Jon Rouse, Chief Officer
The journey so far

Greater Manchester: a snapshot picture

- **£56 Billion GVA**
  Fastest growing LEP in the country

- **2.7 Million People**
  Growth of 170,000+ in the last decade

- **104,000 People Unemployed**
  7.8% (above UK average of 5.5%)

- **77.7 Male Life Expectancy**
  England average: 79.3

- **81.3 Female Life Expectancy**
  England average: 83.0

- **112,000**
  People on long-term sick and inactive

- **12,000 Children**
  Not school ready

GVA – Gross Value Added
LEP – Local Enterprise Partnership
Who we are

• Greater Manchester Health & Social Care Partnership
  – NHS organisations and councils
  – Primary care
  – NHS England
  – Voluntary, community and social enterprise sector
  – Healthwatch
  – Greater Manchester Combined Authority
  – Greater Manchester Police
  – Greater Manchester Fire and Rescue Service
The journey so far

What is Devolution?

- Decision making powers transferred to regional level – £6bn budget for health and social care
- More decisions about Greater Manchester made here
- Provides the means and the opportunity to do things differently to meet the needs of our residents
- Drives the integration of health and social care
The journey so far

Principles

- Part of the NHS and social care system
- Place based commissioning
- Emphasis on prevention and early intervention
- Organisations working together to provide joined up care
- Transparent decision making
- Embracing potential of digital and wide innovation
- Public service estate fully utilised
- Developing the workforce
- Promoting equity and equality
- Involving and engaging residents
The journey so far

Our vision

“To deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8m people of Greater Manchester.”
Four objectives...

• Transform the health and social care system to help more people stay well and take better care of those who are ill
• Align our health and social care system to wider public services such as education, skills, work and housing
• Create a financially balanced and sustainable system
• Make sure our services are clinically safe throughout
What we want to achieve

More GM children will reach a good level of development cognitively, socially and emotionally.

More GM families will be economically active and family incomes will increase.

Fewer GM babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.

More people will be supported to stay well and live at home for as long as possible.

Fewer will die early from cardio-vascular disease (CVD).
Fewer people will die early from cancer.
Few people will die early from respiratory disease.
The journey so far

Our transformation themes

1. Radical Upgrade in Population Health Prevention
2. Transforming Community Based Care & Support
3. Standardising Acute Hospital Care
4. Standardising Clinical Support and Back Office Services
5. Enabling Better Care
Greater Manchester
Health and Social Care Partnership
Local Care Models
The journey so far

The building blocks of transformation

- Local care organisations coordinate delivery of integrated care in each borough
- Boroughs are made up of smaller neighbourhoods - GP practices working with other health and care professionals
- Standardisation across hospital sites and more care in the community, closer to home
- A single local commissioning function in each borough plus a GM Commissioning Hub
Enable conditions to be managed at home & in the community

Secure the contributions of the full range of public service partners to providing early help and prevention

Support individuals & communities to take more control over their own health

Take responsibility for the management of the health & wellbeing of a defined population

Enhanced 7 day services/ 24 hr U/C provision/Integrated PC hubs/ A&E streaming

Support for carers/improved care & health in nursing & residential homes/SUPPORT for people with LD/improved care in homes

Improved patient flow, A&E performance and delayed transfers of care, supported by integrated UC teams, models of ambulatory care and information systems.

Coordination of care for people with dementia/ Suicide prevention/ 24/7 and crisis care provision for CYP

Diagnosing early/Reducing risk of cancer/Getting better/Quality of life after cancer

Paediatrics/maternity/urology/respiratory/Cardiology/MSK/Orthopaedics/ Neuro rehab/HIV/ Vascular/Ophthalmology

Prevention and early intervention across the life course, implementation of GM Common Standards & integrated place based population health commissioning

Place Based Integration across public services to maximise health benefit, Integrated neighborhood teams.

Independent living for older people/Supported housing inc. people with LD/Extra care housing/ Home improvement offer

Enabling people to take more control of their health & well being, inc. asset based community support/self management/patient activation/social prescribing/Personalised care/Personal budgets/Enhanced VCSE

Use of registered lists/Capitated budget/ Risk stratification/joint commissioning approach/electronic records/Population specific outcomes/contracts & payments

Talent development & system leadership/grow our own/Employment offer and brands/Filling difficult gaps.

Participation in Strategic Estates Group and contribution to overall GM Estates Strategy, particularly Utilisation and Investment Pipeline Projects.

More people supported to stay well and live at home for as long as possible.

More of GM children school ready at five years old.

Fewer GM babies with a low birth weight.

Reduced number of obese or overweight children & adults.

Patients with long term conditions feeling more supported to manage condition.

Increased cancer survival rate

Key: PC=Primary care/ASC=Adult Social care/UAEC=urgent, Acute and Emergency Care/MH=Mental Health/IM&T=Information management and technology.
Social Care as part of Neighbourhood Model in GM

- Adult Social Care
  - Mental Health support
  - Community Link Workers
  - Children’s Services
  - Wider public services
  - Voluntary Sector
  - Community Health Services

- Example Services
  - Reablement
  - Well-being teams
  - Care at Home
  - Early/Intervention Prevention Services
  - Supported Housing

- Integrated Commissioning: Pooled Health & Social Care Budget

- GP Practices

- Neighbourhoods 30-50k Population within LCO
Healthier Wigan Partnership neighbourhood model & Integrated Community Services

- **Integrated Community Services**
  - Mental Health support
  - Community Link Worker
  - Start Well/Children’s Services
  - Healthy lifestyles & Social Prescribing
  - Support for Vulnerable Populations
  - Enhanced access to urgent care

**Connections & joint care planning through place based huddles**
- Wider public & voluntary sector services
  - Police
  - Fire & Rescue
  - DWP
  - Housing
  - MASH
  - Live Well Key Workers
  - Other

**Strengthening joint working through co-location, workforce development & relationship building**

Underpinned by agreed system behaviours e.g. One Team, Asset Based Approaches, early intervention

**Link Workers connecting general practice to wider support**
Integrated Community Services (ICS)

ICS is an integrated approach with community nurses, therapists, social workers and social care officers working together in teams under one management arrangement with:

- A Single point of Access for all service users to contact community services
- Services wrapped around GP Clusters (30-50,000 populations) – 7 service delivery footprints

Integrated community response teams that work in partnership to provide:

- A rapid response element that supports patients to remain at home as an alternative to hospital attendance or admission wherever clinically appropriate to do so
- Complex care support to manage patients during a deterioration in illness or who require ongoing complex case management
- Active care element managing patients who require nursing or therapy care to support illness, injury or disease and to promote good health and well-being.
- ICS is now focusing attention on a cohort known as ‘deteriorating patients over 75 years being admitted to hospital’ through development of coordinated care around step up and step down beds, improved advanced care planning and asset based support plans including WWL, NWAS and Residential Care.

All of these elements work interdependently with the intention of patients and residents passing seamlessly between health and social care services and providers depending on the level of care they require.
The journey so far

- **26,000** residents supported in their own home – costs £71m per year
- **7,405** people with learning disabilities receive support - circa £300m per year
- **17,881** care home beds operating at 90-100% occupancy
- **280,000+** unpaid carers

Performance across GM varies:

- Varying levels of quality
- Unsustainable funding pressures
- Fragile provider markets
- Issues with housing quality, design and supply
- Recruitment and retention challenges
- In-kind support provided by carers not well recognised or co-ordinated

### Adult Social Care Transformation

#### Priorities and Workstreams

**Care 2020**
- Personalised care and support
- Workforce
- Quality
- High impact care
- Digital and technology
- LCOs

**Learning Disabilities**
- GM LD Strategy
- Family based care (shared lives)
- Complex Needs
- Supported employment

**Residential and Nursing**
- QI and best practice
- Teaching care homes
- Primary Care
- Medication optimisation
- Provider engagement

**Support for Carers**
- Identification
- Health and wellbeing
- Carers as real and expert partners
- Right help at the right time
- Young carers
- Carers in/into employment

#### Supported Housing
- Age friendly housing
- Evidence base
- LD and MH accommodation
- Enabling planning and delivery
- Intermediate tier
- Technology enabled care

#### Workforce
- Registered Managers
- Apprenticeships

Enablers / cross cutting

**Greater Manchester Health and Social Care Partnership**

**LINKING INTO EACH OF THE ABOVE PLUS THE FOLLOWING ADDITIONAL PRIORITIES**
The journey so far

Care 2020 programme

Care at Home needs to radically transform. The problems facing social care are not just about money

Phase 1: Care at home offer:
- Market stabilisation
- Innovations based on local and national initiatives
- GM care at home standard

Phase 2: Care 2020
- Identify people in communities most at risk of going into inappropriate and unnecessary costly services with limited outcomes; and
- work with partners to support people to maintain their independence with interventions and prevention models
- People avoid going into long term support services and improve and maintain their independence.

<table>
<thead>
<tr>
<th>Person centred care and support</th>
<th>Workforce</th>
<th>Quality</th>
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</thead>
<tbody>
<tr>
<td>Core offer developed by individuals &amp; families</td>
<td>Pay</td>
<td>Single standard of care and quality framework</td>
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<tr>
<td>Asset based approaches</td>
<td>Flexibility and benefits</td>
<td>Joint inspections based on a collaborative and supportive approach</td>
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<tr>
<td>Re-ablement, Wellbeing teams</td>
<td>Skills for life, training, support and progression</td>
<td>Experience</td>
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<tr>
<td>Dementia support</td>
<td>Perception, leadership and recognition</td>
<td>Outcomes</td>
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<td>Housing needs</td>
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<tr>
<td>Community support/activities</td>
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<tr>
<td>Named care and support co-ordinator (care 2020 plan)</td>
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<tr>
<td>Digital and technological solutions</td>
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High impact care models
- Care closer to home (inc integrated primary, acute, community, mental health, social care)
- Targeted case management delivered by upskilled multi-disciplinary teams, with streamlined discharge planning
- Specialist acute-based consultants and nurses via tech or face to face visit
- Community response enhanced visiting schemes
- GPs work alongside a wider team of social care, nursing and specialist s

Digital and technology
- Mobile working such as Diona
- Better Technology enabled care
- Single electronic care record

Other
- LCOs
- Collaborative and joint commissioning across boundaries
- Payment reform
- Shared lives
- Unpaid Carers offer
- Supported housing
- Integrated health and care hubs
The journey so far

Learning disabilities programme

A joint approach to providing better, more proactive and more consistent support to people with a learning disability so they can be part of, and remain independent in their local community.

- Expand shared lives across GM
- ‘Demystify’ shared lives - easy read FAQs produced by self advocates
- Streamline processes pan GM
- Support provider quality improvement

- Resolving factors resulting in excessively high cost placements
- ‘Fair price of care’ banding
- Person-centred approaches
- Pan GM commissioning approaches
- Models of support so people have the right kind of service closer to home

GM Learning Disability Strategy

Housing and family based care

Supported employment

Bespoke commissioning (complex needs)

Strategic provider forum

Coproduction

Transforming Care

- Improve the transition from education to employment
- Increase access to internships, traineeships, apprenticeships and opportunities for employment/self-employment
- Change systems and culture
- A GM approach to supported employment - commissioning and practice standards and top tips for employers
- Public sector leading by example

Asset-based community development in local neighbourhoods

Carers, friends, families and relationships

Housing

Technology and partnerships

Workforce (inc community LD teams, third sector, independent providers, LA and health staff)
Across GM, there are over 560 residential and nursing homes with over 19,000 beds. Collectively, GM will work to address some of the challenges the sector faces, improve practice and support a reduction in the level of avoidable non elective admissions to acute hospitals and DTOC.

<table>
<thead>
<tr>
<th>Strategic themes</th>
<th>Quality improvement and best practice</th>
<th>Teaching care homes</th>
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<tbody>
<tr>
<td>Ethical Framework and valuing the workforce</td>
<td>• Improved quality of care</td>
<td>• A defined approach and methodology of sustainable TCH Models across GM</td>
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<tr>
<td></td>
<td>• Better quality of life and individual experience</td>
<td>• Test sites in each locality</td>
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<td></td>
<td>• Improved partnership working</td>
<td>• Evaluation, review and continuous learning</td>
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<tr>
<td>Developing community assets</td>
<td>Primary care contribution</td>
<td>Medication optimisation</td>
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<td></td>
<td>• current provision, gap analysis against NHS England Care Homes Framework</td>
<td>• GM Medicines policy /procedure for care homes to adopt or adapt</td>
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<td></td>
<td>• sharing of best practice</td>
<td>• Implementation of NICE guidance for Medicines in Care Homes 2014</td>
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<tr>
<td></td>
<td>• incorporation of wider primary care contribution into neighbourhood</td>
<td>• Establishment of how MOCH funding is to be used across GM</td>
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<td>model model through collaborative working</td>
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<tr>
<th>Enablers and stakeholders</th>
<th>GM Provider Engagement</th>
<th>Independent Sector Care Board (GMICSN)</th>
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<tr>
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<td>Service user and carer engagement</td>
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<td></td>
<td>Workforce development</td>
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<td>Supported housing</td>
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<td>Business intelligence and performance</td>
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The journey so far

Support for carers programme

Make real the principles of the GM Carers Charter, so that carers are identified as early as possible, supported to achieve better outcomes around health and wellbeing, receive a broadened offer of support so they receive the right help at the right time; and are also better supported with academic, career and personal pursuits.

**Early identification**
- Primary care standard 5
- Carers champion framework
- Carers information and advice
- Standards for annual health and wellbeing checks
- Think carer training

**Improving health and wellbeing**
- Universal support offer for carers
- Universal digital offer
- Carers resilience training plus train the trainer model of co-produced delivery
- Carers passports

**Carers as real and expert partners**
- GM Carers Partnership - strong voice and representation across GM
- Co-production and shared decision making
- Carers involved (to the level they wish) in the care and support planned for the person they care for
- Carers passports

**Right help at the right time**
- Best practice carers assessment framework
- Co-produced practice standards and training model

**Young carers and young adult carers**
- GM young carers consultation and strategic plan
- Co-produced practice standards and training model
- GM Young Carers Forum
- A GM Schools Standard
- A GM Young Carer GP Standard

**Carers in/into employment**
- Working carers pledge
- Model of good employment practice
- Partnership working with the private and voluntary sector to increase opportunities for carers to enter employment
The journey so far

Supported housing programme

Utilising the opportunities presented through devolution, empower residents to live healthy, independent lives in a suitable home within their own communities and draw on their skills and strengths to contribute to health, wellbeing and economic growth within Greater Manchester.

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<tr>
<th>Age Friendly Housing</th>
<th>LD and MH Accommodation</th>
<th>Evidence Base</th>
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<tr>
<td>Up-scaled extra care provision</td>
<td>Transforming Care and complex needs</td>
<td>Supported Housing Census</td>
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<tr>
<td>New models of accommodation</td>
<td>Transitions</td>
<td>Predictive modelling of need</td>
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<td>Residential and nursing accommodation quality review</td>
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<tr>
<th>Enabling Planning and Delivery</th>
<th>Intermediate Care</th>
<th>Technology Enabled Care</th>
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<tbody>
<tr>
<td>Making best use of existing stock</td>
<td>Analysis of current provision and future need</td>
<td>Support new model of care</td>
</tr>
<tr>
<td>Toolkits to enable local delivery</td>
<td>Development of GM plan</td>
<td>Stock take existing technology</td>
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<tr>
<td>Strategic enabling</td>
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<td>Links with Health Innovation Manchester</td>
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- Support a social care system that is less reliant upon nursing and residential care
- Identify and test opportunities and innovative delivery arrangements
- Oversee and advocate up-scaled provision of extra care
- Create confidence in the market for providers and developers
Workforce programme

Aims to deliver the fastest and most comprehensive improvements in the capacity and capability of the whole GM workforce (paid and unpaid) to improve the health and wellbeing of the population.

**Care 2020**
- A skilled, valued and stable care at home workforce, with social care in the home an attractive career as part of a team around the person (workforce deal)
  - Pay, flexibility and benefits
  - Skills for life (training) support and progression
  - Perception, leadership and recognition

**LD supported employment**
- A coordinated approach to maximising numbers into internships, apprenticeships, traineeships and paid employment
  - Collaboration with partners, and development of existing programmes
  - Opportunities for the public sector to lead by example

**Residential and nursing care**
- A stable and skilled workforce at all levels, enabled by excellent leadership, with a workforce plan to address capacity
  - A GM Registered Managers network
  - A leadership development framework
  - A Teaching Care Homes model

**Carers in/into employment**
- More working carers supported to maximise their ability to remain and progress in the workplace. More carers to be enabled to access new employment
  - Model of good employment practice to support working carers
  - Working in partnership with sector to increase opportunities for carers in employment

**Apprenticeships**
- Maximise opportunities arising from changes to apprenticeships and the levy (including for those returning to work) to establish social care apprenticeship opportunities across GM
  - Social Work apprenticeship
  - integrated health and social care apprenticeships to meet the new models of care