best practice: • All people with learning disabilities and / or autism will be supported within the community wherever possible. • People with severe disabilities and complex support needs will be integrated into typical neighbourhoods, work environments and community settings. • Support will be provided for the placement of individuals with severe disabilities and complex needs in homes and natural settings. • Community living arrangements will be family-scale and / or in line with age-appropriate communal styles. They will all enable individual to have their own space. • We will encourage the development of social relationships between people with severe disabilities and complex needs and a range of other people. • Individuals will be supported to participate in busy community life and develop functional, meaningful, interesting and community living skills. • Families and service users will be involved in the co-design, development, active delivery and monitoring of services.
16/17 action plans with key milestones
1. Development of a common ethical commissioning framework. To develop a commissioning approach that enables the market to offer care solutions that represent best value, offer high quality affordable services and that can be purchased from within the personal budgets that people with a learning disability have to spend. **2. Identification of exemplar care models for upscaling and implementation across GM** To identify schemes and initiatives that demonstrate good practice across GM localities and highlight what works and what does not. Where one locality is able to evidence an approach or service that has resulted in good outcomes, then this will be automatically shared across all localities for consideration. **3. Integrated commissioning functions, working closely with CCG`s and well connected with partners such as housing and VCS** development of a commissioning function across GM that is collaborative in nature between local CCG`s and Councils, reflects the importance of local connections and strategic priorities and can be flexed to support wholescale commissioning across GM when required. **4. GM Discharge framework agreed and established** A framework for ensuring that the work required to facilitate discharges from secure and non-secure environments is agreed to include implementation of Community Treatment Reviews. **5. Telemedicine and assistive opportunities pursued** Take a positive risk taking approach to managing risk in a range of environments using telecare and other technology to mitigate identified risks.

6. Workforce reform opportunities developed blending health and social care roles To ensure that where integrated teams are in existence, roles are developed to be deployed flexibly, recognising the points at which investment is required in specialist roles that can be used appropriately.
Clarity of outcomes required and contribution to financial and clinical sustainability and PSR
• Greater Manchester's ambition for Learning Disabilities services is predicated on four key objectives: o 60% reduction in non-secure beds o 34% Reduction in the number of low secure commissioned beds o Improving in / out reach intensive support o Expansion of community based accommodation

4. Mental Health

Summary:

Five year vision, outcome objectives and phases
• Improving child and adult mental health, narrowing their gap in life expectancy and ensuring parity of esteem with physical health. • Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in GM requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and wellbeing of GM residents.
16/17 action plans with key milestones
Q1 • Links to Children's services specifically CAMHS to be strengthened. • Mental Health links to worklessness and physical ill health to be more clearly articulated and programmes already in existence to address these issues such as 'Working Well' referenced. • Optimise opportunities for all primary care providers to support the delivery of mental health services in line with the GM Mental Health and Wellbeing Strategy • Need more focus on asset based work and lower level community based solutions. 2016/17 • Development of a stepped care multi agency pathway that describes the offer across the whole system based on presenting need. • Development of a GM Transformation plan for CAMHS. • Scope opportunities across GM for commissioning highly specialist elements of the pathway as a collective to improve consistency, equity and efficiency. • Establish GM wide information sharing.
Clarity of outcomes required and contribution to financial and clinical sustainability and PSR
• Simplify provider system and bring together commissioning across GM. • Children and YP a key part of the strategy. • Greater integration across mental and physical health and social care in each of the 10 localities. Mental health integrated within the LCOs. • Support those people who are vulnerable to mental ill health. • Promote employment for people with mental ill health. • Address the wider financial impact of poor mental health on wider public services.

5. Population Health Improvement

Summary:

Five year vision, outcome objectives and phases
• Creating a health and care system capable of contributing to a transformational and sustainable shift in the health of the 2.8 m people who live in GM. • Enable more people to manage health: looking after themselves and each other. • Shift public and clinical behaviours towards early intervention and prevention. • Children under 5 reaching a good level of development to make the most of education and training opportunities and provide the best start in life. • Improving the health and wellbeing of working aged adults and ensuring all residents are connected to the current and future economic growth in the conurbation including quality work, improved housing and strengthened education and skills attainment. • Close the health inequalities gap faster within GM and between GM and the rest of England. • Increasing intervention at scale and finding the missing thousands, who have diseases but do not know it yet. • To support older people to stay well and independent and live at home for as long as possible.
16/17 action plans with key milestones
• Develop specific proposals for **GM level PH commissioning**, including Sexual Health services, drugs and alcohol services and EY health services. • **Screening and Immunisation**: whole pathway approach as part of the Cancer Vanguard arrangements; Local Care Organisations and their new contractual forms and wider PSR developments such as the expansion of Working Well and the Early Years NDM. Priority will be given to those areas which require significant performance improvement e.g. cancer screening and childhood flu. • **Integration of information systems** including Child Health Information Systems, (CHIS). • **Integration of commissioning** such as for sexual Assault Services, which could be linked more strongly to local safeguarding and complex dependency arrangements. • **Health and Justice**: Liaison and Diversion services and opportunities to develop a unique integrated commissioning and delivery model with police custody healthcare. • **Find and Treat Programme:** GM commissioning of NHS Health Checks programme to address variation in price and outcomes and drive up standards; Commissioning a bespoke integrated intervention for the 10% most deprived communities with the poorest health to provide an enhanced service with broader support packages including social support and access to work. • **Cancer Vanguard:** Delivery of year one commissioning intentions: to include commissioning behavioural insights work to support key elements of programme e.g. improving screening attendance. • **Radical upgrade in lifestyle behaviour change support**: Commissioning a GM lifestyle and wellness hub to provide a single access point/portal for behaviour change advice and support including triage into 10 placed based locality lifestyle and wellness service offers.

• **Early Years NDM**: Commission at GM level bringing together the commissioning of HV, FNP related maternity services, perinatal MH services, children centre and early education offers and other targeted support. • **Digital Strategy**: The development of a digital health commissioning strategy aligned across three specific areas: digital innovation, empowered citizens and communities and digital navigation to underpin a radical upgrade in prevention and population health.
Clarity of outcomes required and contribution to financial and clinical sustainability and PSR
• Radical upgrade in lifestyle behaviour change support that delivers innovative approaches at scale to drive long term behaviour changes and reduces current and future demand on health services from lifestyle related long term conditions.

6. Primary Care

Summary:

Five year vision, outcome objectives and phases
• **Delivery of primary care at scale:** The integrated provision of primary, community, social care, mental health and other services, serving defined neighbourhoods of circa 30 – 50,000 people. These integrated neighbourhood teams provide a foundation for the development of Local Care Organisations, operating at a borough/ city wide level. A number of 'early adopter sites' have been identified to implement this new way of working in shadow form early 2016/17. By 2021, Local Care Organisations will be operating in all 10 localities of Greater Manchester. • **A population approach to health and wellbeing:** The creation of a primary care system that more proactively supports people and communities to take charge - and responsibility for - managing their own health and wellbeing, whether they are well or ill. Rolling out the Healthy Living Framework will increase the number of outlets where people are able to access health improvement advice and services. During 2017/18, the Healthy Living Framework will have been rolled out to all community pharmacies in GM and to all community optical and dental practices by April 2018. • **Improving access and responsiveness:** The development of 7 day access plans was part of the commitment to the Healthier Together Programme and was specifically designed make sure that primary care services are available 7 days a week to mirror the move to 7 day working in hospitals. All parts of Greater Manchester are now delivering 7 day services however it is expected these will be redesigned in 2017/18 based on the findings of an independent evaluation and to align to wider commissioning intentions /service transformation. Increased access to dental, pharmacy and optometry services will provide a more responsive service, ensuring people access treatment and advice by the right person, at the right time and closer to home. • **Consistently high quality care** / **reducing unwarranted variation:** The quality of most primary care provision is good, but there are wide and often unwarranted variations in performance. There is a need to reduce this inconsistency so patients, the public and professional colleagues across the health and social care system

are assured that primary care in Greater Manchester is of the highest possible quality. By December 2017, the Greater Manchester Primary Care Medical Standards will be implemented across the 10 localities. Aligned and complementary standards for dental, optometry and pharmacy are also being developed and implemented.
16/17 action plans with key milestones
• **Primary care at scale:** Development, implementation and commissioning of 'early adopter sites' – delivering primary care at scale. Early adopter sites have been identified in at least 4 localities. • **Population health and wellbeing:** - GM wide roll out of Healthy Living Pharmacy Framework to all community pharmacies - delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. - Healthy Living Dental Framework pilot in Wigan. - Mainstreaming 'Healthy gums DO matter' across GM and periodontal care following recent pilot - Eye Care pilot for people with learning disabilities - Pilot asset based training for front line staff. - Sector-led oral health improvement programme • **Improving access and responsiveness: -** 7 day services to primary care, hubs operational in all parts of GM - GM wide roll-out of Minor Ailments Scheme to all community pharmacies. - Implementation of emergency and urgent repeat medication provision to all CCG localities. - Implementation of single Minor Eye Conditions Service across GM. - Extend access to dental health services 'Baby Teeth DO matter' and 'Buddy Practice' - Pride in practice pilot improving access for LGBT population - Delivery of Asylum Health Project establishing co-ordinated good practice in delivery and access to services and development of community asset. • **Specialist dental services:** - developing pathways management for access and delivery of specialist dental care. - Establishment of Managed Clinical Networks, delivering single service model and provider assurance of specialist care - Integrate dental and oral health considerations in the care of children subject to general anaesthetics.
• The Greater Manchester Strategic Plan notes primary care as the driving force behind a prevention-focused approach within localities across Greater Manchester. There is massive untapped potential for primary care to prevent health problems, take action quickly once they are detected and reduce complications that can arise from late diagnosis. Significant health gain will be made by implementing early intervention at scale and identifying the 'missing thousands' who have undiagnosed disease. • In Greater Manchester we want to create a primary care system that more proactively supports people and communities to take charge - and responsibility for - managing their own health and wellbeing, whether they are well or ill. This will draw on a range of approaches that have already been tested in Greater Manchester including work to improve health literacy and to draw on the strengths and assets that exist in communities. • We want to strengthen the focus on wellbeing. This means putting more emphasis

on prevention, self-care, public health, resilience and recovery, and reducing lifestyle and behavioural risks. As noted in the Greater Manchester Strategic Plan, by upgrading prevention and self-care we are proposing to change the way GM people view and use public services, creating a new relationship between people and public services.

- We particularly want to make the most of interaction between the public and dental, pharmacy and optometry services to support self-care and prevention, rather than thinking about contact with primary care purely in terms of illness.
- This fresh approach will mean people will better understand how they contribute to their own health and wellbeing and can make the most of available services. They will have the information they need to prevent ill health, manage any conditions and access the right support in their local neighbourhood when they need it.
- Managing and using information better – including patient records – is one of the principles supporting our overall vision for primary care and will support more consistent quality across services.
- Reducing silos, networks and systems that operate in isolation will enable greater connectivity and integrated electronic communication. This will help co-ordinate patient care when it is appropriate to share data. For example, optometrists could access patients' summary care records and GP records and let the individual patient's GPs know about the results of eye health checks, including any wider health issues these have identified.
- Sharing information in this way will mean action can be taken to support patients to manage their health at the earliest opportune moment, without unnecessarily duplicated assessments. It may be particularly useful in connecting various professionals so they can co-ordinate care for more vulnerable patients and help them to remain thriving members of the community.
- We want to improve the way different health and care professionals work together to get the most from what each profession brings to primary care services and individual patient care. Our aim is for all the various professions to contribute to both the preventative and healthcare delivery agendas, to maintain independent living for the maximum number of people – which will help 'spread the load' across both health and social care – and embed best practice in all services across Greater Manchester. We also want to foster closer working with the acute sector (including hospital pharmacists) to improve the way patients are discharged to the community.

7. Specialised Commissioning

Summary:

Five year vision, outcome objectives and phases
Model to be implemented based on the following principles and outcomes which will guide the development of future service delivery models. These are based on recognised best practice: • Elimination of variation and improvement of patient outcomes and experience. • Achievement of evidence-based clinical standardisation. • Creation of one clinical workforce for key services. • Achievement of consistent and effective clinical governance for all service. • Optimise scale and achieve consolidation of services, where required. • Improve efficiency.

- Achieve integration of care for the whole patient pathway for the GM population.

16/17 action plans with key milestones

- Complete the process to ensure we address long standing non–compliant cancer pathways in upper GI and urology
- Implement outcomes from prioritisation matrix, which has been developed with providers to support identification of the next services for transformation
- Specialist cancer services are to be reviewed within the work of the GM cancer vanguard schemes The model of care is to consider whole pathway re-design which will incorporate all specialist cancer services into the re-design process

Clarity of outcomes required and contribution to financial and clinical sustainability and PSR

The implementation of the strategy will support the commissioning of specialised services to consider different models of delivery. Work is underway with providers to understand what the best approach to this is with the focus being on delivery of high care rather than organisations this will lead to the following outcomes:

- Optimise patient outcomes, access and experience through the integration of care along the whole patient pathway, elimination of variation in referrals, access and outcomes and introduction of integrated and standardised pathways which take account of the needs of the whole patient pathway, including prevention etc.
- Improve efficiency by moving away from fragmented organisation-based delivery to clusters of Single Services which optimise the scale of service delivery and consolidate service delivery, where required. This will ensure services meet the minimum volumes required to optimise patient outcomes and run a 24/7 service.
- Support world-class clinical practice, education & training, research &development and innovation by achievement of evidence-based clinical standardisation, optimising recruitment to local and national clinical trials, increasing research opportunities and resources for GM and optimising training and education of the clinical workforce. The Single Service model will also support the spread and adoption of evidence-based pathways and threshold management from primary care to specialist care.
- Create clinical and system leadership for integrated patient pathway transformation by creating a Lead organisation responsible for developing a Single Service cluster with a single clinical workforce, to achieve world-class standards and clinical outcomes, and consistent and effective clinical governance for key services. Most importantly, such an approach would move from the existing formal procurement processes for Specialised Services to the collaborative re-design of service clusters.

Appendix 3: Initial action plans for broader workstreams to be swiftly adopted by the JCB

8. Skills & Work

Summary:

Three year vision, outcome objectives and phases
The 10 GM Skills & Work Priorities for 2016-19 are: 1. **Careers Education Information Advice & Guidance (CEIAG)**: Based on up to date Labour Market Information, enhance high quality CEIAG across school, FE and Work provision to ensure young people, their parents & teachers and adults understand the range of education, skills and employment opportunities and progression pathways available in GM and as a result make informed choices. 2. **Outcome Frameworks**: Develop outcome frameworks to ensure all work & skills provision supports positive progression pathways and ultimately sustainable employment outcomes for Greater Manchester's young people and adults. Embedded in the provision should be good English and Maths outcomes, digital skills, meaningful work experience and those behaviours/core competencies (enterprise skills) needed in the world of work. The outcome frameworks will underpin future GM commissioning. 3. **Infrastructure:** Develop a GM work and skills infrastructure via the Area Based Review, JCP estate review and One Public Estate to ensure accessible local provision for education and skills to Level 2 /3 with specialist/ technical provision at Level 3/4 and above linked to GM's economic & growth needs and delivered through a discrete number of high quality centres 4. **Attainment:** Focused activity to support the attainment of Level 2 English, Maths and STEM subjects at age 16 across GM, thereby improving Level 3 attainment at 19. 5. **Employer Engagement:** Develop a comprehensive approach to employer engagement and investment in the work & skills system working with the LEP, employer bodies and local authorities, to ensure that: (a) employers are at the heart of the system; (b) employers recognise the value of workforce development and plan and invest in their workforce development needs; (c) the higher level skills needed for economic growth are developed and commissioned by business, recognising that most of this will be funded via FE loans and employer investment; (d) that employers develop good employment practices to support people to retain employment and help people, including via work experience to (re-) enter the labour market 6. **Apprenticeships:** Increase the number, quality and level of Apprenticeships in core and growth sectors in GM via better CEIAG, employer workforce development and co-ordination of public sector activity in response to the Apprenticeship Levy. Apprenticeships also offer opportunities for re-skilling and up-skilling the existing workforce as they move into new roles to support in work progression. 7. **Higher Level Skills:** develop the education and skills system in GM, including via FE/HE Loans, to support young people and adults to develop the higher level (minimum level 3) and STEM skills needed by them to compete and progress in the labour market and by employers to drive productivity. Graduate retention in Greater Manchester is good but there is more to do to enable access to HE and move graduates into SMEs.

8. **Universal Support:** Redesign services to support workless residents ensuring early assessment and rapid response for low need 18-65 year old back into work. Create a universal support offer for all jobseekers and benefit claimants, providing a personalised offer based on their needs and delivered in an integrated, co-located way with local support services, improving the customer experience, and increasing sustainable job outcomes. This will improve the functioning of the GM labour market and ensure that as residents move into and progress in work, there is a reduction in the number of GM residents dependent on in-work benefits.

9. **Specialist Support:** Expand the Working Well Programme and design a new offer for complex 18-65 year olds who have experienced long periods outside of the labour market via Work & Health programme commissioning which fully utilises complementary public services and supports more GM long-term benefit claimants to secure work.

10. **Commissioned Activity:** commission activity that integrates work & skills, supporting the priorities above - including ESF programmes and employment outcomes in GM health (particularly mental health) commissioned programmes

16/17 action plans with key milestones

An action plan has been developed for each of the priorities which detail short, medium and long term actions. Many of these priorities can be progressed in the short term via a range of deliverables that GM is already committed to pursuing to implement the November 2014 and November 2015 Devolution Agreements. Key amongst these are:

- Undertake the Area Based Review and ensure conclusions are implemented – to restructure Post 19 provision analysing: current curriculum, future skills demands of the economy, population trends and the financial position of providers
- The development of an outcomes framework - influencing commissioning of the 16/17 Adult Skills Budget leading to potential budget responsibility in 17/18. This framework can also be used to shape the new Work & Health programme
- The expansion of Working Well up to 2017
- The recommissioning of the Work & Health programme from 2017 to include the ongoing expansion of Working Well
- The development of a GM approach to the Apprenticeship Levy – including a public sector 'ring-fencing' to ensure GM develops the skills it needs to drive growth and reform
- Work with JCP to review and rationalise their estate linked to One Public Estate and the development of integrated local 'early help hubs'
- The work to commission £130m+ of ESF funding to ensure GM achieves the work and skills outcomes that it requires.

Clarity of outcomes required and contribution to financial and clinical sustainability and PSR

There are a number of key areas where Skills & Work priorities and the ambitions in the Health and Social Care Strategic Plan align:

- Integrated Commissioning – In particular the Working Well expansion and Work & Health programme. The Joint Commissioning Board could be a vehicle to deliver an integrated approach to commissioning. There is a particular opportunity around the development of an outcomes framework.
- Prevention and Community Based Care – There are clear links in terms of employer engagement and helping residents remain healthy and in work, creating pathways into job opportunities in the health system and in creating more integrated service delivery in communities.
- Data sharing and analytics capability – More effective customer segmentation and

data sharing across systems and practitioners will help to target our commissioning strategies and enable greater joint working on the ground.

9. Summary: Substance Misuse

Five year vision, outcome objectives and phases

The aim of the review of substance misuse commissioning and delivery is to ensure that **substance misuse commissioning** is better co-ordinated and achieving the best possible outcomes and value for money across GM.

Issue

The nature of substance misuse is complex and changing. We know that;

- Increasing numbers of people are damaging their health through excessive drinking, and there has been an associated rise in the prevalence of alcohol related conditions.
- There remain a large number of Opiate and Crack Users for whom a recovery – orientated clinical service is crucial.
- New types of drug users are emerging; they are younger, likely to be poly-drug users, more diverse, more likely to but drugs online and more willing to try unknown substances
- There are specific behaviours and issues. For example the increase in prescription/over the counter drug misuse, and a surge in the use of new psychoactive substances in particular are common and recognised as challenges and that our system response is still evolving.

The Case for Change

Extensive work has been undertaken over October and November 2015 to construct a single narrative and Vision (Appendix A) that:

- Traces through some of the key changes in patterns of substance misuse, reflecting on the latest developments and how the service offer in GM has evolved and responded.
- Draws together our clearest GM evidence base on how substance misuse interconnects with other issues – from mental health and domestic abuse to worklessness/productivity and child safeguarding challenges and;
- Sets a level of ambition for collaboration across GM

The Current Position

There is a wide recognition that all districts are some way towards successfully recommissioning their treatment system to reflect (i) the changing nature of substance misuse, (ii) a recovery-oriented approach, and (iii) the links to complex dependency

Some areas are recognised as having good recovery and mutual aid, whilst others provide well developed brief interventions for alcohol, and others have good shared care and strong digital services.

And yet there remains a continued sense that there is a mixed picture of drug and alcohol provision across GM, with significant variation in how these services are commissioned, structured and configured, an inconsistent pathway for complex individuals and families seeking to access these services, as well as limited options for new and emerging drug users.

There is also a sense that within GM there are still genuine opportunities to reduce duplication and to identify more efficient commissioning options.

GM has a clear legacy of traditional Opiate and Crack Users in treatment for whom support is absolutely necessary. However, the landscape has shifted and there is, therefore, a strong appetite for GM commissioners to work collaboratively, to establish a clear and meaningful spine of GM commissioning principles, and to give fuller consideration to those interventions that might be co-commissioned against agreed specifications.

We are also cognisant of the need for there to be an equitable offer across GM in relation to the Criminal Justice System and will ensure that our "common standards" reflect this.

The new national Drug Strategy is due to be published in mid-March and we are working closely with PHE to ensure that our proposals are in line with this.

Governance

This work has been commissioned by the AGMA Wider Leadership Team. Strategic ownership sits with Mike Owen, reflecting his lead portfolio for policing and crime and alcohol. The work is led by Kate Ardern, Director of Public Health, Wigan on behalf of the DPHs.

To ensure that the work is situated in all the appropriate strategic discussions on PSR and Health and Social Care Devolution, the work is regularly reported to: PSR Leadership Group; Complex Dependency Executive; GM Directors of Public Health; GM Health and Social Care Early Intervention and Prevention Board – and any other groups as required.

There is however currently a gap in governance and decision making in relation to GM Wide Commissioning

16/17 action plans with key milestones

Next Steps/Project Plan

The body of works being taken forward over the next 6 months (January – September 2016), will deliver

1. A set of shared principles for substance misuse commissioning, reflecting the broader vision and aligned to PSR principles
2. A benchmarking exercise that reviews the current specifications in the ten district and helps to develop a common framework across the domains of
   > early help
   > targeted interventions
   >recovery and community; and
   > treatment
3. An options report with recommendations on what services/interventions might be commissioned collaboratively at different spatial levels.
4. Early market engagement that supports both the incumbent and potential new providers to better understand GM's broader reform ambition

Clarity of outcomes required and contribution to financial and clinical sustainability and PSR

The “case for change” narrative that has been constructed and agreed, draws together our evidence base on: the nature and scale of the GM challenge; how this is evolving; the status of our collective response; and the opportunities now presented through the twin prioritisation of complex dependency and health and social care devolution.

The shared vision statement and principles for substance misuse commissioning across GM, which have been prepared and agreed in consultation with all 10 local authority substance misuse commissioning leads needs to be equally embedded within the H& SC Strategic Plan and Public Service Reform.

The benchmarking exercise will review the current configuration of services available in the ten districts against a common framework (e.g. intervention at the levels of: prevention – harm reduction – specialist treatment). This should establish who commissions what/where, match this against evidence based best practice, and reflect on current performance/outcomes and value for money.

An options report will be drafted with recommendations on what services/interventions could viably be commissioned differently through a collective approach. This should consider specific opportunities exist for greater GM collaboration (across spatial levels - either at GM; cluster; or neighbourhood level), and can build on the existing ways in which we have already collaborated for mutual benefit – for example, in respect of in-patient detoxification and residential rehabilitation. This should also review opportunities to commission together in response to common emerging challenges (e.g. digital engagement and prevention work with young people), or in relation to workforce training and skills development.

An appraisal of the current provider landscape in GM will result in practical recommendations for future market stimulation/development. This may require a dedicated market event, the purpose of which would be to convene existing and potential new providers and undertake a development exercise.

A key requirement throughout this next phase of work is to pinpoint what particular opportunities exist for future collaboration with CCGs. This dialogue will take a different form in each area, but it would be particularly helpful if (for example) the provision of alcohol liaison services and provision of IBA within acute trusts were considered, as part of a wider re-consideration of commissioning options to support a sustainable approach to funding of preventative alcohol services that meet local need.

The wider AGG leadership support for RADAR and RAID services remains, of course, of fundamental importance in line with the confirmed independent cost-benefit evaluation report, as reviewed in line with the attached paper supported by GM CCG Chief Finance Officers and Heads of Commissioning.

Further to this, there may be further essential contributions from CCGs in defining common GM standards, and in defining short/medium/long term opportunities for practical collaboration

Appendix A - GM Vision Statement and Substance Misuse Principles

The GM commissioners have worked together to draft a proposed shared vision for GM substance misuse commissioning, as follows:

GM Partners will work collaboratively to ensure that local systems of substance misuse

intervention and treatment are commissioned and provided in accordance with common principles and standards, so that individuals and families affected by all forms of substance misuse, including alcohol, are supported to achieve recovery and live independently.

We will achieve more for less by:

- Recognising that substance use is diverse and complex, and collectively responding to changing patterns of substance use and behaviour to provide the most effective route to recovery from all types of substance misuse.

- Rooting our approach in prevention and early intervention, anticipating future cost and escalating demand on services, and ensuring responses are appropriate to levels of need and health risk.
- Basing our approach to treatment and harm reduction on a growing evidence base, and a shared understanding of challenges, opportunities and changing circumstances - ensuring that we share learning, expertise and resources.

- Using asset-based approaches to enable long-term and sustained recovery from all types of substance misuse.

- Adopting a whole-person approach to working with complex families and individuals, and integrating provision with wider delivery models tackling Complex Dependency.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

5B

GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION STARTEGIC PARTNERSHIP BOARD EXECUTIVE

Date: 7 March 2016

Subject: Delegation Agreement

Report of: Rob Bellingham

PURPOSE OF REPORT

In 2016/17, NHS England will remain legally responsible for the delivery of its statutory functions within Greater Manchester. To ensure that we fully honour the principle of devolution, NHS England intends to delegate internally responsibility for the operational management of the delivery of the NHS constitution and mandate to the Greater Manchester Chief Officer (GMCO) as its employee.

The attached draft accountability agreement between NHS England (nationally and regionally) and the GMCO describes the terms of that delegation. It is intended that this accountability agreement will endure – if progression from delegation to devolution is made, all principles within this agreement will remain.

RECOMMENDATIONS:

The Strategic Partnership Board Executive are asked to:

1. Agree the content of the paper.
2. Commend the report to both the Programme Board and Strategic Partnership for approval.

CONTACT OFFICERS:

Rob Bellingham
robbellingham@nhs.net

NHS England- Greater Manchester Health and Social Care Accountability Agreement

Purpose

In 2016/17, NHS England will remain legally responsible for the delivery of its statutory functions within Greater Manchester. To ensure that we fully honour the principle of devolution, NHS England intends to delegate internally responsibility for the operational management of the delivery of the NHS constitution and mandate to the Greater Manchester Chief Officer (GMCO) as its employee.

The attached draft accountability agreement between NHS England (nationally and regionally) and the GMCO describes the terms of that delegation. It is intended that this accountability agreement will endure – if progression from delegation to devolution is made, all principles within this agreement will remain.

Background and Context

Following the signing of the Memorandum of Understanding (MoU) to work towards the devolution of health and social care functions by NHS England to the Association of GM Authorities (AGMA) and the Association of GM CCGs, a new architecture has been developed to support the devolution. The proposals on assurance in this paper are intended to be consistent with the principles and arrangements described in the MoU.

The Cities and Local Government Devolution Bill is awaiting Royal Assent. Once the Bill is active, any formal request for delegation of responsibilities to a joint committee of NHS England, AGMA, GM CCGs and GMLAs will take some time to work through associated governance processes.

In the meantime, and in line with the pace of development in Greater Manchester, it is intended to honour the principle of *devolution* even when, for pragmatic reasons, what will have been done in legal terms is *internal delegation* – a 'synthetic' devolution. It is for this reason that it is important to make a distinction between the responsibilities of NHE England (Nationally and Regionally) and the GMCO as an NHS England employee.

Draft Accountability Agreement Development

The draft document (version 12.2) includes CCG assurance framework, CCG assurance delivery, 2016/17 planning round, finance and performance reporting, and has been co-designed by the NHSE Lancs & GM team with the interim GM Devo Team.

Comments on previous versions from John Bailey, Richard Barker, Keziah Halliday, Steve Wilson, Carol Stubley and Sarah Briggs have been incorporated into the current draft.

NHS England- Greater Manchester Health and Social Care Accountability Agreement

1. Purpose

1.1 In 2016/17, NHS England will remain legally responsible for the delivery of its statutory functions within Greater Manchester. To ensure that we fully honour the principle of devolution, NHS England intends to delegate internally responsibility for the operational management of the delivery of the NHS constitution and mandate to the Greater Manchester Chief Officer (GMCO) as its employee.

1.2 This accountability agreement between NHS England (nationally and regionally) and its employee, the GMCO, describes the terms of that delegation, pending any formal request from Greater Manchester for delegation of responsibilities under the Cities and Local Government Devolution Bill. However, it is intended that this accountability agreement will endure – if progression from delegation to devolution is made, all principles within this agreement will remain.

2. Background and Context

2.1 Following the signing of the Memorandum of Understanding (MoU) to work towards the devolution of health and social care functions by NHS England to the Association of GM Authorities (AGMA) and the Association of GM CCGs, a new architecture has been developed to support the devolution. The proposals on assurance in this paper are intended to be consistent with the principles and arrangements described in the MoU.

2.2 The assurance proposals are based on the following assumptions, which are derived from the MoU. For the purposes of this agreement, Greater Manchester Health and Social Care (GMH&SC) is defined as the programme of health and social care commissioning in Greater Manchester, headed by the GMCO, who is employed by NHSE England.

- GMH&SC intends to deliver the NHS Constitution and Mandate commitments in full;
- GMH&SC will demonstrate, through a business case, how it will be a financially and clinically sustainable system within five years (the CSR period) - assurance of delivery of the 5 year plan should be aligned with assurance of in-year delivery;
- The 37 statutory organisations in GMH&SC (12 CCGs, 10 Local Authorities; 15 provider trusts) will continue to exist as sovereign bodies and hold their existing budgets and accountabilities.

2.3 The scope of the devolution deal within the MoU is all-encompassing in terms of health and social care and NHS England will devolve into GMH&SC (subject to governance) responsibilities for specialised commissioning, primary care and other directly commissioned services.

2.4 The Cities and Local Government Devolution Bill is awaiting Royal Assent. Once

the Bill is active, any formal request for delegation of responsibilities to a joint committee of NHS England, AGMA, GM CCGs and GMLAs will take some time to work through associated governance processes.

2.5 In the meantime, and in line with the pace of development in Greater Manchester, it is intended to honour the principle of *devolution* even when, for pragmatic reasons, what will have been done in legal terms is *internal delegation* – a 'synthetic' devolution. It is for this reason that it is important to make a distinction between NHE England (Nationally and Regionally) and the GMCO as an NHS England employee.

3. Current Statutory Requirements for CCG Assurance

3.1 This document has been cross referenced with a paper prepared by NHS England on the proposed retention or delegation of its statutory functions.

3.2 NHS England has a duty under s.14Z16 of the NHS Act 2006[1] (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. NHS England must publish a report each year which summarises the results of each performance assessment.

3.3 The assurance status is subject to continuous review with an annual assessment, therefore the status of a CCG can be changed at any time through recommendations made to the Assurance Oversight Group. NHS England publishes an annual summary report based on the assurance status for each CCG at the end of the year.

3.4 The details of the CCG Assurance Framework are NHS England policy rather than set is statute or regulations and can be amended by the Commissioning Committee of the Board.

4. Proposed Principles for CCG Assurance in GM

4.1 In co-designing with the interim GM Devo team the proposed arrangements for CCG assurance within GM, the following principles have been applied.

- It is recognised that GMH&SC remains part of the wider NHS and social care system, such that NHS England can be assured GM will deliver against the minimal operational standards required nationally.
- NHS England will retain legal responsibility for CCG assurance in accordance with the NHSE Assurance Framework. Operational management of the assurance process will be delegated to the GMCO as its employee, who will be required to follow NHS England assurance processes and criteria. There will,

[1] http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted
[1] https://www.england.nhs.uk/commissioning/ccg-auth/

however, be flexibility on how the process is delivered within GM

- NHS England will be supportive of any additional GM assurance process that does not conflict with the national framework but encourages improved outcomes
- Through delegation to the GMCO, GM will be assured once, as a place, for delivery of the NHS Constitution and mandate, financial control and quality (subject to agreement about not allowing inequalities to develop through unwarranted variation)
- The process will be proportionate and minimise the burden on the organisations involved;
- Be consistent with the principle of subsidiarity (decisions are made at the most appropriate level) within GMH&SC, recognising the 'place' (Locality Authority footprint) as the primary unit of planning;
- Be developed in the context of the emerging governance arrangements for the NHS in GMH&SC;
- Acknowledge the continuing formal and legal accountability of individual CCGs;
- Recognise that the approach in a devolved GMH&SC system is to integrate governance, planning and delivery;
- Be a continuous process developed in partnership with the GMH&SC system;
- Aim to move the focus of assurance to quality of care and experience and outcomes for the population of GMH&SC;
- Recognise that data is part of the intelligence to build an assurance picture about GMH&SC, but that an understanding of the local economies in the context of a GMH&SC system will be essential;
- Be aligned and developed alongside the assurance and regulation processes being developed and agreed with the NHS Improvement
- Clarify what each locality and GM as a conurbation aims to achieve.

5. **Standard Operating Model**

5.1 In the GMH&SC Health and Social Care Devolution Governance paper it was proposed that:

5.2 *A robust GMH&SC assurance / performance management framework has been developed, that focuses on system wide performance, rather than compartmentalise each of the component parts. This framework, it is proposed, will need to include a suite of metrics that are suitable for GMH&SC and focuses energy on achieving the outcomes that GMH&SC is seeking to achieve as documented in the GMH&SC Strategic Plan. This will ensure that that constituent parts of the GMH&SC health and care system are not working to different regulatory regimes and works for the benefit of those using the services.*

5.3 The Governance paper goes onto to propose that '*a system of assurance is developed and agreed between the regulatory bodies that GMH&SC is assured as a place, and that GMH&SC will assure its component parts internally'.* This does not preclude that in the circumstances prescribed (or set out in law) and if required, intervention powers will be used that are retained by NHS England and the Secretary of State.

6. CCG Planning Round

6.1 On an annual basis, NHS England requires CCGs to submit an Annual Plan, and that plan is assured. There will be a difference between how this will work in transition for 2016/17 and how future planning rounds will be managed.

6.2 The approach to the assurance of planning will be consistent with the devolution agreement in Greater Manchester but will also provide assurance that the requirements of the planning guidance is being taken forward by commissioners in Greater Manchester working with NHS and local government partners.

6.3 Each CCG in GM will develop an individual operational plan for 2016/17 in line with NHS England's planning guidance. It is required that CCGs will meet the requirement for individual activity, finance and transformation (ie QIPP) submissions via UNIFY. NHS England (Nationally and Regionally) will only review an aggregated GM plan – GMH&SC will review the 10 locality plans and will put in place arrangements to do so, that NHS England will confirm as appropriate.

6.4 The planning guidance expects CCGs to demonstrate plans in a number of clinical and service areas (not least against the 10 priorities in the NHS England business plan). The handling of the assurance of any individual elements in the 2016/17 will be a matter for discussion and agreement between NHS England Regional team and the GMH&SC team.

6.5 Individual CCG operational plans will have to be consistent with the Sustainability and Transformation Plans (STPs) expected to be required for the planning round, with the activity and finance plan numbers in the STP reading across in full to the operational plan for each CCG in 2016/17.

6.6 The narrative requirement for the STP will reflect national guidance, consistent with any specific messages agreed for the handling of the STP in Greater Manchester as part of that guidance.

6.7 The STP will need to include specialised commissioning and NHS England's direct commissioning plans in Greater Manchester.

6.8 The STP is expected to be a shared plan between the providers and commissioners within Greater Manchester, informed by local government issues for example as captured in Health and Wellbeing Strategies and Better Care Fund plans, on agreed unit of planning footprint. The configuration of the unit of planning in Greater Manchester is expected to be agreed before the end of January 2016.

6.9 The assurance of the STP is expected to include an approach across the arm's length bodies (ALBs) including NHS improvement, PHE and HEE. Agreement of aggregated thresholds for delivery of NHS Constitution targets will need to reconcile with the demands of NHS Improvement in agreeing recovery trajectories with providers.

6.10 The lead responsibility for the assurance of the STP(s) will be within the GMH&SC team supported by the regional team and involving ALB colleagues.

6.11 NHS England will provide advice on the aggregate achievement expected at GMH&SC level to contribute to the NHS plans as a whole.

6.12 NHS England regional team and incoming GMH&SC team will work together during the transition period (up to 31st March 2016).

6.13 NHS England regional team will make staff and resources available to support any work required with individual CCGs subject to agreed limits on delivery and capacity within support service level agreements.

7. CCG Assurance Framework

7.1 A key principle that will form part of the accountability agreement is that, NHSE will discharge its functions in relation to the 12CCGs in GM through delegation to the GMCO and not directly on an individual basis with each CCG.

7.2 GMH&SC remains part of NHS England. NHS England intends to delegate responsibility for the operational management of the delivery of the NHS constitution and mandate - a key part of which is the assurance framework - to the GMCO as its employee.

7.3 The GMCO will internally assure its constituent CCGs, and will be required to follow NHS England assessment processes and criteria. There will, however, be flexibility on how the process is delivered within GM.

7.4 NHS England will retain the responsibility to publish the annual assessment of CCGs.

7.5 The GMCO will advise NHS England on the assessment and performance of each of the individual GM CCGs.

7.6 The GMCO will deliver the legal assessment requirements of NHS England and the NHS requirements outlined in the NHS Constitution and Mandate.

7.7 NHS England retains the right to intervene in prescribed circumstances as set out in Appendix 1 – further, GMH&SC will support NHS England in providing a direct line of sight on operational performance issues to the Secretary of State as and when required.

7.8 GMH&SC will determine the structure of its System Resilience Groups and how to ensure resilience across the elements of each system to include elective and non-elective services.

7.9 GMH&SC will participate in the moderation process and provide evidence as required.

8. CCG Assurance Delivery

8.1 NHS England will meet quarterly with the GMCO to ensure that the NHS Constitution and Mandate commitments are being met in full by GMH&SC as an aggregate. In exceptional circumstances additional meetings may be required.

8.2 GMH&SC will agree internally how it will manage delivery of the NHS constitution and mandate across GM and how it will work with other regulatory bodies, in particular NHS Improvement to support this.

8.3 Where GMH&SC is not delivering the requirements of the NHS Constitution and mandate at an aggregate level the GMH&SC team will set out for the regional team its proposal for improvement. Required actions could include:

- Improvement/recovery plan
- Monitoring of the standard at a different frequency (eg monthly)
- Requirement for GM to seek further prescribed support to secure recovery

8.4 When an individual CCG performance is outside of the normalised range (Appendix 1), the GMCO will seek to resolve and inform NHS England Regional team of progress. In the instance of sustained non-delivery, GMH&SC and NHS England will consider next steps and the potential to exercise NHS England powers of intervention. In the first instance this may include:

- An individual CCG being required to attend the quarterly review
- The request for an individual CCG to attend a regionally convened meeting
- The request for both CCG and provider to attend a tripartite meeting with NHSE and NHS improvement

8.5 If GMH&SC wishes NHS England to exercise its wider powers of intervention under section 14Z21 of the NHS Act 2006, they will be required to evidence reasons and to request from NHS England the ability to use those powers, eg dissolution powers.

8.6 Where individual CCGs are consistently outside the normalised range (Appendix 1) on performance standards, then GMH&SC will manage improvement in partnership with the regulatory bodies. In cases where improvement has not been realised then GMH&SC can seek additional improvement support from NHS England regional team.

8.7 The GMCO will continue to notify the NHS England regional team of any Never Events or 12 hour breaches within the timescales specified.

8.8 The GMCO will provide additional ad hoc briefings as required for example for Department of Health meetings

8.9 From time to time, NHS England will require GMCO (and where agreed with ALBs, whole health economies) to submit additional plans and information for assurance during the year.

9. Finance

9.1 A separate financial framework for GM has been developed to operate in 2016/17 – this covers delegated budgets, planning rules, financial assurance processes and transition arrangements. The following points are drawn from that more detailed framework.

9.2 GMH&SC will be required to demonstrate to NHS England progress against the milestones set out in the 5 year Greater Manchester clinical and financial sustainability plan.

9.3 Each year NHS England publishes the financial business rules that CCGs and NHS England Direct Commissioning functions must comply with. These rules currently include the requirement to maintain the surplus carried forward from the previous year or 1% whichever is the greatest,to plan for a 0.5% contingency, to ensure that 1% of total allocations are set aside as a system risk reserve and to apply national PbR choice and competition rules. The draw-down of prior year surpluses is agreed within a national control total on an organisation specific basis.

9.4 The principles behind these rules are to promote good financial control and management and to set controls which will help ensure the commissioning system remains within its overall affordability envelope.

9.5 NHS England will therefore set an overall GMH&SC wide control total for drawdown of prior year surpluses and GMH&SC will manage the distribution of that control total within its individual CCGs.

9.6 Subject to the agreed drawdown of prior year surpluses GMH&SC will be required to maintain at least an aggregate 1% carried forward surplus from one year to the next. GMH&SC will manage the level of contribution required from each individual CCG, subject to any additional negotiations with NHS England and other ALBs as indicated by paragraph 44 of 'Delivering the Forward View – NHS Planning Guidance 2016-21'.

9.7 GMH&SC will be required to manage the use of drawdown and the requirement to maintain a carried forward surplus at individual organization level to ensure the continued financial sustainability of individual CCGs as well as the overall aggregate position. The requirements of the national business rules will be delivered in aggregate on a GM basis with the split to be determined by GMH&SC.

10. Performance reporting

10.1 An agreed suite of performance reporting products will be made available by NHS England to GMH&SC. Composite reports on the delivery of the NHS constitution and mandate across GM CCGs, together with a draft agenda and a schedule of key lines of enquiry, will be provided by NHS England to GMH&SC a week in advance of quarterly review meetings.

10.2 Where the GMH&SC team is managing NHS England functions and staff, they will have access to all NHS England databases subject to Information Governance compliance.

11. Quality and safety

11.1 NHS England Regional team will require assurance in respect of quality and risk, and that robust systems and processes are in place. In order to provide that assurance, the following systems are in place and should be maintained at a GM level:

11.2 **Quality surveillance Group (QSG**). Expectation that this will be maintained as a requirement of the National Quality Board. GMH&SC will be represented at QSG to allow system oversight and thematic issues across GMH&SC and country wide. It will also facilitate the instigation of single item QSGs and risk summits where there are heightened concerns about a provider.

11.3 As part of this process it is expected that the work streams in relation to the following work streams would also be maintained:

- Direct Commissioning QSG-Sub group
- Monitoring and reporting of quality metrics including serious incidents, incident management, Health Care Associated Infections (HCAIS), never events, Hospital Standardisation Mortality Ration (HSMR) / Summary Hospital level Mortality (SHMI) and staff surveys as part of an early warning system and ongoing quality monitoring. The impact on quality for patients who have breached A&E waiting times standards are also considered within these metrics.
- Collaboratives to maintain CCG and clinical engagement for quality – Infection Prevention and Control, Safeguarding, Quality and Safety, Practice Nurses and Continuing Health Care (CHC) all report directly to QSG.

12. Decision making

12.1 It is required that GMH&SC maintains a formal decision log and that all decisions made in exercising NHS England functions within the agreed scheme of delegation will be reported to the NHS England Regional team on an agreed basis.

13. Risk Register

13.1 There is an expectation that GMH&SC will develop a risk register which captures top risks within the system and share this register and appropriate mitigations with NHS England as part of the quarterly review meetings.

14. Further devolution - Risk and Mitigation

14.1 The arrangements described within this document will stand for year 1 of devolution in GM. As the model of devolution rises towards full devolution, the

agreement will need to be updated and amended.

14.2 During 2016/17, a full assessment of risk arising from further devolution, and a robust mitigation plan, will be developed to ensure that quality, safety and finances are protected within the revised accountability arrangements

UPDATE – *HEALTHIER TOGETHER* IMPLEMENTATION PLANNING – SOUTH EAST SECTOR

- Since judgement was made in January, upholding the *Healthier Together* decision at judicial review, the Greater Manchester Team has now strengthened its central arrangements for oversight and assurance of the implementation process. (Eastern Cheshire are represented at Programme Board level).

- Correspondingly, each of the four Sectors in Manchester has progressed with establishment of its own programme management arrangements.

- In the South East Sector of Manchester, the mandate provided by the *Healthier Together* decision relates directly to providers and commissioners in Stockport and Tameside, and they are required to develop plans to implement the agreed service models and achieve the *Healthier Together* best practice standards, within a "single service" grouping – that is, through combined teams of consultant (and other) staff, working cross-site where necessary.

- Eastern Cheshire CCG and Trust have opted to participate in the South East Sector programme in respect of General Surgery only, and North Derbyshire CCG are also key partners, in view of the significant flow of their residents into Greater Manchester (and some to Macclesfield) from the area north of Buxton.

- A revised programme structure has now been put into place. This includes a Programme Board on which all relevant Chief Executives are represented, a senior officer Programme Management Group, and a Clinical Leadership Group, comprising the Programme's Clinical Director, Specialty Leads and Medical Directors.

- Clinical Workstream groups, covering the scope *of Healthier Together* have been designated – in General Surgery, Diagnostics, Acute Medicine, A&E, Critical Care and Anaesthetics. There are also groups established to work through, for instance, the Manpower/HR implications, Finance and Contracting, and Communications.

- The Senior Responsible Officers for the Programme are Ranjit Gill, Chief Executive of Stockport CCG (Commissioner), and Ann Barnes, Chief Executive of Stockport FT (Provider). The Interim Programme Director is Ann Schenk, identified from the workforce at Stockport FT.

- The most significant changes within the *Healthier Together* model relate to General Surgery. It is intended that Stepping Hill Hospital (the hub) will become one of four centres in Manchester for the management of high risk/complex emergency and elective general surgical cases. Suspected emergency surgical cases picked up by Ambulances in the Sector will be taken to the nearest of these four sites. Stepping Hill will, therefore, receive directly (via ambulance) known or suspected high risk general surgical emergencies. It will also receive transfers of such cases identified at its partner sites. In terms of high risk elective abdominal and colorectal surgery, the model also anticipates that these would be concentrated in the hub.

- Local sites would be expected to maintain services for lower risk cases, within a model providing daily hot clinics, day case/low risk admission and local outpatient and diagnostic capability. Appropriate capacity and skills will be maintained in all parts of the network through operating in a "single service" model. Within the Greater Manchester *Healthier Together* model,Tameside DGH and Stepping Hill Hospital will havea full A&E service.

- To date, in the South East Sector, it has not been possible to reach agreement among clinicians on the appropriate distribution of casemix and services between the hub (Stockport) and local (Tameside and Macclesfield) sites. This is because there are varying views on the definition of "high" or "low" risk conditions, and of the services needed to support them.

- It is essential, however, that the Sector reaches a settled view promptly. Without this, it is not possible to progress to understanding in detail the impact on co-dependent services, the manpower planning, activity or financial projections, capacity planning etc. which will underpin the implementation plan.

- A process has now been proposed that will enable a detailed evaluation of a small number of alternative models for General Surgery. A key dimension will be the ability of any one model to deliver the best practice standards set out in *Healthier Together*. Clinical views on the options will be sought from the cross-trust General Surgical Working Group and, ultimately, the Programme Board will be asked to determine the way forward.

- The first draft timeline for the South East Sector Programme envisages initial implementation from April 2017. This may be changed as more detail becomes available, but it serves to highlight the pressing need for some very concentrated work in the coming months in order to confirm the model, produce a detailed analysis, statement of case and

costings, and implementation plan, by July this year. The governing bodies of each partner in the Sector will be asked to endorse the case.

- In the meantime, a Memorandum of Understanding is in draft, formalising each party's engagement in the process. This will receive early consideration by this Board.

- A proposal will also shortly be finalised for the resourcing needed to support the implementation programme. At that point this organisation will need to consider any call on a local contribution.

- It is worth remembering that, at its heart, this work is intended to establish new ways of working which will underpin a more widespread and consistent delivery of best practice standards, and through that means, better outcomes for surgical patients. The evidence described by *Healthier Together* estimates that greater centralisation and specialisation for high risk cases in GM would save about 300 lives per annum. Although a number of sites, like Macclesfield, have clinical outcomes in surgery that measure very favourably with national comparisons, there are no sites in *Healthier Together* that currently achieve the full range of standards, particularly in respect of senior medical presence, and, looking forward, sustainability is a serious concern, given manpower and financial constraints.

22/3/16

NHS
Stockport
Clinical Commissioning Group

Response to the Public Health Annual Report 2015/16

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900
Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
This report highlights the responses of the CCG to the relevant recommendations included within the Public Health Annual Report 2015/16. Governing Body is requested to approve the responses for action and endorse the content of the report.
Please detail the key points of this report
The Annual Public Health Report is an independent professional report of the Director of Public Health to the Council, the NHS and the people of Stockport. The presentation version (appended to this report) includes the new material for this year. It fulfils the function that an Annual Public Health report usually fulfils at this point of the cycle, to consider specific issues and make a set of recommendations for the year. The subjects covered this year are: •Behaviour change •Top Ten for Number Ten, the manifesto produced in July 2014 by the North West Directors of Public Health •Some additional material on the NHS and social care The CCG's suggested responses to the recommendations are appended to this report.
What are the likely impacts and/or implications?
The content of the Public Health Annual Report is a guiding document for the CCG in promoting public health aims and ensuring that prevention is a key thread of its commissioning activity.
How does this link to the Annual Business Plan?
Public Health outcomes are a key part of the CCG's Business Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
N/A
Clinical Executive Sponsor: R Gill
Presented by: V Owen Smith
Meeting Date: 27 April 2016
Agenda item:

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

22nd Annual Public Health Report for Stockport 2015/16

PRESENTATION VERSION

NHS The Council's public health duties are part of the comprehensive health service established under the National Health Service Acts

22nd Annual Public Health Report for Stockport - 2015/16

Versions of the Report

The Annual Public Health Report is an independent professional report of the DPH to the Council, the NHS and the people of Stockport.

This year two versions of the Annual Public Health Report have been prepared.

The full version, which appears on the Council website in electronic form, consists of five levels:

- Level 1 is a series of tweets.
- Level 2 is an overview with a paragraph on each chapter.
- Level 3 is a series of key messages with about a page (sometimes two or three) for each chapter.
- Level 4 has a full descriptive analysis for each chapter.
- Level 5 includes supplementary information.

Level 1 commenced being tweeted in August 2015 and will continue until March 2016

Levels 1, 2, 3, 4 and 5 are now on the Council website at
http://www.stockport.gov.uk/services/socialcarehealth/healthandwellbeing/publichealth/

Level 5 will be further developed after the Joint Strategic Needs Assessment 2015/16 has been completed.

This full version of the report has been designed for use as an electronic process in which people can start with the tweets or overview and then choose when they wish to go to the more extensive material.

Much of the full version is simply the 21st Annual Public Health Report with tweets added and with updated tables and figures although there are some significant new materials (see below). The 21st Annual Public Health report was a comprehensive account of the health of the people, which I usually only produce once every five years. The presentation of it in three levels was much welcomed hence the decision to add two more levels and to tweet it.

The **presentation version** includes the new material for this year. It fulfils the function that an Annual Public Health report usually fulfils at this point of the cycle, to consider specific issues and make a set of recommendations for the year.

The subjects covered this year are

- Behaviour change
- Top Ten for Number Ten, the manifesto produced in July 2014 by the North West Directors of Public Health
- Some additional material on the NHS and social care

Contents & Overview

I ask local MPs and political parties to press for reversal of the Government's abandonment of a minimum unit price for alcohol and also for plain packaging of tobacco products.

I ask that all schools have a programme of SRE consistent with best practice guidance.

I advise individuals to follow the Five Ways to Well Being. I also ask them to stop smoking, drink sensibly, eat a healthy diet, be physically active, maintain a healthy weight, make use of NHS preventive services such as vaccination and screening, take sensible steps to avoid accidents and infections, deal with stress, keep good social relationships and have fun.

Behaviour Change

Return to contents

Behaviour Change : Tweets

- People's behaviour is affected by over 100 well-recognised predictable errors of perception, called cognitive biases
- People overassess risks they have often heard of and underassess risks that are imprecise and unclear
- People value things they have and might lose twice as much as they would value gaining them anew (loss aversion)
- Loss aversion means that the downsides of change will be perceived more clearly than the benefits
- Asked if something is worth more or less than X they will subsequently value it more highly the higher X
- This is true even if they know X to be random e.g. the last four digits of their telephone number
- We must see healthy behaviour as normal. Most people most of the time on most issues do what they think is normal
- Role models and welcome messages are important in presenting behaviour as normal
- Resetting what happens in default of an active choice can help protect people from cognitive biases
- Michie's behaviour change wheel helps identify influences on behaviour
- We must be as sophisticated in helping people do what is healthy as commercial marketers are in selling products
- People may have a right to harm themselves. That doesn't create a commercial right to persuade them to do so
- Rules can strengthen people's resolve to do what they know they ought to do

Behaviour Change : Key messages

Most of our systems of politics, economics, governance and supportive advice have traditionally operated on the assumption that people behave rationally and that when they seem to be behaving irrationally it is because of constraints that prevent them making the sensible choice. This view was shown to be wrong by the psychologist Thomas Kahnemann. For this work he won a Nobel Prize. It launched an entire new branch of economics (behavioural economics).

He showed that human beings have two systems of thought. One of these is a rational system with which people engage in the figuring out of problems. This is mentally demanding. In fact it is so mentally demanding that people cannot both think in this mode and walk quickly at the same time. The other is a much quicker system based partly on some hard wired evolutionary traits, partly on experience and partly on perception. The problem is that this system contains some predictable perceptual inaccuracies which lead to people making incorrect decisions.

For example

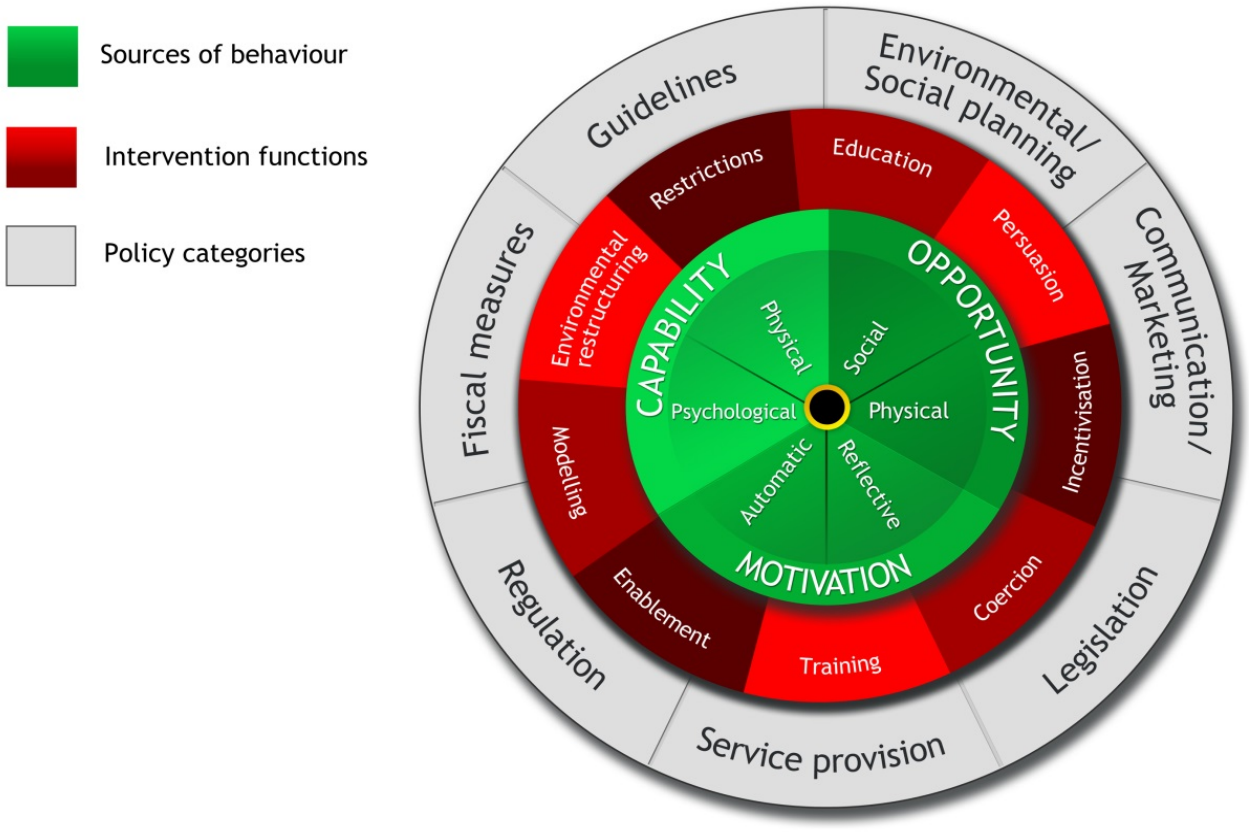
- Asked to assess the likelihood of a flood killing more than 1,000 people in California due to an undersea earthquake and, later in the same questionnaire, the likelihood of a flood killing more than 1,000 people somewhere in America, people will assign a higher likelihood to the flood in California from a specific cause than they will to the flood anywhere in America from any cause. A moment's thought will reveal that this is irrational since every flood in California from an undersea earthquake is also part of the category "a flood somewhere in America from any cause." People overassess the likelihood of risks that they have heard of and are familiar with and underassess risks that are imprecise and unclear.
- Asked firstly whether something is worth more or less than X and then what it is actually worth, the higher the value of X the higher people will value the object. This is true even if they know that X is a random number. It is true even if they were asked to use the last four numbers of their telephone number as X.
- Given £20 and told that you must either pay £5 or gamble on whether to lose £10, which would you do? Given £10 and told you can either be given another £5 for certain or can gamble on being given £10, which would you do? These are identical gambles – each is a choice between a certainty of £15 or a gamble between £10 and £20. But more people will gamble in the former formulation than in the latter. People are more averse to loss than they are receptive to the chance of gain. About twice as much.
- Monkeys were trained to trade tokens for food and provided with an expensive provider who sometimes gives more than they should have had or alternatively a cheap provider who sometimes gives them less. The

occasional loss was more than made good by the cheaper price but they still chose the more expensive provider. Loss aversion is therefore a hard wired instinct that evolved tens of millions of years ago.

These are just three of the cognitive biases that have been described. There are over a hundred.

Most people would be able to recognise how these three cognitive biases are each used in marketing. Yet they would be hard put to name any instance of them being used in altruistically motivated public service behaviour change campaigns. We owe it to people to speak to them as they are, not as some theory tells us they should be.

Michie et al have linked the various influences on behaviour in a model called the Behaviour Change Wheel



Key points for us to remember are

- Loss aversion means that the downsides of change will be perceived more clearly than the benefits.
- It is important to present the preferred behaviour as normal. Most people most of the time on most issues do what they think is normal.
- Welcome messages can help do that – for example notices saying “You are welcome to breastfeed here” can help breastfeeding mothers overcome a sense of embarrassment.
- Conversely restrictions can help present an activity as abnormal.
- Rules which are difficult to enforce can nonetheless be highly effective if they push with the grain of what people know they ought to do (e.g. seat belt legislation, smoke free areas) because they normalise behaviour. However this doesn’t work if they don’t push with the grain and people think they are just irksome rules.
- Role models are also important in presenting behaviour as normal.
- Default arrangements which make the right choice normal and force people to make an active choice in order to behave differently are highly effective. This could be something as simple as providing the diet drink automatically unless the sugary version is requested, instead of the other way round. Or sending out public transport details for how to get to something with a note saying “Information for travel by car available on request.”
- Campaigns which help people see that they are not alone, and that they can make change, fulfil a number of purposes – normalisation, bandwagon creation, mutual support, opportunities for collaborative action

Behaviour Change: Full Analysis

Behaviour change is central to many health objectives. We need to persuade people to adopt healthier behaviours, to use health services more effectively, to act in ways which improve the environment and promote the health of others, to reduce the demand made on hard-pressed services, to help others.

Most of our systems of politics, economics, governance and supportive advice have traditionally operated on the assumption that people behave rationally and that when they seem to be behaving irrationally it is because of constraints that prevent them making the sensible choice. This view was shown to be wrong by the psychologist Thomas Kahnemann. For this work he won a Nobel Prize. It launched an entire new branch of economics (behavioural economics).

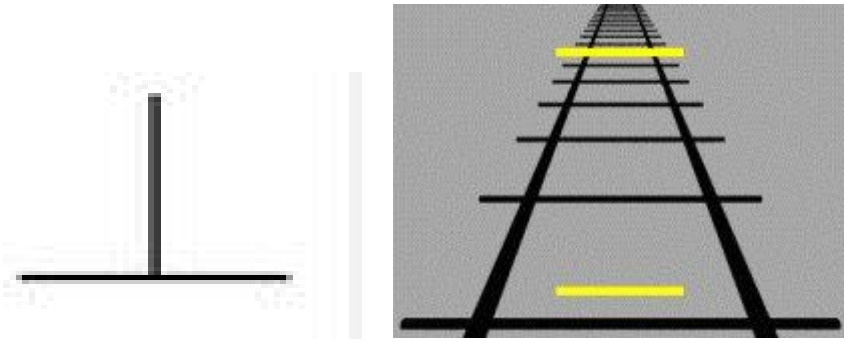
He showed that human beings have two systems of thought. One of these (system 1) is a rational system with which people engage in the figuring out of problems. This is mentally demanding. In fact it is so mentally demanding that people cannot both think in this mode and walk quickly at the same time. The other (system 2) is a much quicker system based partly on some hard wired evolutionary traits, partly on experience and partly on perception. The problem is that this system contains some predictable perceptual inaccuracies which lead to people making incorrect decisions.

Misperception

People can be misled by misperception.

Visual illusions are an example

On the left the vertical line looks longer than the horizontal one but in fact they are the same length.



On the right the upper line looks longer than the lower line because the brain thinks it is further away but in fact they are the same length.

From Misperception to Cognitive Bias

The misperceptions in system 2 are similar to these simple visual illusions but go much further and they affect the way people interpret and apply their experiences. This kind of misperception is called a cognitive bias.

For example

- Asked to assess the likelihood of a flood killing more than 1,000 people in California due to an undersea earthquake and, later in the same questionnaire, the likelihood of a flood killing more than 1,000 people somewhere in America, people will assign a higher likelihood to the flood in California from a specific cause than they will to the flood anywhere in America from any cause. A moment's thought will reveal that this is irrational since every flood in California from an undersea earthquake is also part of the category "a flood somewhere in America from any cause." People overassess the likelihood of risks that they have heard of and are familiar with and underassess risks that are imprecise and unclear.
- Asked firstly whether something is worth more or less than X and then what it is actually worth, the higher the value of X the higher people will value the object. This is true even if they know that X is a random number. It is true even if they were asked to use the last four numbers of their telephone number as X.
- Given £20 and told that you must either pay £5 or gamble on whether to lose £10, which would you do? Given £10 and told you can either be given another £5 for certain or can gamble on being given £10, which would you do? These are identical gambles – each is a choice between a certainty of £15 or a gamble between £10 and £20. But more people will gamble in the former formulation than in the latter. People are more averse to loss than they are receptive to the chance of gain. About twice as much.
- Monkeys were trained to trade tokens for food and provided with an expensive provider who sometimes gives more than they should have had or alternatively a cheap provider who sometimes gives them less. The occasional loss was more than made good by the cheaper price but they still chose the more expensive provider. Loss aversion is therefore a hard wired instinct that evolved tens of millions of years ago.

These are just three of the cognitive biases that have been described. There are over a hundred.

A list of them extracted from Wikipedia appears in level 5 of this chapter

Behaviour Change

These cognitive biases lead people to make incorrect decisions. After every train crash there are people who switch to the car instead, because train crashes are so unusual that the media will focus on them. Moving to a system which is so much less safe that the media doesn't even report the daily accidents isn't rational, but it is entirely predictable. It is the "California flood".

Stockport Council saves on insurance premiums by not insuring against risks under £500,000. Rationally it is better for a large organisation to bear these losses than to pay an

insurance premium to an insurer who will simply take a predictable rate of occurrence and add a profit to it. This rational calculation is unusual – loss aversion usually kicks in.

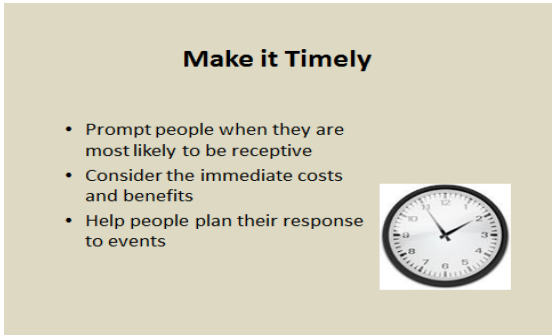
Most people would be able to recognise how the three cognitive biases with which we opened this section are each used in marketing.

Yet they would be hard put to name any instance of them being used in altruistically motivated public service behaviour change campaigns. We owe it to people to speak to them as they are, not as some theory tells us they should be.

It is sometimes suggested that for public service organisations to use such methods would be unethical. Why is it ethical to manipulate people into harming themselves for somebody else's commercial gain but unethical to manipulate people into benefiting themselves?

EAST

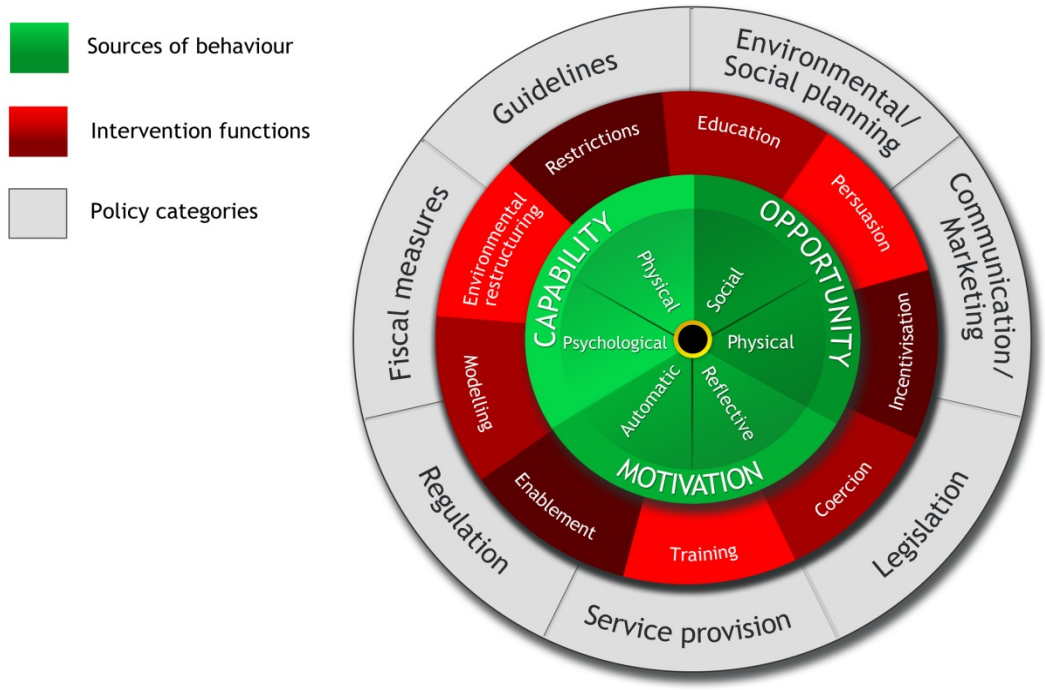
The name libertarian paternalism has been used to describe a model of behaviour change which leaves people free to act as they wish but puts in place arrangements which lead to most people doing the right thing most of the time. The EAST model summarises this.



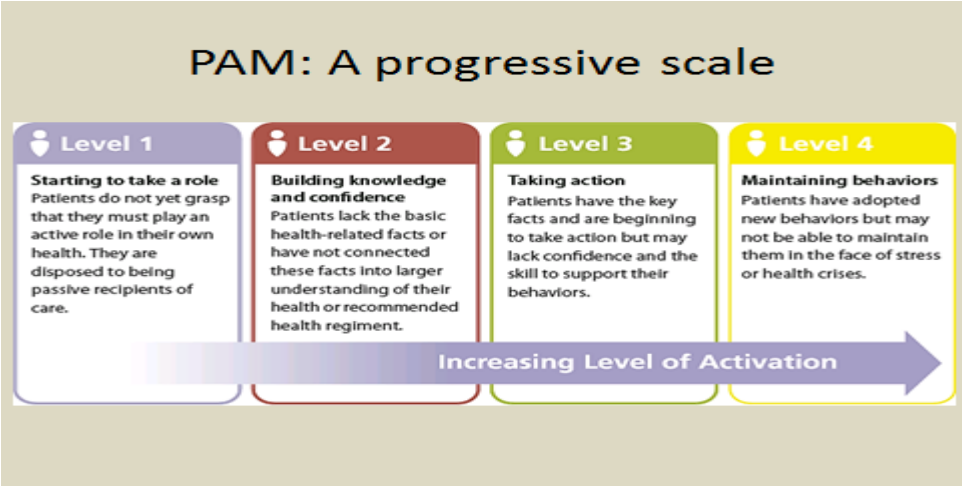
Other useful techniques favoured in this model include getting people to commit to something in the future rather than immediately (just as marketing offers free trials relying on the inertia selling of the post-dated direct debit), making sure that the best choices are most prominent (just as marketers pay for their brand to be prominently displayed in supermarkets) and creating bandwagons.

The Behaviour Change Wheel

Michie et al have linked the various influences on behaviour in a model called the Behaviour Change Wheel



Patient Activation



Measures which increase patient activation include developing skills and a sense of mastery, encouraging ownership of one's own health, stimulating autonomous motivation, using peer support, changes in social environment, coaching, education, and interventions tailored & targeted to PAM levels. This requires change in clinician perspectives and behaviour in relation to patients**.**

Technical or Adaptive Change

Technical or Adaptive Change

Technical: a tadpole can learn to swim faster and further around the pond (incremental change)

Adaptive: to come out of the pond a tadpole becomes a frog (radical change)

Personal and organisational development both require adaptive change to enable people to expand their horizons, respond to new situations and develop new understanding and skills…

… but our default is often to rely on technical changes

TECHNICAL PROBLEMS	ADAPTIVE CHALLENGES
1. Easy to identify	1. Difficult to identify (easy to deny)
2. Often lend themselves to quick and easy (cut-and-dried) solutions	2. Require changes in values, beliefs, roles, relationships, and approaches to work
3. Often can be solved by an authority or expert	3. People with the problem do the work of solving it
4. Require change in just one or a few places; often contained within organizational boundaries	4. Require change in numerous places; usually cross organizational boundaries
5. People are generally receptive to technical solutions	5. People often resist even acknowledging adaptive challenges.
6. Solutions can often be implemented quickly—even by edict	6. "Solutions" require experiments and new discoveries; they can take a long time to implement and cannot be implemented by edict
Implement electronic ordering and dispensing of medications in hospitals to reduce errors and drug interactions	Encourage nurses and pharmacists to question and even challenge illegible or dangerous prescriptions by physicians

The Six Es

EDUCATION – ensuring people know the facts about the consequences of behaviour is essential but it is not in itself enough.

ENCOURAGEMENT - supporting change and positively reinforcing it

ENABLEMENT – we must make it easy to change. The healthy way should be the easy way.

EMPOWERMENT - we must empower people to change by normalisation and by creating communities committed to change

ENGINEERING – systems and environments can be changed to support healthy choices

ENFORCEMENT – rules have their place

Implications for Strategy

Key points for us to remember are

- Loss aversion means that the downsides of change will be perceived more clearly than the benefits.
- It is important to present the preferred behaviour as normal. Most people most of the time on most issues do what they think is normal.
- Welcome messages can help do that – for example notices saying "You are welcome to breastfeed here" can help breastfeeding mothers overcome a sense of embarrassment.
- Conversely restrictions can help present an activity as abnormal.
- Rules which are difficult to enforce can nonetheless be highly effective if they push with the grain of what people know they ought to do (e.g. seat belt legislation, smoke free areas) because they normalise behaviour. However this doesn't work if they don't push with the grain and people think they are just irksome rules.
- Role models are also important in presenting behaviour as normal.
- Default arrangements which make the right choice normal and force people to make an active choice in order to behave differently are highly effective. This could be something as simple as providing the diet drink automatically unless the sugary version is requested, instead of the other way round. Or sending out public transport details for how to get to something with a note saying "Information for travel by car available on request."
- Campaigns which help p[people see that they are not alone and that they can make change fulfil a number of purposes – normalisation, bandwagon creation, mutual support, opportunities for collaborative action.

The difference between technical and adaptive change needs to be understood. Many of the major successes of public health have been adaptive changes which were ridiculed in their inception. Sewers were highly controversial – "The Times" once said that it would rather have the cholera than the hectoring of Dr. Snow. Children had always died in infancy – you just had more of them to make up for it. Women had always died in childbirth – just read any Victorian novel. Clean air was a ridiculous idea in the 1930s. Adaptive change needs to be pursued over a long time period beginning with making the case, then with encouraging

experiment, then with generalising those experiments and making new norms. A focus on short term immediate achievements, although important, must not lead us to fail to take the early steps towards the creation of future adaptive change. It is important that public health professionals are free to prepare the ground for future developments in policy, as our predecessors did. Here in Stockport that is fully understood, welcomed and defended. It is almost an uncontroversial statement. It deeply concerns me that there are many local authorities where this is not the case and there are serious concerns about whether it is the case in Public Health England.

Top Ten
for
Number Ten

Top Ten for Number Ten: Key Messages

Disraeli said that the health of the people is the first concern of Government. The following is the list of Ten Points for Number Ten adopted by the North West Directors of Public Health in July 2014

Priority 1:
Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health and social outcomes

Priority 2:
Introduce a sugar sweetened beverage (SSB) duty at 20p per litre to help address poor dental health, obesity and related conditions

Priority 3:
Commit to the eradication of childhood poverty to meet targets set by the Child Poverty Act 2010 and improve the health and wellbeing of all children

Priority 4:
Work with employers to increase payment of the living wage and introduce a higher minimum wage to improve quality of life, happiness and productivity in work

Priority 5:
Ban the marketing on television of foods high in fat, sugar and salt (HFSS) before 9pm to reduce children's exposure to unhealthy food advertising and improve diet choices

Priority 6:
Implement the recommendations contained within the "1001 critical days" cross party report to ensure all babies have the best possible start in life

Priority 7:
Implement tougher regulation of payday loan companies to improve the health and wellbeing of people with debts

Priority 8:
Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds

Priority 9:
Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing

Priority 10:
Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption

Top Ten for Number Ten: Full Analysis

The manifesto of the Directors of Public Health for the North West Ten Points for Number Ten" is reproduced exactly in the words in which it was produced in July 2014 (except for references, which have been omitted here but will appear at level 5). However after each of the priorities I have added a personal comment.

Foreword (written by Abdul Razzaq, Chair, North West Directors of Public Health Group)

One of the key elements of the Director of Public Health role is to provide population advice on behalf of their populations, and to advocate for evidenced based interventions at both a local and national level.

Our aim is simple. Collectively we are working to improve the health and wellbeing of individuals, families, communities, towns and cities. We are striving to address health equity and ensure that everyone has a fair chance in achieving their maximum potential and contributing towards their own wellbeing and that of others around them. Social capital and asset-based approaches are being pioneered in the North West with local residents leading the movement for change and control over their lives. However substantial health inequalities still exist in the North West and so national policy is also really important in helping us drive improvements in health for our populations.

There has been significant work undertaken over the last ten years on improving public health, for example with the implementation of the smoking ban, a government commitment to implement standardised packaging for tobacco, increases in seasonal influenza immunisation, and improvements in MMR vaccination uptake. However, there is still more work to do, for example the implementation of standardised packaging, and with continued discussions around price and taxation policies for both tobacco and alcohol.

It is with this in mind, and with the 2015 General Election on the horizon, that the North West Directors of Public Health have developed this public health manifesto, to provide a coherent set of top ten priorities for Local Authorities, NHS, Public Health England, policy makers, advocacy organisations and Government departments to consider for immediate implementation. The development of this North West public health manifesto also allows us to formally input into the national Association of Directors of Public Health (ADPH) and Faculty of Public Health (FPH) manifesto discussions.

The top ten priorities are based on a robust evidence-based approach that if implemented in full will result in improving the physical and mental health and wellbeing of the population, and reducing health inequalities, further and faster than current trajectories. Investment and implementation in the ten priorities will not only save countless lives but build a better quality of life for a new generation.

I look forward to your support and further dialogue on how we transform the manifesto into a charter and mandate for change in the best interests of the Public's Health.

Abdul Razzaq Chair, North West Directors of Public Health Group

Priority 1:

Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health andsocial outcomes

Alcohol related harm is a major public health concern in the UK. In England alone, the cost to the NHS is estimated at £3.5 billion per year. Current statistics indicate that 16% of men and 9% of women in the UK drink on five days per week, and 9% of men and 5% of women drink every day.

National surveys show that 27% of men and 18% of women drink more than double the government's lower risk guidelines for alcohol on at least one day a week (8 and 6 units respectively).

The harms associated with alcohol consumption are well-established. In 2010, over 21,000 deaths were caused by alcohol consumption, 5% of all deaths in England but the harmful consequences of alcohol consumption impact on a range of health, mental wellbeing and social outcomes at both a personal and societal levels. Evidence suggests that implementing minimum unit pricing for alcohol is an effective policy tool for reducing population levels of alcohol consumption and related harm amongst heavier drinkers without penalising moderate drinkers. Modelling of the impact of a minimum price of 50p per unit suggests it would reduce consumption by 7% in England and by 6% in Scotland In England it is predicted that over time this would reduce alcohol-related deaths (3,060), hospital admissions (97,700) and crimes (42,500).

My comment I support this entirely. Another possibility, theoretically preferable but probably impossible to organise, would be to issue people with a Smartcard allowing them to buy a healthy amount of alcohol tax free and then hugely increase the taxation on alcohol purchased beyond that.

Priority 2:

Introduce a sugar sweetened beverage (SSB) duty at 20p per litre to help address poor dental health, obesity and related conditions

SSBs include any drink that has sugar added to it. SSBs make up 39% of all soft drink consumption in the UK, with overall consumption estimated at 92 litres per person per year. SSBs are the most frequently consumed beverage for those aged 4-18 years and intake is particularly high amongst adolescent. A range of poor health outcomes are strongly associated with intake of SSBs including being overweight and obesity, cardiovascular disease, type 2 diabetes, hypertension and dental caries. Childhood SSB consumption has been identified as a factor contributing to adult obesity.

There is evidence to suggest that a 20% price increase for SSBs would be acceptable to 52% of the population. Assuming that price rises are passed on to the consumer, it is predicted that a 20% tax on SSBs would lead to a reduction in purchases, and therefore in overall consumption and daily energy intake. In the UK it has been estimated that this would lead to reductions of 1.3% (180,000 people) in the prevalence of obesity and 0.9% (285,000 people) in the number of people overweight, with the greatest effects likely to be seen among young

people With additional anticipated benefits for dental health from reduced sugar consumption and no downsides for health from drinking less SSBs, a tax on SSBs has clear benefits as a policy tool for improving public health.

My comment I support this entirely. Concern has been expressed that such a tax would be regressive but this objection could be overcome if the proceeds were fed back into measures to improve low incomes.

Priority 3:

Commit to the eradication of childhood poverty to meet targets set by the Child Poverty Act 2010 and improve the health and wellbeing of all children

An estimated 3.5 million children in the UK, 27% of all children, live in poverty. An estimated 2.5 million live in damp housing,1.5 million live in households that cannot afford to heat their home and over half a million are from families who cannot afford to feed them properly. Growing up in poverty impacts on life chances and is associated with delayed cognitive development, lower school achievement and unemployment, low income work and unskilled jobs in adulthood. Children in poverty are at increased risk of a range of poor health and social outcomes including adverse birth outcomes, obesity, diabetes, asthma, mental health problems and reduced access to healthcare. Children of persistently poor parents are at risk of becoming poor adults themselves and any children they have are at risk of growing up in poverty.

The Child Poverty Act (2010) includes two targets to be achieved in the UK by 2020:

(i) less than 10% of children in relative poverty, and
(ii) less than 5% of children in absolute poverty.

While the Government have introduced policies to improve outcomes for children in poverty, current evidence indicates that these targets will be not achieved and even with higher employment and benefit maximisation, projections suggest these targets could not be reached. It is clear that new ambitious actions across policy domains are needed to tackle child poverty to meet the targets of the 2010 Act and to improve health, wellbeing and social outcomes for children.

My comment. Since this was written the Government has recast these targets downwards. Child poverty has long-lasting impacts on the health of those affected. I am deeply concerned by these effects on future generations.

Priority 4:

Work with employers to increase payment of the living wage and introduce a higher minimum wage to improve quality of life, happiness and productivity in work

The Living Wage is an hourly wage, calculated to provide an acceptable standard of living to employees and their families and it is currently optional for UK employers to pay a living wage.

The Living Wage is set at £7.65 per hour outside of London in comparison to the National Minimum Wage of £6.31 per hour for workers aged over 21. It is estimated that

over 5 million people in the UK, or one in five employees, earn less than the Living Wage. The proportion of UK workers in low-paid work is higher than the average for other OECD countries, behind only the USA.

Lower income leads to reduced ability to afford essential goods such as food, clothing and heating, reduced participation in social activities and increased debt. This can have a clear impact on the mental wellbeing and physical health of adults and children. Being paid the Living Wage has been associated with increased mental wellbeing and financial benefits in comparison to workers remaining on low pay. Employers also benefit from implementing the Living Wage through increased worker productivity and reduced staff turnover. Wider implementation of the Living Wage and raising the national minimum wage are thereforeessential policy tools for improving the quality of life of the UK's lowest earners.

My comment:-

I would strongly congratulate the Government on increasing the National Minimum Wage.

The term "The Living Wage" in the above description was written before the term "the Living Wage" was appropriated to mean simply the National Minimum Wage. It is unhelpful when meaningful terms are redefined to have a different meaning, especially when there was already a term for the new meaning. The term The Real Living Wage is emerging to have the meaning that was used in this paragraph, although I would prefer it if a less value-laden term were available. I strongly support the idea that people should be paid the Real Living Wage.

Therefore whilst the Government is to be congratulated on the steps it has taken it needs to go further.

Priority 5:

Ban the marketing on television of foods high in fat, sugar and salt (HFSS) before 9pm to reduce children's exposure to unhealthy food advertising and improve diet choices

The obesity crisis in the UK is well documented and likely to worsen in the future, with an estimated 50% obesity rate by 2050 at a cost of £50 billion a year. Currently around one third of 10-11 year olds are overweight with estimated obesity levels at 19%. Furthermore an estimated 9% of 4-5 year olds are thought to be obese Childhood obesity predicts obesity during adulthood and is associated with onset of diseases including diabetes, hypertension, heart disease and stroke.

Evidence supports the influential effect of food marketing on children's food preferences and consumption. Despite a UK ban on advertising HFSS foods in programmes made for children, a recent study showed that the level of exposure of children to television food advertising for HFSS foods has not reduce. One reason may be that children are likely to watch programmes that also attract an older audience where advertising of HFSS foods is still permitted.

Further measures are therefore required to reduce children's exposure to unhealthy food advertising. NICE guidance recommends that restrictions on the television advertising of HFSS foods be extended until 9pm, with evidence suggesting that such action could reduce exposure amongst children by 82%. A ban on advertising of HFSS foods on television before 9pm is therefore an essential policy priority in helping children make positive and healthy food preferences and choices.

My comment:- Proposals like this are sometimes described as "the nanny state" but protection of children raises quite different questions from those affecting adults and in any case a right to harm yourself does not give rise to a right, for purely commercial motives, to persuade other people to harm themselves.

Priority 6:

Implement the recommendations contained within the "1001 critical days" cross party report to ensure all babies have the best possible start in life

The first few years of life are a critical period for a child's development.

In 2013, over 5,500 children unborn or under the age of one in the UK were the subject of a child protection plan, and the NSPCC estimates that a quarter of all babies in the UK have a parent affected by domestic violence, mental health issues or drug and alcohol problems. Evidence indicates that half of all adults in England suffer at least one adverse childhood experience with 9% suffering four or more.

Between birth and two years of age, a baby's brain grows from around 25% to 80% of its adult size. While there are many factors that influence brain development, one of the main drivers of this policy approach is the belief that infants that are neglected, abused or exposed to stress are less likely to develop connections in the brain that support healthy social, emotional and cognitive development. Exposure to adverse experiences in childhood is associated with a wide range of health-harming behaviours in later life and to poor physical and mental health outcomes.

Interventions that develop secure attachments between infants and their caregivers are viewed as the key tools in this policy area; evidence suggests they support maternal mental health, promote positive parenting and can generate long-term cost savings. Health visitors can reduce post natal depression, while home visiting programmes (e.g. Nurse Family Partnership) for at risk mothers can improve health-related behaviours in pregnancy, reduce child maltreatment and childhood injuries, and reduce mental health problems, substance use and criminal behaviour in adolescence. Parenting programmes have shown positive impacts on both parent and child behaviours, particularly in reducing child conduct problems

My comment I entirely support these cross party proposals

Priority 7:

Implement tougher regulation of payday loan companies to improve the health and wellbeing of people with debts

It is estimated that between 7.4 and 8.2 million payday loans were arranged in the UK in 2011/2012 at a value of £2-2.2billion. A payday loan is a short-term and unsecured loan repaid at a high interest rate in full on a fixed date. Such loans are seen as attractive due to very short approval periods from easily accessible lenders. The average cost of borrowing has been estimated at £25 per £100, but additional costs are accrued for transmission of funds and for late payments, which occur in approximately one in five loans.

Financial difficulty is a widespread issue for people who use payday lenders and being in debt is associated with the development of a range of mental health problems including anxiety, stress and depression.

In addition seekers of short-term loans are more likely to have a low income and be in poverty, which further compounds the negative health outcomes for these individuals and their families. For those borrowing money, high interest rates and additional costs are likely to increase debt and financial insecurity, which may create a cycle of further debt and use of money lenders.

The Government has recognised the problems caused by easily accessible and harmful payday loans and new regulations imposed by the Financial Conduct Authority are expected to reduce the number of payday lenders. It is important that the impact of new regulations is closely monitored and that tougher regulations are introduced in the future if required. While regulation of payday loans is an important policy tool, as options for payday loans are reduced it will be important to encourage responsible money lending across other sources of shortterm, high-cost credit, and to consider how other measures can improve access to credit and savings, and debt management advice, particularly for those on low incomes.

My comment:- As noted in the recommendation some progress has been made but needs to be monitored.

Priority 8:

Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds

Current UK guidelines recommend that children participate in moderate activity for at least 60-minutes every day, and vigorous activity on at least three days per week. Current data show that only 21% of boys and 16% of girls aged between 5 and 15 years in England, reach the recommended level. Physical inactivity is a significant risk factor for obesity and several related chronic health diseases including type 2 diabetes, coronary heart disease, stroke and certain cancers. Being overweight in childhood is associated with a number of health problems, both during childhood and in later life.

Policy action is therefore required to reduce the future burden of ill health arising from physical inactivity. For each inactive child who reaches the recommended activity levels, savings are

estimated at £40,000 over the lifetime through reduced healthcare costs4. For school-aged children, physical activity not only improves physical health, but has positive implications for behaviour, attitudes and academic achievement.

Children up to the age of 16 spend up to 45% of their waking time at school during term-time, and as a consequence schools provide the optimum opportunity for influencing and promoting health and health behaviours in children.

My comment It is especially important to note that physical activity improves educational attainment so eliminating it to "make more time for lessons" is wholly counterproductive.

Priority 9:

Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing

Active travel incorporates physical activity into daily life. In 2012 only 39% of all urban trips under five miles made in England were by cycling or walking, with the average number of walking trips in the UK decreasing by 27% in 2012 from 1995/961. Cyclists and pedestrians in the UK can be deterred by lack of facilities and misperceptions of poor road safety, while a perception of expensive fares and inconvenience (in comparison to car use) reduces use of public transport. Transport methods are strongly linked with a wide range of public health outcomes.

In the UK an estimated 67% men and 57% women are overweight or obese and physical inactivity contributes to obesity and a number of chronic conditions.

Emissions from cars reduce air quality and contribute to noise pollution and climate change with 25% of the total

UK emissions of carbon dioxide estimated from road emissions.

Amongst young males, driving is associated with increased fatalities in comparison to methods of active transport.

Increasing levels of habitual physical activity by creating local environments where walking and cycling are safe and attractive, and facilitating use of public transport has therefore emerged as an important area of public health policy. Local policies can have a significant impact on the quality of the local environment as well as the health and wellbeing of residents. Nationally, a scenario of increased active travel, with subsequent reduced car use, produces estimated savings of £17 billion over 20 years through reduced spending on non-communicable diseases including type 2 diabetes, cardiovascular diseases, cancers,dementia and depression.

My comment I agree entirely.

Priority 10:

Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption

Front of pack labelling is viewed as an effective means of providing consumers with information to help them make informed decisions about their diet. In the UK, food manufacturers and supermarkets can currently opt in to the 'traffic light' front of pack labelling system for pre-packed food. Back of pack standardised labelling will be compulsory for all pre-packaged foods throughout the European Union by 2016. A voluntary agreement on alcohol labelling currently exists in the UK with information provided on unit content, drinking in pregnancy, and the daily benchmarks.

Excessive consumption of pre-packaged foods and alcohol is contributing to the rising health burden from non-communicable diseases such as diabetes, cancer and cardiovascular disease. The use of different measurements across food labels and technical information can make information difficult to understand and inconsistent food labelling is associated with the consumption of too much sugar, fat and salt. Accurate tracking of alcohol intake requires knowledge of the alcohol content of different drink servings and evidence suggests that, on the whole, people who drink lack such an understanding3.

Through simplifying and standardising labelling on all pre-packaged food, consumers will be better placed to make comparisons between products and make decisions based on accurate nutritional knowledge. Standardised front of pack labelling is therefore viewed as an important policy tool to help improve dietary choices among the population. Evidence suggests text-based alcohol labelling has little impact on drinking behaviour and public health advocates have therefore called for clear and factual health warning labels on alcohol products, similar to the mandated warnings found on tobacco products

My comment It is very important that people have proper information and find it easy to identify the healthy choice.

Health & Social Care:
Further Change, Further Plans

Health & Social Care : Further Change, Further Plans – Key Messages

CHANGE IN THE HEALTH SERVICE

2013 Structures

The health service was radically reshaped in 2013.

I particularly welcomed:

- The transfer of public health to the local authority;
- The creation of the Health and Well Being Board as a committee of the local authority providing a single focus for strategic oversight within a democratically accountable context;
- The strong clinical input into commissioning and extra power given to GPs.

I did however have six matters of concern.

- I am concerned that procurement bureaucracies may undermine the new structures.
- I am concerned that Health and Well Being Boards have inadequate powers
- I have always believed that the distinction drawn between the health service and social care is artificial and that they would be better combined.
- I am deeply concerned at the absence of any local structure responsible for general practice.
- The Government has drawn a totally new distinction between “the health service” and “the NHS” with public health being described as part of the health service but not of the NHS. I believe this will cause confusion.
- Although clinical commissioning is a step back towards Nye Bevan’s vision of a family of health professionals, there is no corresponding step in providers.

Commercialisation

For the last two decades a process of private sector involvement in the NHS has been under way, now institutionalised and accelerated in the Health & Social Care Act 2012, in a way which will inevitably accelerate it further. It doesn’t matter to a person receiving care whether they get it from a state employee or a private company provided it is paid for by the state, is of good quality and is free at the time of use. Some private companies and charities undoubtedly make valuable contributions to the NHS. But competition to provide better care can only take place if quality can be measured in a contractual indicator, and the risk is that it will be easier to generate profit by distorting those indicators than by actually improving care, as has happened elsewhere in the world.

Moreover a commercial motive could diminish the commitment to other values, and hence destroy Nye Bevan's vision that the people, pursuing health as a social goal, would be supported by a family of professionals committed to that same goal. Indeed the health service, at least in the hospital service, is now suspicious of that vision, perceiving it as a restraint upon the labour market.

Financial Pressures

NHS funding is essentially static. Unlike most of the public sector it is not being cut but increases are very small. Demand for NHS care is rising at such a rate, due to a demographically ageing population, diminished self-reliance, and medical advances, that static funding represents a significant challenge. The Nicholson Challenge required more benefit from static resources. In the current Parliament this amounts to a £30bn shortfall of which the Government will fund £8bn, leaving a challenge of finding £22bn by obtaining more benefit from static resources. This challenge, rather than cuts in resources, is the basis of the present financial challenge to the NHS.

The Distinction Between the Health Service and the NHS

Ever since 1948 the term "the NHS" has been the brand name of an entity legally called "the comprehensive health service". In the first quarter of a century of the NHS this term included the Health Depts. of local authorities who were one of the three wings of the "tripartite" NHS. In 1974 local authorities ceased to manage any part of the comprehensive health service but in 2013 local authorities were made responsible again, as they had been between 1948 and 1974, for operating as part of the comprehensive health service the local public health function, including commissioning of drug and alcohol services, sexual health services and lifestyle services (including NHS health checks). In 2015 this was extended to include health visiting. However the Government did not simply use the terminology that was used between 1948 and 1974. Instead it referred to these services as being "part of the health service but not part of the NHS". I said in my Annual Public Health Report at the time that I believed this terminology would be confusing and was philosophically and historically inaccurate. These fears have been proved right especially in relation to branding, access to information and, most importantly of all, funding. In the course of this Parliament funding of public health services will not rise in line with NHS funding but will instead be cut by 15%. This is at a time when containing demand through prevention is the cornerstone of the financial strategy of the NHS. NHS England and NHS bodies are faced with the choice of either abandoning that strategy, thereby undermining its potential to meet its own challenges, or to make good the cuts from its own funds, in which case those cuts will diminish the growth made available to them.

Progress since 2013: The Benefits of Working Together

Four of the areas in which I expressed concern in 2013 were

- I am concerned that procurement bureaucracies may undermine the new structures.
- I am concerned that Health and Well Being Boards have inadequate powers.
- I have always believed that the distinction drawn between the health service and social care is artificial and that they would be better combined.
- I am deeply concerned at the absence of any local structure responsible for general practice.

In all four of those areas since 2013 progress has been made locally and at Greater Manchester through the creation of Stockport Together (a partnership between the local authority and local NHS bodies with pooled budgeting), through the pooling of health and social care budgets at Greater Manchester level as part of the devolution settlement, through the involvement of NHS providers in both of these initiatives, and through the application for devolution of general practice commissioning to the CCG from1st April 2016 (result of application still awaited) .

CHALLENGES FOR THE NHS

Quality of healthcare

Health service organisations must maintain a strong commitment to quality if we are to avoid some of the problems that have happened elsewhere manifesting themselves here.

Rising demand on services

Despite improving health, demand for NHS services rises relentlessly. In part this results from an ageing population, especially to the extent that the ageing is due to demography rather than increased life expectancy. Partly it results from inefficiencies in the delivery of care, paradoxically often resulting from changes in care which were intended to promote efficiency – particularly striking is the greater use of Accident & Emergency departments as a first port of call because of nationally dictated changes in general practice which undermined continuity of care and the strength of the doctor/patient relationship. Partly however, it results from an increasing tendency to seek professional help for problems which in the past people would have dealt with themselves or to seek specialist care for problems which in the past would have been dealt with by GPs.

The NHS Contribution to Prevention

Early Diagnosis - The ambition of the CCG is that everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisations, vaccinations and health checks.

Lifestyle Advice - It is important to ensure that opportunities are not lost to give lifestyle advice in the course of NHS care. There is evidence that brief interventions – simple messages from health professionals in the course of professional contacts

– are valuable and effective and so the principle must be followed of “making every contact count”.

Unifying health & social care into services based on need with prevention reducing rising demand

Health service resources are finite and are used to help people. It is not therefore ethical to waste them. The use of available resources to achieve as much as they can is, therefore, an essential part of managing the NHS.

To do this it is important to concentrate not on supply (the services currently provided and their problems) or demand (meeting what people think they want) but on need (that which has been shown by evidence to provide an important benefit) and to aim to reduce that through prevention. It is often said that prevention makes savings only in the long term but there are areas where prevention can make savings much more quickly. This is the only way to meet our immediate financial challenges. We must invest in these areas now to produce benefits for the future.

STOCKPORT TOGETHER

Stockport Together is a collaboration of key health and social care partners in Stockport; there are four key programmes of work.

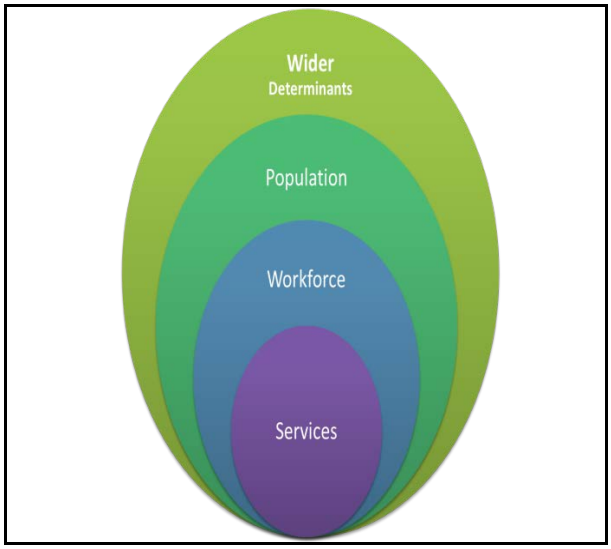
- Prevention and Empowerment - to prevent ill-health and empower residents to take control of their health
- Proactive Care – strengthening community capacity and improving health literacy, service quality, and outcomes of care for people such that fewer people will require hospital admission and consequently reduce demand
- Urgent Care – improving the quality, timeliness and clinical cost effectiveness of the urgent care system such that people avoid hospitalisation and/or return “home” more safely and more quickly
- Planned Care - improving the patient experience and outcomes across the planned care system whilst increasing efficiency and value for money

Structurally Stockport Together is working to bring together the social care and public health commissioning processes of the local authority with the commissioning functions of the CCG , to combine the health and social care community services into a multispecialty community provider and to bridge the divide between commissioning and provision by outcome-based commissioning.

Its strategy is focussed on prevention and empowerment, expanded proactive care and reform of both planned and urgent care.

This section deals with the prevention and empowerment programme although there are preventative elements and a focus on self care in each of the three other programmes

Prevention and Empowerment. Through a series of workshops and informed discussion we have identified 4 key themes.



Wider determinants: Influencing system wide decisions that will have a positive impact on health.

Population: Proactive targeting those at risk and empowering behaviour change.

Workforce: Supporting culture change so that everyone prioritises prevention at every contact.

Services: All services have prevention embedded within pathways and utilise coordinated IT systems.

The role of the preventative and empowering care system is to focus on preventing disease and illness before they occur and creating healthier homes, workplaces, schools and communities so that people can live longer, healthier and more productive lives and reduce the reliance on health and social care services.

To achieve this ambition we are committed to transforming and scaling up those programmes that have a strong evidence base, that are co-produced with local communities, that utilise new IT opportunities and that are delivered by staff who understand what is motivating the health behaviours and needs of our residents.

It recognises that self-care and self-management are essential components of this new delivery model and that we can work proactively with local residents to improve their levels of activation, capacity and competence to address healthy behaviours and manage chronic long term conditions.

Looking specifically at each key theme

Wider Determinants: We will identify system wide factors that are currently contributing to poor health outcomes in Stockport and use our local knowledge and national evidence base to achieve sustainable change. Building on our work in the Stockport Health Promise and through such programmes as Feeding Stockport and the Tobacco Alliance we will make a public health contribution to policy decisions relating to employment, the local economy, infrastructure, education and housing to enable healthier behaviours to be built into everyday lives. We will pay specific

attention to addressing wider determinants in our deprived communities using the intelligence and experiences of local residents.

Population:

Utilising GP, health, and social care records and other information sources we will extend our risk stratification approaches such as QRISK to proactively target those at risk such as patients with no recorded blood pressure (BP) readings, those at risk of diabetes, patients with raised liver function testes, smokers and those with respiratory conditions and those with mental health concerns. We will revise our Public Health Enhanced Services with GPs and provide them with training and additional equipment to proactively support such patients. We will utilise our innovative health inequalities programmes and our revised Healthy Stockport offer to develop alternative settings to deliver health checks, BP testing and roll out the 'Stockport String' community engagement tool. We will link with neighbourhood teams and the new Targeted Prevention Alliance of voluntary sector providers to enable prevention activity to be managed and delivered at a local level. We will expand our understanding of what the underlying issues are for each locality through listening, engaging and consulting with appropriate leaders and opinion formers in these communities. We will be flexible in how funding can be used to support localities to work with their communities to facilitate healthier lifestyles.

Workforce.

We will train and empower the workforce to deliver positive and consistent health promoting messages, enabling the workforce to deliver primary prevention interventions proactively and holistically wrapped around the person's needs. This will build on Stockport Health Chat, and will develop more advanced behaviour change techniques incorporating motivational interviewing and patient activation that can be used in clinical settings. We will develop young people health chats training and extend our popular wellbeing programmes so that.

We will take the health of all our employees seriously and review and extend a range of activities that enable our staff to themselves make positive health choices and take control of their own health. We will challenge the current work environments that inhibit the health and well-being of their staff.

Services

We will continue to redesign, transform and procure our services such as Healthy Stockport (lifestyle advice and support), sexual health, early years and drug and alcohol services so that they are consistent with our new prevention and empowerment models. We will extend programmes such as the 'Stop before your Op' which utilise clinicians as powerful change agents to promote key health messages to patients at key decision making times in the patient journey. We will work with colleagues in proactive, planned and urgent care to embedded prevention

within all pathways and coordinate IT systems so that all staff can use opportunities to promote health messages and address individual's healthy behaviours in their consultations.

Finally we will ensure that we integrate such ambitions within the Place Based Agreement in the Public Health and Prevention in Greater Manchester as part of the wider devolution deal.

Health & Social Care: Further Change, Further Plans: Full Analysis

CHANGE IN THE HEALTH SERVICE

The health service faces a number of challenges at the moment.

New Institutional Structures

New commissioning bodies have been established with the commissioning work previously carried out by the PCT divided between the local authority (most public health issues), Public Health England (some public health issues, most notably immunisation, screening and health protection), the Clinical Commissioning Group (most hospital and community services but not general practice) and NHS Greater Manchester, a local area team of NHS England (specialist commissioning, general practice, dentists, optometrists and pharmacists).

There is a very real question of whether these changes have been worth the time, energy and money spent on them, but now that they exist are they fit for purpose? Viewed from a historical and organisational public health perspective they are a curate's egg.

I particularly welcome

- The transfer of public health to the local authority. Public health was part of the local authority under Nye Bevan's original NHS (as indeed were community health services). Moving it from local authorities to health authorities in 1974 separated it from the capacity to influence social and environmental factors. This seriously undermined Nye Bevan's vision of the NHS as an organisation which would improve the health of the people not only by providing treatment according to need rather than ability to pay but, of equal importance by addressing the determinants of health. It is often forgotten that the local authority Health Departments which cleared the slums and cleaned the air in the 1950s and 1960s were one of the three wings of Bevan's NHS. Those who have forgotten this often refer to his claims that the NHS would improve the health of the people as if they were an unrealistic overestimate of the power of medicine and nursing. They were nothing of the kind – they were amply borne out by the successes of the local authority Health Depts. Moving public health back into local government regains this vision.
- The strong clinical input into commissioning and the extra power given to GPs. An important element of Nye Bevan's original vision was the idea that in addressing the health of the people as a social goal the people would be supported by a family of health professionals dedicated to that vision. This vision has been undermined in recent years and the trust shown in GPs as commissioners is a step back in the right direction.
- The creation of the Health and Well Being Board as a committee of the local authority with statutory membership including professional and partnership representation alongside councillors and patient representatives. This provides for the first time a single focus for strategic oversight within a democratically accountable context. Under Bevan's original structure the only strategic oversight of the whole system was national, although the local bodies which ran the local service had strong democratic roots. The creation of

health authorities in 1974 created a local strategic body but at the expense of the more limited perspective that was inevitable from the loss of the capacity to influence major determinants. The removal of local authority and community representatives from health authorities in the early 1990s created a democratic deficit in the NHS. Health and Well Being Boards are another step back to earlier more idealistic visions.

I do however have six matters of concern

- I am concerned that procurement bureaucracies may undermine the new structures.
- I am concerned that Health and Well Being Boards have inadequate powers
- I have always believed that the distinction drawn between the health service and social care is artificial and that they would be better combined. I am pleased at our local work on integration and at some recent national initiatives but think it would have been better if this had been built into the changes from the outset
- I am deeply concerned at the absence of any local structure responsible for general practice.
- For the first time ever the Government has drawn a distinction between "the health service" and "the NHS" with two of the new health service commissioning organisations – the local authority public health function and Public Health England – being described as part of the health service but not part of the NHS. I believe this will cause confusion. It seems to have been derived from the belief that the 1974 redefinition of the NHS as a treatment service had taken such a deep hold that any recovery of the earlier definition must be associated with a new nomenclature. I think that was a mistake. If we are recreating what Nye Bevan called "the NHS" the best name for it would have been "the NHS" and calling it "the health service" with the term "NHS" applied to a subset is confusing.
- Although clinical commissioning is a step back towards Nye Bevan's vision of a family of health professionals, there is no corresponding step in providers. On the contrary the strategy appears to be one of further erosion.

The first four of these are now being addressed by various local initiatives.

- A move towards outcome-based commissioning with accountable care organisations that are tasked to achieve particular outcomes helps breakdown the bureaucratic arms length separation of commissioner and provider
- The development both in Stockport and at Greater Manchester level of a partnership between NHS bodies and local authorities extends the democratic input into the working of the NHS
- Health and social care is being integrated in Stockport within Stockport Together and at Greater Manchester level within the devolution agreement
- It is now possible for CCGs to have commissioning of general practice devolved to them and Stockport CCG has applied for this. The result of the application is awaited. If approved it would take effect from 1st April 2016.

Commercialisation

For the last two decades a process of private sector involvement in the NHS has been under way, which began under the government of John Major, continued in the first term of Tony

Blair and then accelerated in the second and third terms of that government. The Coalition Government has institutionalised this in the Health & Social Care Act 2012, in a way which will inevitably accelerate it further, although the present Government actually seems somewhat less committed to this than the Coalition, probably because of the pressure of resource constraints.

On the one hand it doesn't matter to a person receiving care whether they get it from a state employee or a private company provided it is paid for by the state, is of good quality and is free at the time of use. There are undoubtedly benefits to competition if it is competition to provide better care. Some private companies and charities undoubtedly make valuable contributions to the NHS.

On the other hand there are serious doubts as to whether commercial competition can indeed be competition to provide better care. Such competition can only take place if quality can be measured in a contractual indicator, and the risk is that it will be easier to generate profit by distorting those indicators than by actually improving care. Moreover a commercial motive could diminish the commitment to other values, and hence destroy Nye Bevan's vision that the people, pursuing health as a social goal, would be supported by a family of professionals committed to that same goal. Indeed the health service, at least in the hospital service, is now suspicious of that vision, perceiving it as a restraint upon the labour market.

It is important to appreciate that commercialisation does not only affect commercial providers. It affects NHS providers and social enterprises as well as they have to respond to actual or potential commercial competition.

CHALLENGES FOR THE NHS

Financial Pressures

The following are the basic facts concerning health service finances nationally.

Health service budgets have increased in real terms but very slightly.

Underspending increased in the last Parliament. This was also very slight, but it slightly exceeded the increase in budgets so health service spending slightly decreased in real terms. Now, however, the situation has become one in which NHS bodies show significant deficits.

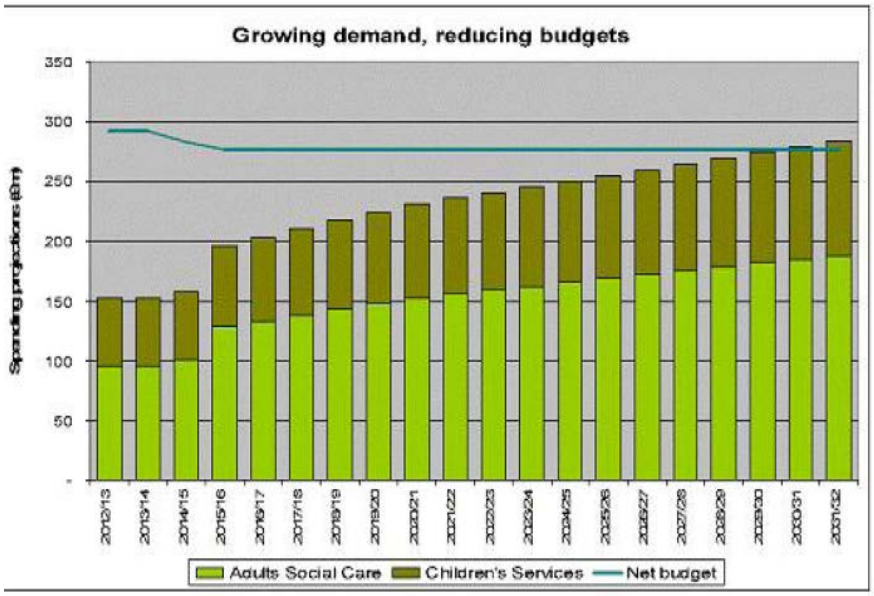
Although much was made politically of these two figures, with the governing parties emphasising the first and opposition parties presenting the second as a contradiction to the first, the truth is that they do not contradict each other, both are insignificant and health service spending is essentially static. The emergence of deficits however is a significant problem.

Local authority public health grants increased in the 2010 Parliament above the baseline public health spending of PCTs by more than the general increase in health service funding. This was the only part of the health service to experience noticeable growth (and the only part of the local authority not to be experiencing serious cuts). This accorded with advice from the British Medical Association (well placed to see both sides of the story) that the benefit to the NHS of better prevention would ease its burdens more than a slight reduction in its financial difficulties. Spending on public health is such a small proportion of the health

service budget that quite large proportionate increases can be made with only a small impact on NHS spending. Unfortunately however this sensible move is now being abandoned with local authority public health grant facing a 15% cut in the current parliament.

Demand for NHS care is rising at such a rate, due to a demographically ageing population, diminished self-reliance, and medical advances, that static funding represents a significant challenge. The so-called Nicholson Challenge in the last Parliament stated that the NHS needs to achieve 20% more benefit from static resources over a 5 year period. In this Parliament the equivalent challenge is that the NHS needs to achieve £30bn worth of increased activity (or reduced demand) with only £8bn of increased funding. This challenge, rather than cuts in resources, is the basis of the present financial challenge to the NHS.

Although health service spending has not been cut, social care spending has been affected by the serious cuts in local authority spending, where Government cut support by 43% between 2010/11 and 2016/17. This is reflected in the Graph of Doom which shows that the combination of rising need for social care and diminishing local authority funding threatens, unless a way is found to curb social care spending, to eradicate all other local authority services.



The Graph of Doom

This figure was originally produced by Barnet Council, but applies equally to all councils. It shows how the rising cost of social care and children's services coupled with a falling Council budget reaches a point at which the two figures meet.

The Government is now to allow Councils partially to address this problem by increasing Council tax but this does not fully resolve the problem.

Reduced social care spending inevitably adds to the burden on the health service.

As well as these overall changes there have been shifts in resource distribution which have benefitted areas with ageing populations at the expense of areas with deprived populations.

This is irrational since it is the gap between healthy life expectancy and life expectancy which creates demand, not life expectancy alone.

Quality of healthcare

A relentless focus on quality is the cornerstone of a high performing provider organization. Providers that prioritise quality improvement in an open and transparent way ensure that the organizational culture has quality at its heart. Providers should encourage reporting cultures and systems that encourage reporting of near misses and prioritise actions to learn systematically from errors. Participation in national quality audits, procedure registers and benchmarking against NICE best practice are all vital to ensure that quality is maintained.

Commissioners need to ensure that they view quality through an enquiring lens, focusing on outcomes and capability and patient experience, ensuring that they intervene where they have concerns and don't simply spectate a poor quality system. As more providers enter the market, it is important to ensure that lead commissioners scrutinize quality on behalf of others.

Healthier Together has given Greater Manchester the opportunity to define a high quality provider system with the production of Healthy hospital and primary care standards. Devo Manc can build on this but should learn from leaders in quality improvement who demonstrate that a focus on patient experience of care drives quality improvement in clinical teams.

With the national focus on weekend mortality, it is vital that any redesign of the system takes into account current best practice around staffing levels.

Providers should ensure that priority is given to all staff being trained in safeguarding, deprivation of liberty and the mental capacity act and the duty of candour.

Problems have occurred elsewhere when the centrally driven target culture of the NHS has led local managements to concentrate on meeting targets, even artificially, rather than maintain good care – this was the problem a Mid Staffs Sometimes care has been undervalued relative to performance of tasks – even seen as getting in the way of efficiency. This has led to situations where in some parts of the country old people have been left hungry and thirsty because staff have not found the time to help them eat and drink. Such "efficiency" not only immediately undermines the whole purpose of an NHS but is even counter-productive in its own terms because it delays discharge and adds to treatment costs as the patient does not recover as quickly or as well. In some cases, as at Winterbourne View, this culture can develop further into a culture of self-serving casual cruelty.It is tempting to view these problems as aberrations that occurred elsewhere but the whole point of the Keogh Report is that the only way we can be certain that they will not happen here is if we focus actively on the pursuit of quality. This is what the above processes are intended to achieve.

Rising demand on services

Despite improving health, demand for NHS services continues to rise relentlessly. In part this results from an ageing population, especially to the extent that the ageing is due to demography rather than increased life expectancy. Partly however, it results from an

increasing tendency to seek professional help for problems, which in the past people would have dealt with themselves. Partly it results from inefficiencies in the delivery of care, and the national focus on new models of care has been designed to address this. The better care fund brought health and social care commissioners together to focus on increased community capacity to reduce bed pressure in acute hospitals; the Vanguard pilots are testing different models of providing increased services out of hospital for older people and those with long term conditions. GP federations are working together to provide an increased range of services out of primary care.

The NHS Contribution to Prevention

Early Diagnosis - The ambition of the CCG is that everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisations, vaccinations and health checks.

Unifying health & social care into services based on need with prevention reducing rising demand

Health service resources are finite and are used to help people. It is not therefore ethical to waste them. The use of available resources to achieve as much as they can is, therefore, an essential part of managing the NHS.

To do this it is important to concentrate not on supply (the services currently provided and their problems) or demand (meeting what people think they want) but on need (that which has been shown by evidence to provide an important benefit) and to aim to reduce that through prevention. It is often said that prevention makes savings only in the long term but there are areas where prevention can make savings much more quickly. This is the only way to meet our immediate financial challenges. Despite the current financial pressures, we must invest in these areas to produce benefits for 2016/17 and beyond

The NHS as a healthy setting

It is imperative that NHS premises promote health to its staff, visitors and patients. An estate that facilitates:

- active travel and active working breaks
- healthy eating – in particular, not allowing the sale of food and drink high in refined sugars and unhealthy fats
- mental well being for staff

and promotes health in a visible way that people can access advice about healthy behaviours.

Unifying Health and Social Care

The distinction between health and social care was drawn at the time the NHS was first founded and was rooted in the concept that what was needed to care for old people corresponded to the care the more affluent members of society purchased in private hotels. Nye Bevan referred to the new elderly people's homes that councils were establishing as "private hotels for the working class" and separated them from the NHS because he didn't want people to make a hospital bed their home. Indeed the Poor Law hospitals, newly nationalised and yet to find their place in the NHS, had still to throw off connotations of the workhouse. Whatever may have been the merits of the distinction in that situation an ageing

population, a focus on maintaining people in independence and a situation where the average person receives most of their lifetime healthcare expenditure in the last year of their life, all add up to a situation where unification is essential. Stockport CCG and Stockport Social Services are pursuing this goal through the establishment of Locality Hubs within Stockport Together.

A Service Based on Need

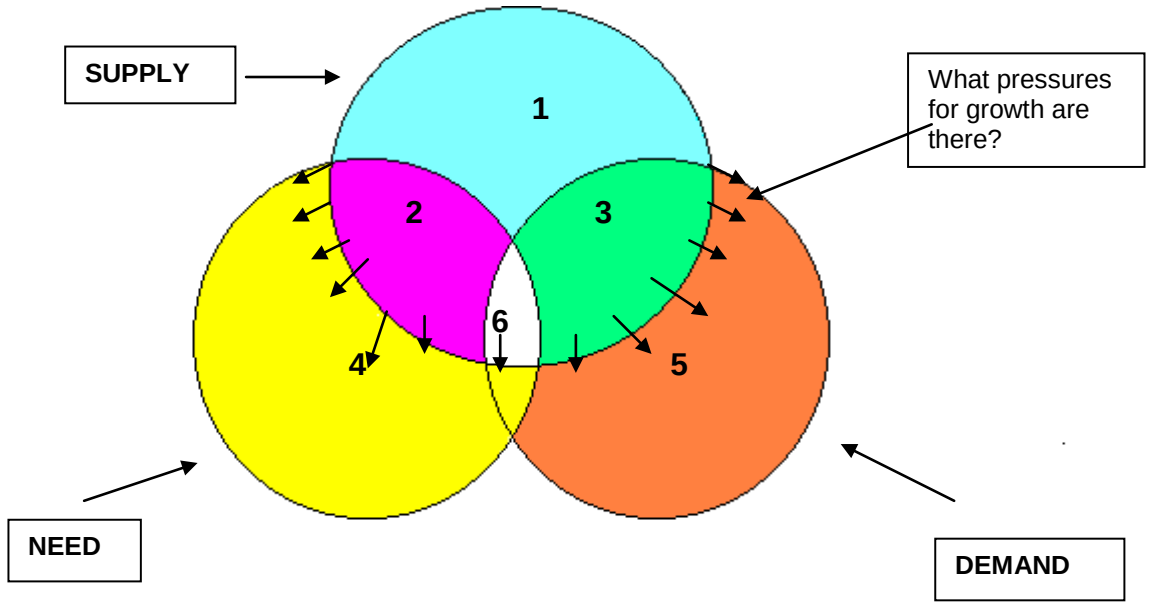
The relationship is shown in the following diagram by Stevens and Gabbay:

What is supplied? **What** do people currently do to address this problem? Is this:

→ *efficacious***?** i.e. a *treatment or change* is efficacious if it significantly lengthens the life or improves the quality of life of a significant proportion of the people to whom it is given or applied

→ *effective?* i.e. a *service* is effective if it delivers efficacious treatment or change to the substantial majority of those who would benefit from it

→ *efficient?* i.e. a *system* is efficient if it so uses its resources as to maximise the effectiveness of the greatest possible number of the services it supports.



WHAT IS NEEDED?

→ What does the evidence suggest would work to address this problem?

WHAT IS DEMANDED?

→ What do people want to do to address the problem?
→ Why is this what they want to do?
→ Who have we consulted?
→ How do we know this is what is demanded?

Health service resources are finite and are used to help people. It is not therefore ethical to waste them. The use of available resources to achieve as much as they can is, therefore, an essential part of managing the NHS. To do this it is important to concentrate not on supply (the services currently provided and their problems) or demand (meeting what people think they want) but on need (that which has been shown by evidence to provide an important benefit).

In areas which are needed and supplied but not demanded (2 on the diagram) there may be problems of securing uptake. Unneeded supply (1 and 3) should be decommissioned as it wastes resources that could be used to meet unmet needs (4) but if it is wrongly perceived as valuable by the public (3).this will be harder. In meeting unmet needs we need to be careful not to confuse them with demands which are not in fact evidence-based (5). The aim is to bring the three circles together so the public only demand what they actually need and that is supplied (6)

The main purpose of a healthcare system is to improve the health of the people.

Health gain is achieved when:

- **years are added to life**
- **life is added to years**

Health gain occurs through a wide range of activities, not just health care, which is why this report opened by asking what everybody can do to address the major health problems of Stockport. But health care services have the feature of being provided primarily for health gain – there is no purpose in carrying out a healthcare activity unless it lengthens somebody's life or increases somebody's capacity to enjoy the life they have.

Health care services are not unique in being provided primarily to provide health gain – the same could be said of environmental health, industrial health and safety services, certain regulatory systems and health protection services. All such services ought to subject themselves to the discipline of asking whether they are achieving, within their particular field, the maximum health gain that is possible from the resources they use.

This isn't a precise mathematical exercise because human reality is never precise, there is no easy way to value one kind of health gain against another in a single currency, we can't always measure health gain, one of the benefits the NHS provides is the peace of mind of knowing it will be there for you when you need it so it would be entirely wrong to write off certain activities entirely on harsh cost/benefit analyses which neglected equity and much experimental and research activity achieves little health gain at present but lays the ground work for developments which will achieve health gain in the future. Although it is not a precise mathematical exercise it must become a way of thinking. We must appreciate that we invest in health services in order to achieve health outcomes.

It is often said that both need and demand are infinite (or at any rate greater than society could possibly afford) so that a health service will always need to ration care either explicitly or implicitly. This may well be true in certain areas such as measures like cosmetic surgery which aim to perfect the patient rather than return them to normal, experimental treatments, last ditch treatments with very low prospects of success, treatments which have very small (often purely theoretical) benefits over cheaper treatments, treatments for minor aches and

pains, one to one lifestyle advice and psychological counselling, and the substitution of professional care for the kind of advice and support which in the past would have been obtained from friends. In these fields it may well be that society needs to decide how much it can afford and the NHS must then prioritise. However in most fields of care there is a specific and definable volume of need and it could all be provided if society wished to afford it.

In many fields of care this specific and definable volume of need could be reduced by prevention and that is just as effective a way of achieving the health gain, and may well be cheaper.

It is often said that the health gain from prevention is delayed and long term. That can be true for some forms of prevention but others achieve early benefits. For example

Prevention of coronary heart disease in middle aged and elderly people has an immediate impact on heart attacks and angina attacks.

Reductions in smoking reduce health service utilisation within less than three years

Reductions in falls in the elderly reduce health service and social care costs immediately

Improved social integration of older people reduces progress to dependence and hence future social care costs. For a population of people within 5-10 years of their life expectancy this benefit would be felt within 3 years

Employment of people with mental health problems reduces health care and social care costs immediately

It is important that these early benefits of prevention are achieved as the health and social care system moves towards the financial crisis that I described in the previous chapter. Action is needed now to bring about benefit in the next few years..

STOCKPORT TOGETHER

Structurally Stockport Together is working to bring together the social care and public health commissioning processes of the local authority with the commissioning functions of the CCG , to combine the health and social care community services into a multispecialty community provider and to bridge the divide between commissioning and provision by outcome-based commissioning.

Its strategy is focussed on prevention and empowerment, expanded proactive care and reform of both planned and urgent care.

The following account discusses its prevention and empowerment strategy

Overall Prevention and Empowerment Vision for 2020

•Our purpose is to reduce health inequalities and enable more people to live healthy lives for longer

•Our approach will build and strengthen individual and community assets and resilience through:

–Increasing the availability and take up of support for adopting healthier ways of living, addressing both mental and physical aspects of health

–Working with communities and organisations to develop social, economic and physical environments that are more conducive to health and well-being.

•This will lead to reduction in both the overall prevalence and the inequalities in illness, disability and premature mortality

Design Challenges

1.Increase the range, capacity and accessibility of behaviour change support across 5 levels of intervention

2.Develop effective ways to proactively seek out people with undiagnosed conditions or health-risk behaviours

3.Increase numbers engaging with health behaviour change support

4.Empower communities to gain more control over the drivers of their own health and wellbeing

5.Support staff in embedding prevention in all their interactions with people using services

Prevention and Empowerment

Financial Challenges

•There is considerable uncertainty about future financial resources for prevention and empowerment due to:

–Public Health grant reducing significantly in current and future years

–Council financial settlement for next year not yet known

–Unknown local impact of Devo Manc prevention work

–Implications of NHS funding increase to be determined

•The proposals in this document are based on additional funding of £3M above current levels, as proposed in the original Stockport Together vision. The pace and scale of implementation will depend on the availability of such resources.

Overview of benefits

•The future model of care for Prevention and Empowerment is designed to

–Prevent disease and illness before they occur by empowering the population to take control of their health as far as possible – giving them tools, skills and information to address unhealthy behaviours and manage their own health as far as possible.

–Prevent premature death and chronic disability by increasing early identification

–Build healthy communities, which improve social connections and support healthier ways of living

–Reduce health inequalities within Stockport

–Reduce reliance on the health and social care system.

•Delivery of the model requires a significant cultural shift in attitudes and behaviours from both the population and the workforce, and for prevention to be embedded across all health and social care pathways in Stockport.

<u>High level objectives</u>

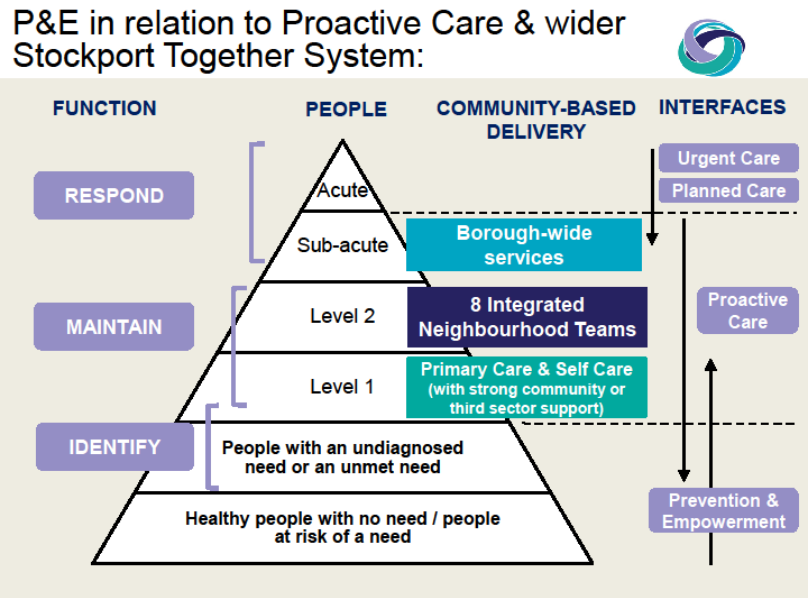
•Increase numbers of people engaging with individual lifestyle & wellbeing support to, and increase % of successful outcomes year on year

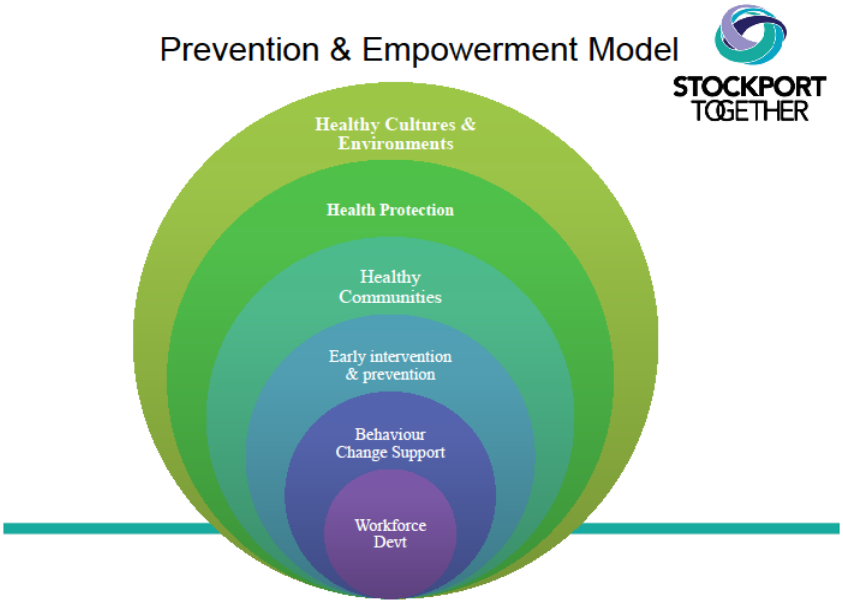
•Increase numbers of successful completions of alcohol and drug treatment and recovery interventions

•Increase numbers accessing online/app based lifestyle and well-being support

•Find and treat more people with previously undiagnosed hypertension, AF or pre-diabetes by 2017-18

•Increase rates of screening and immunisation





Overview description of model

The model includes five service components:

•Behaviour change support: we will increase the accessibility and capacity of support services to deliver individual and group support to address the lifestyle factors including smoking, alcohol misuse, diet, physical activity and mental well-being.

•Early intervention and prevention: building the capacity of front-line health, social care and other services to identify health behavioural risks and early symptoms, provide appropriate brief advice and facilitate access to further information and support, utilising ICT and skills development to embed prevention in every pathway

•Healthy Communities: we will work with communities of place or of interest to help develop the assets and networks which provide access to support and resources, thereby promoting healthier ways of living and increasing resilience at community as well as individual level.

•Health protection: enhanced immunisation and infection control activity to improve health at both individual and population level by preventing and controlling epidemics and outbreaks.

•Healthy cultures and environments: this component addresses the factors in our physical, social and cultural environment which impact on our health and well-being directly or through affecting our behaviours. This includes issues of inequalities and social exclusion as well as the built and natural environment and social norms.

Delivery of these components will be founded on a strategic staff development programme which clearly articulates a consistent model for promoting health and facilitating behaviour change, including a range of levels and content tailored for different broad groups within the workforce. This will need to be underpinned by effective leadership and embedding of prevention in new and existing job roles and supervision.

Behaviour change support

This includes the following service components and developments

•Healthier living hub providing information, advice and referral, (face to face, by phone or online) on lifestyles and wellbeing issues

•Simple integrated electronic referral system to connect people to the healthier living and self-care hubs

•Healthy Living Pharmacies to provide enhanced support for prevention and self-care

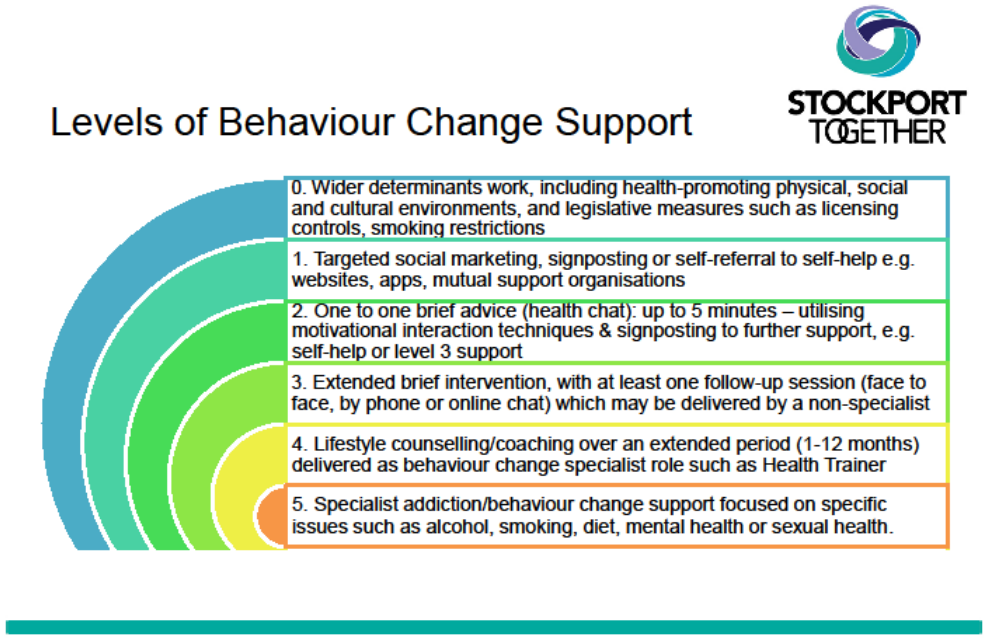
•Renewed Healthy Stockport service, providing one to one and group support to help people address their lifestyle and behaviour issues. This will include new neighbourhood-based health trainer roles in all neighbourhoods, with provision weighted to more deprived areas

•Increased capacity for social prescribing, including Arts on Prescription, Walking for Health

•Promotion of cancer screening take up and early symptom checking

•Specialist support for people with entrenched behaviour issues including drug or alcohol dependency, low mental well-being, physical inactivity and eating disorders

•Increasing capacity of the Targeted Prevention Alliance of voluntary sector providers to enable prevention activity particularly for vulnerable people to be tailored to and delivered at a local level



Early identification and prevention

Key to the P&E model is the identification of need and motivation of people to access preventive support and services and this will be delivered by means of:

•Prevention embedded in every pathway, facilitated by integrated IT, to facilitate the capture of opportunities for preventive advice and support. All health and social care services will be commissioned to include this as core business. This will require a holistic approach to the person which takes account of wider needs, circumstances and assets, to enable them to achieve better health.

•Find & Treat: Development and testing of risk modelling tools which utilise GP, health, and social care records to extend risk stratification approaches to proactively target those at risk such as people with no recorded blood pressure (BP) readings, those at risk of diabetes and those with mental health concerns

•Increasing the reach of the older people's health check questionnaire, which will help identify needs and opportunities for prevention

•Building the capacity and reach of the Know Your Numbers project, to deliver health checks, BP testing and brief advice in non-medical settings in the community.

•Targeted social marketing to engage identified segments of the population whose lifestyles are more likely to be risking their health, Promoting take up of appropriate screening programmes.

•We will also work in partnership with other public service providers such as housing providers, Benefits Agency, GMFRS and Police to engage people in health promotion and support.

Healthy Communities

Individual and community empowerment are interdependent and at community level engagement will support development of community assets, capacity and resilience across the borough, including volunteering. This will be integrated with the Proactive Care programme work including Targeted Prevention Alliance and Well-being and Independence Network, as well as the Investing In Stockport Locality Working model, and encompass:

•Settings based approaches, including workplaces, communities, hospitals, schools and public services, which have potential to combine individual, group and wider population approaches to health promotion and improvement, and in the process address issues such as social isolation and build capacity for promoting health.

•Community engagement activities may be targeted at population groups with increased risk of unhealthy behaviours or particular harms, to deliver changes in normative beliefs, attitudes and behaviours. This could include:

–Activities and campaigns within workplaces: Stockport Together partners will seek to be exemplar employers, setting an example for others to follow in taking the health and well-being of all our employees seriously and reviewing and extending a range of activities that enable our staff to make positive health choices and take control of their own health.

–Engaging target groups within communities to promote healthy lifestyles or participation in screening programmes by going to the places where they are, such as supermarkets, sports venues, religious institutions, community activities

–Developing Champions for Health and peer supporters in communities and other settings

–Campaigns, including: Know Your Numbers (hypertension)/ Stockport String/Diabetes/ Stop Before the Op etc.

Health Protection

•Immunisation and infection control work will be enhanced with additional capacity to undertake:

–Immunisations to prevent Flu, HPV, MMR etc. order to prevent outbreaks and epidemics

–Infection control including work with residential and nursing care

Healthy Cultures and Environments

•This element will focus on creating healthier environments, including homes, workplaces, schools and communities so that people can live longer, healthier and more productive lives and ultimately reduce the reliance on health and social care services. The Stockport Health Promise is a vehicle for securing potential health promoting/protecting impacts of a range of council services. This work area will

–Identify system wide factors that are currently contributing to poor health outcomes in Stockport and use our local knowledge and (inter)national evidence base to achieve sustainable change.

–Ensure a public health contribution to policy decisions relating to employment, the local economy, infrastructure, education and housing to facilitate healthier ways of living and healthier social, economic and physical environments. Pay specific attention to addressing wider determinants in our deprived communities using the intelligence and experiences of local residents.

Workforce development

•Delivery of the prevention agenda depends on cultural change, including engagement of the Stockport Together agencies and other partners' workforces to develop the attitudes, skills and processes required to deliver an empowering, prevention-focussed approach to health and social care. This and will include:

–Making Every Contact Count (Patient Activation): Train and empower the workforce to deliver positive and consistent health promoting messages, primary prevention interventions and motivational support proactively and holistically wrapped around the person's needs.

–Building on Stockport Health Chat, Patient Activation model and Connect 5 and develop more advanced behaviour change techniques incorporating motivational interviewing and patient activation approaches that can be used in clinical and non-clinical settings, by appropriately trained staff, professionals or volunteers in health, social care and related fields such as housing or Police.

•This will be interdependent with the wider cultural change objectives of Stockport Together, as well as the workplace health initiatives, to create rewarding and engaging workplace cultures in which staff are empowered, skilled and motivated to actively capture opportunities for prevention and it is recognised as a core part of their roles

•This will be supported with the identification of and support for a prevention and empowerment lead in every setting: neighbourhood/ practice/ team

•Taking a population approach means seeking to deliver wider social change which creates new norms of healthier ways of living. This involves addressing the wider determinants of health, such as:

–Planning and environmental work to make active travel easier and more attractive

–Housing conditions including heating and insulation and shared spaces

–Promoting attitude and cultural changes including in our workplaces, in our relationships with food, alcohol and tobacco, attitudes to exercise, and looking after our own emotional health and well-being

–Addressing the availability of goods and services that are health promoting (e.g. healthy food) and health harming (e.g. alcohol)

Recommendations

Return to contents

RECOMMENDATIONS 2015/16

Public Health Processes within Agencies

The process whereby the Annual Public Health Report makes recommendations which the various agencies respond to is well established and is recognised in various formal processes. However public health has become more fully integrated into the working of the Council, Stockport Together increasingly adopts a preventive orientation, and one of the Deputy Directors of Public Health (Vicci Owen-Smith) is increasingly developing her role as being also the Clinical Director (Public Health) of the CCG and Associate Medical Director (Public Health) of Stockport NHS Foundation Trust. Hence most interaction between public health advice and the various agencies of the town now takes place in a much more integral process than just a report and a response. My first few recommendations reflect this and acknowledge those other processes.

1. I congratulate the Council, and the other agencies party to the Stockport Health Promise, on the commitments they have entered into in the Health Promise and I recommend that they continue wholeheartedly to pursue those commitments.
2. I congratulate the various agencies party to Stockport Together on adopting a strategy which has a strong preventive component and which also seeks to pursue a balance of care which acknowledges the importance of proactive early intervention. I recommend that they continue wholeheartedly to pursue this strategy.
3. I congratulate the Stockport NHS Foundation Trust on its work, as a pilot area, on developing public health standards for hospitals and I recommend that it formally adopts them and continues to pursue a high level of achievement of these standards.

Resource Strategy

Resources are tight in all organisations. The pressures on the NHS are considerable and far exceed the resources made available to it, generous though those resources are by the current standards of the public services. The Council faces very severe financial reductions and it would be untruthful to suggest that they can be achieved without adverse consequences. The police also face severe pressures and I note with particular concern that it has not been possible this year to pursue vigorously the issue of illicit tobacco.

4. I congratulate the Council on pursuing a public sector reform strategy focused on reducing need through prevention, on the promotion of resilient communities, on the optimisation of resources to focus on outcomes and on radical service redesign. I recommend that it continues to do so. Indeed I

believe that in current financial circumstances any other approach would have highly damaging consequences.

5. I recommend that a health impact assessment tool be incorporated into the integrated impact assessment of Investing in Stockport business cases.
6. I recommend that Stockport Together aims to optimise resources across the whole of the health and social care system rather than treating the NHS and social care separately. Otherwise the consequences of reductions in social care expenditure will seriously add to pressures on the NHS.
7. I value greatly the roles currently played by the police in local communities, in mental health, in crime prevention, and in the enforcement of laws relating to health.

National Action to Improve Health

I have always included in my Annual Public Health report recommendations to local MPs and political parties. This reflects the impact that national policy has on the health of the people and the fact that our capacity as a town to influence that impact is channelled through our MPs and political parties. The recommendations are, of course, pursued without regard to political party considerations. The more controversial they are the more careful I am that they can be professionally justified. It is impossible to properly consider the matters which impact on the health of the people without considering resource optimisation, impossible to discuss issues of resource strategy without addressing the national context and impossible to discuss that context without entering areas of controversy. I have therefore very carefully considered the following professional recommendations.

8. I recommend that Stockport MPs and political parties fully support the Government's strategic welfare to work objective and debate how to improve its implementation.
9. I recommend that Stockport MPs and political parties pursue the adoption at national level of a strategy based on the principles set out in recommendation 4.
10. I recommend that Stockport MPs and political parties debate the implications of Government protecting NHS budgets but cutting social care budgets in a situation where the two services operate as a coherent whole, increasingly with combined budgets.
11. I recommend that Stockport MPs and political parties also question the description of public health as a "non-NHS" service when it is part of the comprehensive health service which has, ever since 1948, been called "the NHS", when the bulk of its expenditure is with NHS bodies and when prevention is central to NHS financial strategies.
12. I recommend that Stockport MPs and political parties carefully consider and debate the implications of the scientific evidence on austerity and its implications for consideration of unconventional financial strategies.

13. I applaud the government on the successful implementation of the recent ban on smoking in cars with a person under 18 present and on smoke free prisons. I recommend that Stockport MPs and political parties acknowledge that effective national strategies on tobacco, alcohol, and obesity (including sugar and physical activity) must be an essential part of containing NHS costs and that opposition to such strategies can therefore be viewed as carrying heavy financial costs which must be accounted for.
14. I recommend that Stockport MPs and political parties fully understand and support the NHS Five Year Forward View.
15. I recommend that Stockport MPs and political parties consider the proposals put forward by the North West Directors of Public Health as to priorities for Government action to improve health.
16. I recommend that Stockport MPs and political parties consider the Due North report and also consider the opportunities for public health opened up by the Northern Powerhouse.
17. I recommend that Stockport MPs and political parties warmly welcome the increase in the national minimum wage and support further progress towards the living wage as originally defined (what is increasingly becoming called “the real living wage” although I dislike that term and would prefer a better one)

Behaviour Change

I have always included in my Annual Public Health Report advice addressed to the people of Stockport as individuals and I do so again. This year however, with the new chapter on behaviour change, I also ask all agencies to consider how we can educate, encourage, enable and empower people to pursue this advice, supported by engineering and enforcement where appropriate. The recommendations included here are intended to lead to discussions which will help shape some further Health Promises in the 2016/17 Health Promise.

18. I present to the people of Stockport the advice contained in chapter 29 as to how they can improve their own health and I ask all agencies to consider how they can contribute to educating, encouraging, enabling and empowering this process, supported by engineering and enforcement where appropriate.
19. I recommend that all agencies consider how they can make healthy choices the most prominent choices.
20. I recommend that all agencies consider whether there are areas where they can make healthy choices the default choices.
21. I recommend that all agencies consider how they can indicate a welcoming approach to healthy choices, for example by displaying notices welcoming breastfeeding.
22. I recommend that steps be taken to ensure that the implications of loss aversion as a cognitive bias, and its implications for change strategies, are more fully understood.

Some Further Contributions of Health & Social Care Systems to Prevention

A wide range of contributions of the health and social care system to prevention are contained in recommendations 2 , 3, 6 and 18-22 but nonetheless there are some further strategies that need to be developed to address the wider strategies of healthy ageing and welfare to work

23. I recommend that Stockport Together considers how the health and social care system can contribute to healthy ageing by avoiding iatrogenic ageing. The word “iatrogenic” means “caused by healthcare” and what I mean by “iatrogenic ageing” is the situation where people prematurely become dependent and frail as a result of a treatable illness being attributed to old age, or as a result of advice being given which encourages people to prematurely consider themselves old.
24. As a specific example I recommend that Stockport Together considers how the health and social care system can contribute to healthy ageing by the better identification of frailty and its treatment by physical activity
25. I recommend that Stockport Together considers how the health and social care system can contribute to welfare to work strategies and to the well-being of sick and disabled people by recognising the therapeutic potential of helping keep people in work when they become chronically sick and work is appropriate.
26. I recommend that Stockport Together considers how, by promoting work and other forms of meaningful life activity where appropriate, the health and social care system can contribute to welfare to work strategies, to the well-being of people with mental health problems, and to resource optimisation in mental health services.
27. I welcome the steps that have been taken to make NHS sites completely smoke free. I recommend stricter enforcement by Stockport NHSFT of its existing policy and I recommend that other providers follow its lead.

Some Further Contributions of the Council to Prevention

A wide range of contributions by the Council to prevention are contained in recommendation 1, 4, 5, and 18-22. I also recommend the following additional actions to be considered for inclusion in the 2016/17 Health Promise.

28. I recommend that providers of ‘built’ and ‘green’ infrastructure more closely co-ordinate their outputs in order to work towards a liveable and climate-resilient Town Centre including attention to Urban Heat Effect
29. I recommend that in its work on public realm the Council fully appreciate the social, environmental and economic benefits of trees
30. I recommend that there be serious consideration of much more widespread adoption of 20mph speed limits within the borough.
31. I recommend that the Council commit to a Council led development showcasing an exemplar approach to Green Infrastructure (including a green

roof, green walls and accessible public space) to provide a local leading example of the economic, social and environmental benefits of such an approach.

32. I recommend that Stockport Family considers how it can further develop its approach to promoting child safety and preventing child injury

RECOMMENDATION	SUGGESTED CCG RESPONSE
1. I congratulate the Council, and the other agencies party to the Stockport Health Promise, on the commitments they have entered into in the Health Promise and I recommend that they continue wholeheartedly to pursue those commitments.	The CCG acknowledge its responsibilities around the Health Promise to: • continue the integration of health and social care through Locality Hubs and in that context will seek to put in place a pattern of care which optimises resources through prevention, early diagnosis and the more efficient harmonisation of services and clinical pathways. • pursue a campaign to increase levels of early diagnosis of hypertension. • explore developing the role of community pharmacists in prevention. • pursue a "making every contact count" programme.
2. I congratulate the various agencies party to Stockport Together on adopting a strategy which has a strong preventive component and which also seeks to pursue a balance of care which acknowledges the importance of proactive early intervention. I recommend that they continue wholeheartedly to pursue this strategy.	The CCG acknowledges the Prevention and Empowerment model as one of the 4 key programmes in Stockport Together. The CCG is committed to ensuring that the focus on prevention and early identification remains at the forefront of new developments, particularly in primary care.
3. I congratulate the Stockport NHS Foundation Trust on its work, as a pilot area, on developing public health standards for hospitals and I recommend that it formally adopts them and continues to pursue a high level of achievement of these standards.	The CCG will work with the Foundation Trust to ensure that these standards are implemented to improve outcomes.
6. I recommend that Stockport Together aims to optimise resources across the whole of the health and social care system rather than treating the NHS and social care separately. Otherwise the consequences of reductions in social care expenditure will seriously add to pressures on the NHS.	The CCG acknowledges that its role in Stockport Together and integrated commissioning is crucial to achieving this aim.

18. I present to the people of Stockport the advice contained in chapter 29 as to how they can improve their own health and I ask all agencies to consider how they can contribute to educating, encouraging, enabling and empowering this process, supported by engineering and enforcement where appropriate.	The CCG will work with the public, through digital and social media, radio and local newspapers, campaigns and through local services to begin to embed a culture of empowerment.
19. I recommend that all agencies consider how they can make healthy choices the most prominent choices.	The CCG will use its commissioning influence to ensure that its providers promote healthy choices.
20. I recommend that all agencies consider whether there are areas where they can make healthy choices the default choices.	The CCG, as a partner in Stockport Together, will support any policy to actively promote healthy choices as the norm.
21. I recommend that all agencies consider how they can indicate a welcoming approach to healthy choices, for example by displaying notices welcoming breastfeeding.	The CCG will use its commissioning to influence providers to welcome breast feeding.

22. I recommend that steps be taken to ensure that the implications of loss aversion as a cognitive bias, and its implications for change strategies, are more fully understood.	The CCG recognises the value of using behavioural Insights as a mechanism to improve health and welcomes the opportunity to explore this approach to make a difference to people's lives.
23. I recommend that Stockport Together considers how the health and social care system can contribute to healthy ageing by avoiding iatrogenic ageing. The word "iatrogenic" means "caused by healthcare" and what I mean by "iatrogenic ageing" is the situation where people prematurely become dependent and frail as a result of a treatable illness being attributed to old age,	The CCG, as a partner in Stockport Together, commits to reviewing the evidence and best practice particularly in relation to the work in communities and neighbourhoods.
24. As a specific example I recommend that Stockport Together considers how the health and social care system can contribute to healthy ageing by the better identification of frailty and its treatment by physical activity.	The CCG is working with EMISWeb to identify cohorts of patients with frailty and will, through Stockport Together, work to promote physical activity in these patients.
25. I recommend that Stockport Together considers how the health and social care system can contribute to welfare to work strategies and to the well-being of sick and disabled people by recognising the therapeutic potential of helping keep people in work when they become	The CCG acknowledges the roles that employment plays in promoting wellbeing. Stockport Together emphasises the importance of encouraging healthy behaviours, and harnessing community resources to support people to manage long term conditions. We will work as part of Stockport Together to develop community assets and support so that people can be supported to remain in work for as long as possible.

26. I recommend that Stockport Together considers how, by promoting work and other forms of meaningful life activity where appropriate, the health and social care system can contribute to welfare to work strategies, to the well-being of people with mental health problems, and to	The CCG supports the ambition of Stockport Together to achieve parity of esteem and resource for mental and physical wellbeing. People with mental health problems will be supported to stay well by building support and capacity in communities, and by being able to access expertise at the right time, in the right place.
27. I welcome the steps that have been taken to make NHS sites completely smoke free. I recommend stricter enforcement by Stockport NHSFT of its existing policy and I	The CCG supports the promotion of smoke free sites in all public areas and will work with the Foundation Trust towards stricter enforcement.

NHS
Stockport
Clinical Commissioning Group

Report from Primary Care Commissioning Committee

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900
Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?

This report provides an overview of the considerations at the Primary Care Commissioning Committee at its first meeting following the full delegation of functions from NHS England on 1 April 2016. There are no decisions required.

Please detail the key points of this report

The Primary Care Commissioning Committee has been established by the CCG to exercise the management of the delegation functions and the exercise of the delegated powers from NHS England in relation to the commissioning of primary care medical services.

The Committee met for the first time on 6 April 2016 and considered an update on the Level 3 commissioning responsibilities which included:

- Planning by the CCG to resource the delegated functions including the contractual elements and ongoing support for general practice.
- The support which would continue to be provided to the CCG by NHS England at Greater Manchester Level through a Memorandum of Understanding.
- The approach which would be taken to assuring the quality of general practice services and the development of a primary care dashboard of key indicators

The Committee approved permanently two applications for boundary reductions which had been submitted by Park View and Bramhall Park Medical Centres. It was noted in both cases that the proposals supported the continued approach to the neighbourhood working being developed through the Stockport Together Programme and would not impact on patient choice.

The Committee also received an update on a number of recent CQC Inspections which had been carried out in general practice and noted in particular that Marple Cottage had been noted by NHS England as being an outstanding practice.

An appendix shows the key outcomes of the inspections across the main areas.

Following the meeting the CCG was informed that The Surgery had received an inadequate inspection rating. The CCG will be working with NHS England to support the practice in responding to the actions required.

What are the likely impacts and/or implications?

The work of the Primary Care Commissioning Committee is integral to managing the delegated functions from NHS England and ensuring the continued high quality provision of primary care medical services in Stockport.

How does this link to the Annual Business Plan?

The work of the Committee supports the delivery of the Annual Business Plan and ensures the CCG complies with its statutory duties.

What are the potential conflicts of interest?

Conflicts of interest for members of the Primary Care Commissioning Committee continue to be managed in line with the NHS England Statutory guidance, in particular for those members of the Committee who are GPs.
Where has this report been previously discussed?
The issues covered by this report were considered at the Primary Care Commissioning Committee on 6 April 2016
Clinical Executive Sponsor: Dr Viren Mehta
Presented by: Jane Crombleholme
Meeting Date: 27 April 2016
Agenda item: 14

Locality	Code	Practice	Overall Practice Rating	Date of CQC Inspection	Date Report Published	Are Services Safe	Are Services Effective	Are Services Caring	Are Services Responsive to peoples needs	Are Services Well Led
Skockport	P88600	Dr Hany Azmy	**Good**	06-Oct-15	29-Oct-15	Good	**Good**	Outstanding	Good	Good
Skockport	P88002	Marple Bridge	**Good**	21-Oct-15	12-Nov-15	Good	Good	Good	Good	Good
Skockport	P88021	Marple Medical Centre	**Good**	07-Oct-15	12-Nov-15	Good	Good	Good	Good	Good
Stockport	P88044	Bredbury Medical Centre	**Requires Improvement**	07-Oct-15	12-Nov-15	Requires Improvement	Good	Good	Good	Requires Improvement
Stockport	P88024	Gatley Medical Practice	**Good**	20-Oct-15	26-Nov-15	Good	Good	Good	Good	Good
Stockport	P88610	Dr G Gupta	**Good**	21-Oct-15	19-Nov-15	Good	Good	Good	Good	Good
Stockport	P88006	Marple Cottage Surgery	**Outstanding**	04-Feb-16	16-Mar-16	Good	Outstanding	Good	Outstanding	Outstanding
Stockport	P88632	Stockport Medical	**Good**	17-Feb-16	18-Mar-16	Good	Good	Good	Good	Good
Stockport	P88016	Bramhall Park MC	**Good**	02-Mar-16	06-Apr-16	Good	Good	Good	Good	Good

NHS
Stockport
Clinical Commissioning Group

Report from Remuneration Committee

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900
Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
This report provides an overview of the discussions from Remuneration Committee which took place on 22 March and recommended to Governing Body the approval of a 1% consolidated pay increase be applied to staff on non-Agenda for change pay scales.
Please detail the key points of this report
A Pay and Conditions Circulate (Agenda for Change) was considered by the Remuneration Committee which described the changes which would come into effect for staff on Agenda for Change pay scales. It was also noted that additional requirements regarding pay spine increases for those employees on bands 8c, 8d and 9 would be enacted and would be dependent on the achievement of locally determined levels of performance. The Committee considered the information in detail and it was proposed on the basis of equity for all those in the employ of the CCG, that the proposed 1% increase to non-Agenda for Change staff be recommended to Governing Body for approval. The agreement reached was unanimous.
What are the likely impacts and/or implications?
The proposal will have a financial impact on the CCG.
How does this link to the Annual Business Plan?
The remuneration of non-Agenda for Change staff is integral to ensuring that the organisation meets its statutory requirements and ensures sufficient capacity to deliver organisational plans and priorities.
What are the potential conflicts of interest?
Those members of the Governing Body who receive non-Agenda for Change salaries will be impacted on by the proposal.
Where has this report been previously discussed?
The issues covered by this report were considered at the Remuneration Committee held on 22 March 2016.
Clinical Executive Sponsor: Jane Crombleholme
Presented by: John Greenough
Meeting Date: 27 April 2016
Agenda item: