PURPOSE OF REPORT:

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

RECOMMENDATIONS:

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

CONTACT OFFICERS:

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1.0 GENERAL

1.1. We have made a number of appointments to key posts in the Partnership team over the last few weeks. I am also pleased to state that Carolyn Wilkins, the Chief Executive of Oldham Council, has agreed to take a lead CEO role on population health on behalf of all the local authorities.

1.2. Following the decision on urgent care reform we will be moving swiftly to put in place the team to lead this work. To this end, we have agreed with NHS Improvement to form a joint team which will be led by Anne Gibbs, our Joint Director and Steve Christian, Head of Service Improvement, NHS Improvement.

2.0 ACCOUNTABLE CARE SYSTEMS

2.1. NHS England and the other national partners have published a refreshed Delivery Plan for the Five Year Forward View. This includes the announcement of nine Accountable Care Systems (ACS), which will be STP areas that commit to a higher level of integration and a set of other ambitions in return for greater freedoms and some transformational resource. The concept is modelled in part on Greater Manchester and indeed we are described in the document as an 'operational' ACS. I have agreed with NHS England that GM should join the network of ACS’s on the understanding that this does not fetter the exercise of our discretion under the devolved arrangements.

3.0 ASSURANCE

3.1. We have undertaken our Q3 Assurance meeting with NHS England under the devolution accountability agreement. The meeting was generally positive with a number of areas of commendation, particularly with respect to the RTT target, cancer targets, non-elective activity levels and finance. There was specific focus on the performance of our urgent and emergency care system, numbers of cancelled operations and use of mixed sex accommodation in a couple of our hospitals. The strongest concern was expressed about the continued numbers of 12 hour waits at Pennine Acute Trust.

3.2. We have also held the majority of the Q4 assurance meetings with the localities which have all been productive discussions. There has been an emphasis this time on progress on transformation plans, particularly for those geographies not yet through the Transformation Fund process. Other common themes have included Continuing Health Care, mental health and digital strategy. As part of these meetings we also held a closed session with the CCG on their leadership and governance as part of the formal annual assessment process.

3.3. We have continued to make good progress in reducing Delayed Transfers of Care (DTOCs), reaching c.3.5% in the last couple of years, down from a peak of 7% a couple of months ago.
3.4. I am very pleased to report that we are now in a position in Greater Manchester where all our hospital stroke care units are ‘A’ rated, meaning that we probably now have the most consistent high quality hospital stroke care in the country.

4.0 CLOSURE OF CALDERSTONES HOSPITAL, WHALLEY

4.1. On 27 March NHS England announced the decision to close in full the Whalley hospital facilities for people with learning disabilities. This was not the option that Greater Manchester Health and Care Partnership preferred – we considered that there was a case to retain a small amount of the secure accommodation. We are therefore currently reflecting on the decision across the Partnership and will engage with the relevant families before planning next steps with NHS England.

5.0 BETTER CARE FUND

5.1. As part of the process of publishing the revised Better Care Fund framework there will be an option for local areas to put themselves forward as pilots to graduate from the Better Care Fund. Areas will need to show maturity in terms of their integrated care arrangements, such as governance, management, levels of pooling etc, as well as good levels of performance with respect to reducing non-elective admissions and DTOCs. In reality, at this time, probably 4-5 of the 10 areas in Greater Manchester would stand a reasonable prospect on their own merits for being considered as a pilot area. We are therefore engaging with the relevant national Departments on whether they would accept the case for GM as a whole or whether we will have to do this in two stages. It does though place emphasis on the importance of the current Commissioning Review and the need to move to full integrated commissioning arrangements across all GM localities.

6.0 ‘RIGHTCARE’

6.1 On 20 April we hosted a NHS RightCare event where we brought together all the GM localities to consider the evidence on where we have adverse variation in key Greater Manchester care pathways, in terms of performance and therefore also value-for-money. We learnt from some of the best practice examples elsewhere in the country, e.g. Bradford Healthy Hearts Programme, and also internationally, e.g. Canada’s performance on hyper-tension control. The local teams spent time reflecting on their local plans and we also considered those these where we need to work across Greater Manchester. The RightCare programme will form a key part of our locality assurance programme in 2017/18.
7.0 ‘ONE MILLION MENTORS’

7.1 The national charity, Uprising, has joined with local GM partners and sponsors to launch their online platform to recruit mentors for young adults in Greater Manchester, aged 18-25. This is a very exciting programme that has the potential to guide young people, often from deprived and marginalised backgrounds, through the first stages of their adult life, enabling them to fulfil their potential. In the first pilot phase they are looking to recruit about 150 additional mentors and I am hoping that the health and care sector will contribute at least 30 of those. If the pilot is successful, then the numbers required will obviously grow very significantly. I have signed up and I hope that other senior leaders in the sector will consider doing so. All the details are at onemillionmentors.org.uk.

8.0 STAKEHOLDER ENGAGEMENT

8.1 Working with Health Innovation Manchester we hosted a visit from a group of Dutch companies interested in work on health and care integration and life sciences research. We also participated in a visit from a senior HM Treasury team that included study visits to Salford and City of Manchester.

8.2 I spoke at the Chief Nursing Officer’s conference in Birmingham and the North West Public Health Conference.

8.3 I undertook an extended visit to CMFT’s research facilities, including the Genomics Medicines Centre, in advance of their bid for continued status as one of the national genomics research centres.

9.0 FORWARD LOOK

9.1 Due to the pre-election restrictions, we will now be bringing forward our business plan for 2017/18 in June and our annual report in June/July, depending on availability of final performance and financial information. Over the next couple of months we will also be bringing forward the framework for the development of the Acute Clinical Services Strategy, our Quality Improvement Framework, mental health investment plan and workforce strategy. The first Children’s Health and Wellbeing Board will take place at the end of May, with an initial focus on reducing numbers of hospital admissions for children with relatively common conditions of asthma, diabetes and epilepsy.

10.0 RECOMMENDATIONS

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