Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 28 January 2015

Subject: Living Longer Living Better Programme – Update

Report of: Living Longer Living Better Citywide Leadership Group (CWLG)

Summary

This update report from the Living Longer Living Better (LLLB) Programme is split into two sections:

- Section One – Progress Report.
- Section Two - One Team: Place Based Care.

Recommendations

The Board is asked to:

- Note progress towards implementing the One Team – Place Based Care model, including strengthened leadership and governance arrangements.

Board Priority(s) Addressed:

Contact Officers:

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Background documents (available for public inspection):

The Blueprint for Living Longer Living Better was set out in '*Living Longer Living Better, An Integrated Care Blueprint for Manchester*', presented to the Health and Wellbeing Board in March 2013.

This was followed by the 'Living Longer Living Better Strategic Outline Case' presented to the Health and Wellbeing Board in June 2013, which described in more detail the three main areas or 'domains' of the city's plans for integrated care.

In November 2013, the Health and Wellbeing Board received a Strategic Business Case, which described in more detail the care models, the population groups and the financial case for change.

The LLLB Strategic Plan was presented to HWB in September 2014, and brings together the documents listed above.

Further progress updates on LLLB have been provided to the Health and Wellbeing Board throughout 2014.

Section One – Progress Report

1. Purpose of report

This report updates the Health and Wellbeing Board on progress with regard to implementation of the LLLB Programme ('the Programme'). It focuses upon implementation of the One Team vision, this being the means by which Manchester residents will be supported to live longer and live better.

2. Progress

The current focus of the Programme is on the implementation of the One Team model (see Section Two of this report for more detail on this). This covers both the first phase implementation of adult social care into community services as well as developing the 2020 vision for the full One Team model.

2.1 Mobilisation

The CWLG has put in place the working arrangements for implementation of the first phase and the 2020 vision. This includes city level work relating to design and associated supporting areas e.g. estates, IT, workforce etc. Each workstream has senior level leadership and work is now progressing in each (see appendix A for a list of workstreams and leads.) The arrangements will be accountable through the CWLG into the new leadership and governance arrangements. Arrangements are being put in place within organisations to ensure that they can make the necessary changes internally to implement the model.

North Manchester, as an 'early implementer site' (EI), has established local governance arrangements via a Joint Health and Social Care Integration Steering Group which acts as the Programme Board. A Project Initiation Document (PID) has been jointly agreed. A design principle adopted is that 'form' will follow 'function' and models 'populated' by the workforce with the most appropriate skill, knowledge, experience, and profession dependant on the outcomes of the design. This is currently being done in readiness for implementation of the first phase EI area which includes Intermediate Tier services. Work by the Estates enabling workstream is providing a tactical response to the estates requirements for mobilisation of EI.

There are also established project management arrangements within Central and South's systems to work towards, and achieve, the April 2016 design for health and social care integration. By the end of March the city design team working with the three local areas will have achieved:

1. An overview of integration in each area which supports and acts as a foundation for the April 2016 design
2. A high level city design for health and social care integration by April 16, to enable discussions to clarify ambition and scope and will be developed between the design team and the city wide Co-Production Group.

3. A framework of areas that will act as board assurance within the three provider trusts to assure that the statutory organisations are aware of the opportunities and implications of a wider integration process at scale and pace.

2.2 Communication and engagement

The Citywide Leadership Group (CWLG) has started to communicate the One Team vision with stakeholders. A full communications plan will be developed by the communications workstream over the next month. Post-communication feedback to date has been positive but has usefully highlighted some of the challenges that will be faced in implementation.

2.3 Alignment of existing programmes

The CWLG has worked to align or incorporate other programmes of work to the One Team model. For instance:

- Primary care has been a separate part of the system strategy, yet is a fundamental part of out of hospital care. Primary care is fully incorporated into the One Team model and an early focus of engagement activities,
- A workshop was held between the CWLG and leaders from the Mental Health Improvement Programme. A number of actions have been agreed including earlier implementation of community based mental health services into the One Team model, developmental work around provider partnership models in the Mental Health system and stronger connection with physical healthcare,
- A joint housing and health workshop was held on the 20th of January, with the objective of building closer working relationships between the Programme and the Housing sector. The Housing sector has identified a representative to work closely with CWLG over the coming months to develop relationships further,
- Advantage is being taken of the experience and strengths of the Age Friendly Manchester Team to support the Programme,
- Operational planning of CCGs for 2015/16 will include strong focus upon delivery of the priorities of the Executive Health and Wellbeing Group (EHWBG) and will have strong emphasis upon implementation of the One Team model.

2.4 Recognition

The Programme has gained recognition in the following reports:

The Programme has been used as a case study in a King's Fund report on system leadership.
http://www.kingsfund.org.uk/publications/system-leadership?gclid=CIDtyovwhsMCFSfLtAodWi4AGQ

Integrated care teams have been featured as a case study within a joint report between the Royal College of GPs and the College of Social Work.
http://www.tcsw.org.uk/uploadedFiles/TheCollege/Media_Centre/Media_Releases/Partners%20for%20Better%20Care%20RCGP%20and%20TCSW%20paper.pdf

The CWLG has been successful in gaining grant funding from the Northwest Leadership Academy to support shared leadership development and is currently pursuing grant applications for organisational development funding to aid the development of integrated teams.

3. Devolution business case

Following last month's EHWBG the CWLG has undertake some brief scoping of how Manchester might approach the funding and freedoms which may be available as part of the Greater Manchester (GM) business case for health and social care. The following areas are being worked on:

- Asset development (estates and IT infrastructure),
- Community asset building,
- Organisational development and workforce planning,
- Service development,
- Non infrastructure IT.

Common themes include:

- Joint vehicles for system infrastructure such as estates and IT bringing together investment/divestment planning, bringing ownership and capital receipts back into the city, collective productivity and reshaping these in order to underpin co-ordinated out of hospital care and strong connection with community assets,
- Connections with other strategic areas such as developments in housing and transport, economic growth, responding to population growth and generating employment,
- Investments which have a return on investment greater than one year or complications due to separate funding streams/mechanisms,
- Strengthening the links between public assets and those in communities.
- Modernising the systems use of technology,
- Development of culture, leadership and joint working at every level in the system,
- Investing in skills to support new working practices.

These themes will be developed in more detail over time as and when the criteria for the business case become clearer, particularly the arrangements relating to payback as some of the potential developments have stronger economic models than others. Manchester has been identified as one of four areas which will be a 'deep dive' site as part of the development of the GM case.

These developments focus upon building community based care and can be drawn together with thinking regarding hospital services and building research capability.

4. NHS funding opportunity to develop new models of care

The NHS operating guidance[1] gives the opportunity for health systems to submit expressions of interest to be 'vanguards' to prototype new models of care. This gives access to a national fund of £200m. The CWLG are looking into the benefits of this in the context of a Manchester system proposal. This is subject to any options to put forward at a GM level.

5. Section 75 progress

The Better Care Fund (BCF) is expected to provide the funding to support the development of the Programme. The three Manchester CCGs and the City Council are required to set up a Section 75 agreement for a pooled budget the BCF in 2015/16, a year in which the financial positions of all partners within the city are challenged. The key objective is to give greater transparency and control over use of funding to support local integration of health and care services and to realise benefits from integration.

A key aspect of the agreement is that the external auditors must review the document to assess the potential financial accounting implications of the terms and conditions, in particular, to ensure that all risks are understood surrounding the treatment of surpluses and deficits in the pool at the financial year end.

A significant proportion of the pooled fund will support the continued funding of specific services commissioned by the Council and the three Manchester CCGs as set out below:

- Carers breaks and reablement commissioned by the three Manchester CCGs,
- Social care services commissioned by the Council with a health benefit,
- Capital investment for adult social care services commissioned by the Council,
- Disabled Facilities Grant payments commissioned by the Council towards the cost of providing adaptations and facilities to enable disabled people to live independently,
- Manchester Better Care Fund (MBCF) plan submitted to NHS England has now received an assurance rating of 'Approved'.

The pooled fund is also intended to provide funding for specified Care Act 2014 responsibilities for the Council from April 2015. The final Section 75 agreement is planned to be reported to the Health and Wellbeing Board for approval on the 25th March 2015.

6. Risks and issues

Many of the risks identified in previous report are being addressed, resulting in a stronger basis for future delivery. A focus needs to be maintained upon key areas of risk, including the development of the culture, skills and mechanisms for working across organisations; this will be a key issue when promoting new ways of working with front line staff. Current short term pressures regarding finance and performance create a challenging environment for implementing change in some regards but have

[1] Forward view into action: Planning for 2015/16 – NHS England

also generated some increased impetus as the means for addressing these challenges.

Section 1 - Appendix A – Workstream leadership

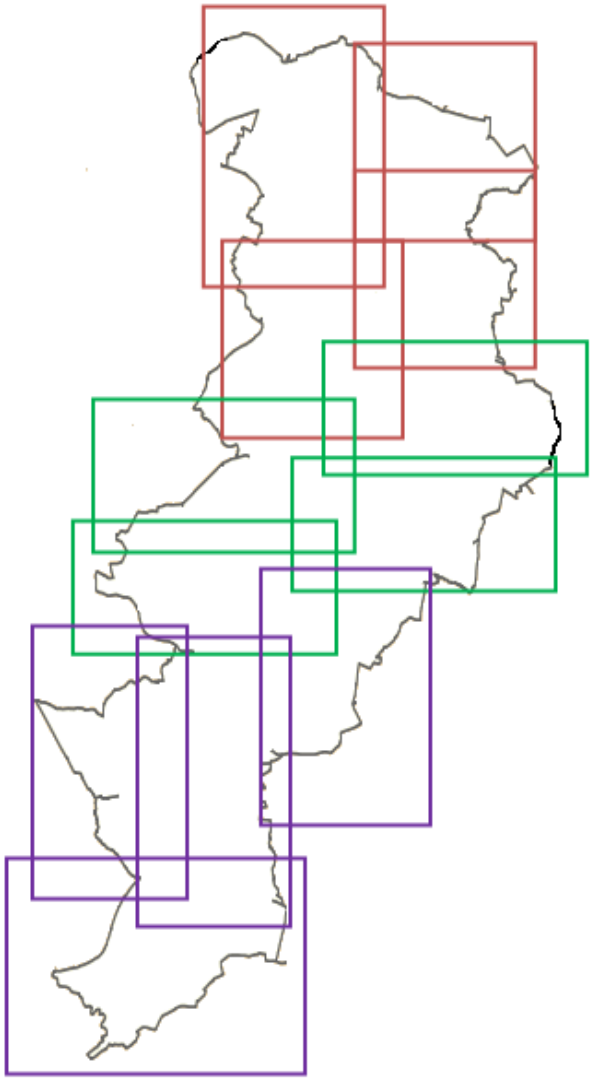
Enabling Workstream	CWLG Lead	Organisation
Design (including board assurance)	Sara Radcliffe (Phase 1) Ed Dyson (2020)	CMFT CMCCG
Estates	Joanne Royle	MCC
Information Management & Technology (IM&T)	Peter Connolly	UHSM
Workforce	John Harrop	MMHSCT
Communications	Nick Gomm	Citywide CCG
Performance & Evaluation	Sam Bradbury	Citywide CCG
Finance & Commissioning	Claudette Elliott	SMCCG
Self Care Group	Helen Speed	NMCCG
Co-Production Group	Deborah Lyon	PAHT
Reference Group	Helen Speed	NMCCG

Section Two - One Team: Place Based Care

The report below was produced in November 2014 and the direction of travel set out has been agreed by all Programme partners and EHWG. Section One of this report outlined progress against implementing this model.

MANCHESTER CITY COUNCIL

NHS
North, Central and South Manchester Clinical Commissioning Groups



Developing a One Team approach in Manchester

Commissioning place based care

1. Executive Summary

This describes a vision for community based care in 2020 and to move from projects to large scale change. It takes the Living longer, living better (LLLB) programme into a new phase of implementation and scales up and speeds up development of community services to achieve the programme vision:-

Figure one: LLLB vision and strategic aims.

It describes a framework of community based care defined by geography or 'Place' and establishing a 'One Team' approach. The One Team approach brings together professionals within the community, including primary care, to work together for the needs of local communities as well as their organisational and professional roles. There would be approximately 10-12 teams across the city working locally towards common goals for their communities but also networked across the city as one system.

This approach brings together professionals and gives them the means by which they can deliver effective coordinated care. It shifts from projects and discrete service developments to building capacity and skills within teams thus increasing the offer to the public and the outcomes they gain as a result.

The implementation will be large scale and complex, taking five years. It will require development of the infrastructure as well as changes to how and where some front line professionals work. This will require a significant step up of capacity, skills and working arrangements in commissioning, provision and cross system leadership. Partner organisations in the Living longer, living better programme have supported this vision and are seeking progress with implementation.

2. Introduction

Manchester's health and care system has set itself an ambitious challenge to raise itself from the foot of the league tables and to match the outcomes of residents to the significant assets of the city. The Living longer, living better programme was established to develop community based care to take a more coordinated and proactive approach to care delivery in order to keep people well and keep people out of hospital. This programme has made significant changes to community based care but the pace of change is not meeting the scale of the city's ambition.

Progress to date has been through implementation of service models and pathways. These have been successful but have created incremental change through investment of approximately £10m. However, as part of an overall health and social care budget for the city this means only a small proportion of our resource in staff, infrastructure and equipment is focussed toward our goal. It lacks a coherent shape in terms of service model and infrastructure as an emerging system. This risks creating a different form of fragmentation and underachievement of our goal.

This paper seeks to describe the model by which care is delivered in the city by 2020 and to give a framework by which providers work together to develop community based services and build capacity over time to increase the community offer and improve outcomes for people in the city. One Team is a means to an end rather than the end in itself which are described in section three. The paper outlines the key next steps to be taken in order to make this a reality.

3. Vision for Manchester Health and Care

a. Vision for the population of Manchester

Health and care leaders have established a shared vision for community based care as stated below:-

"By 2020 the Living longer, living better programme will have radically transformed Manchester's community based care system. This transformation will support people to live longer, healthier lives by ensuring a wide range of high quality health and social care services are easily accessible within communities, and are centred on the individual and their specific health needs."

This vision is expressed through four strategic aims:-

Improving health outcomes – Contribute to an improvement in key quality of life and life expectancy outcomes in Manchester by driving improvements in the community based care system, ensuring a range of new, innovative place-based services are centred on the individual.

Improving service standards – Ensure that the new community based care system delivers high quality, easily accessible services regardless of where in Manchester an individual lives.

Financial sustainability – Deliver a financially sustainable community based care system for Manchester that enables a safe reduction in the overall spend on health and social care services and a rebalancing of resources from in-hospital to community based care.

Supporting self reliance – Increase the volume, range and effectiveness of prevention and early intervention services available, including a wider choice of resident self care options, to enable people to maintain their independence within a strong community support network.

4. Developing a One Team approach

a. Rebalancing our system

In order to fulfil the LLLB vision commissioners wish to see community based care grow within the health and social care system and for this to be resourced by a reduced need for activity in hospitals, nursing and residential care homes. This reduction will be achieved by community based services keeping people well enough so as not to need hospital or residential care rather than merely a shift in where care is delivered.

b. One Team approach

Professionals working together in the community should be defined by the Place they serve as well as their professional group and their employer. Place is defined by a geographical area and its population. Front line staff should see themselves as part of 'One Team', working to achieve shared outcome goals for their population. They should be given the freedom to adapt, innovate and self organise in order to improve how they deliver care and improve the outcomes for their population. Teams should provide care but also enable and empower people to care for themselves.

Rather than new services being established growth should be in capacity and skills and reducing barriers in order to increase the offer to the public and thus increase their care and wellbeing. By 2020 this approach will need to develop and the offer grow in order to generate the 20% shift from hospital care, this being the ambition of the health and care system.

c. Configuration

The assumption is that the majority of provision should be based around teams covering approximately 40-50k residents (subject to options appraisal). This would mean 10-12 local teams for the city. All community based services should be considered for delivery on this basis. Some services might be better suited to work at a larger scale i.e. North, Central, South or city e.g. children's end of life care services due to specialist staff or intermediate care due to infrastructure. Similarly, some would work to a smaller size where very local community focus adds value. General Practice, for instance, is very effective at working with a much smaller population group set within local neighbourhoods. It would be detrimental to primary care to configure it to a larger population. However, it is imperative that primary medical care works as an integral part of the team arrangements. At whatever geography professionals work their touchstone for care delivery is the local team(s) within which they work.

d. Connection

The new community based care system should work in a connected ways with effective relationships between local teams and with other parts of the system. They need to be connected with other health and social care provision, indeed many services can actively interface e.g. consultant geriatricians or specialist nursing reaching into teams. Teams should connect to local assets such as community groups, voluntary sector organisations and community facilities. Most importantly they should connect with residents, patients and their carers to engage and enable

them to be as healthy as they can be. Dedicated capacity should be incorporated into teams to achieve this.

e. Painting a picture

Commissioners don't seek to prescribe the detail of how teams should be developed but an example of how it might work in adult services is described for illustrative purposes below. This is by no means to limit the scope of the design work.

Local Team*
Pharmacy
Community nursing
Community Mental Health
Primary medical care
Social Care including assessment, care management and reablement
Active Case Management
In reach of secondary care services e.g. community geriatrician, specialist nursing
Team leadership, operational management and administrative functions
Connection with the community
Micro commissioning**

*This would mean aligning existing staff from these professional groups rather than creating a new separate team. The aim would be to use investments over time to build the teams' capacity and skills. It does not suggest any change of employment status.
** Micro commissioning is purchasing of relatively low cost items such as aids and adaptations, dressings, small care packages. This could potentially be from a unified budget.

This example is a natural evolution from work to date but consideration should be given to other areas of work e.g. Early years, planned care services now and toward 2020. Whilst the shift to this approach should be phased it is important to plan ahead in order to future proof estate and IT investments as scope broadens over time.

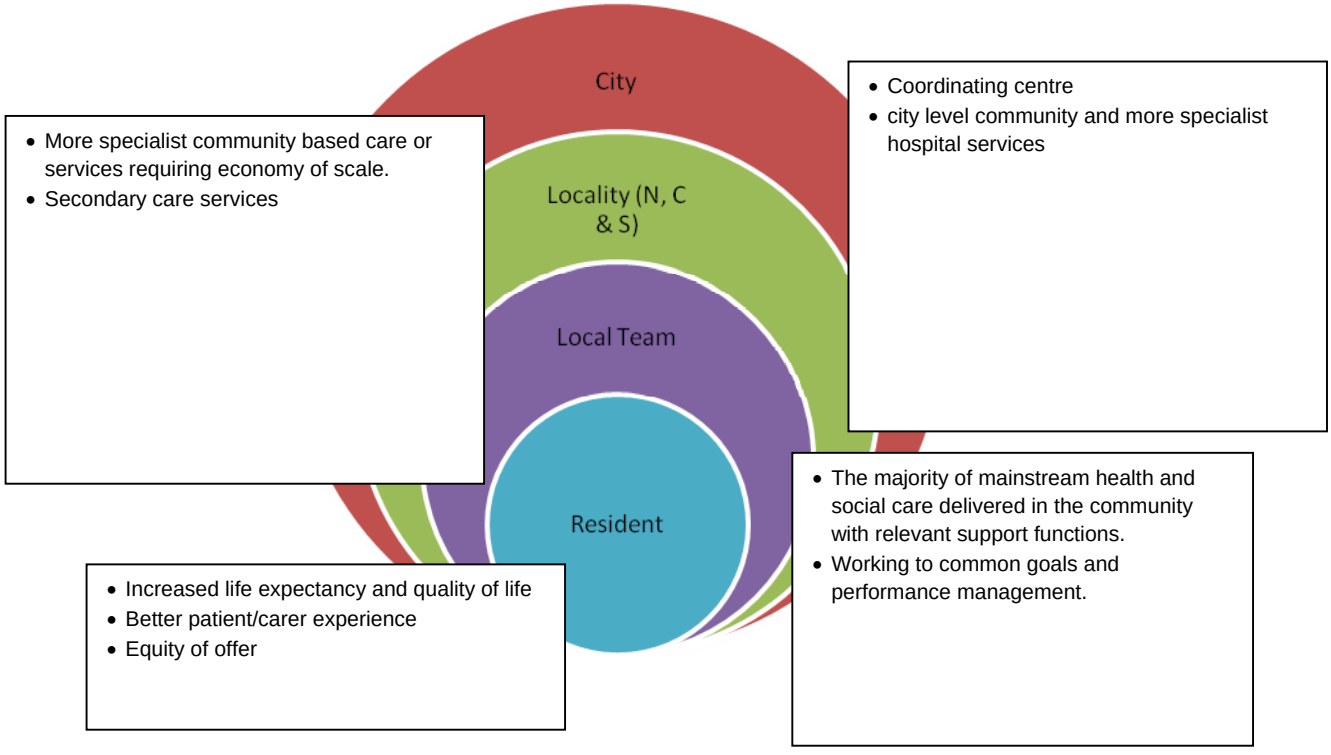


Figure three: One team model

Set up

- Co-located staff/services in buildings in each local area. Connected satellite premises e.g. general practice and pharmacy where provision is at a more local scale.
- Simple means of coordinating access to services
- Shared access to online records
- A single performance framework with outcome goals on which the team is collectively measured and for which it is accountable.
- Shared management, administrative and back office functions
- A clear identity to the team and an OD/Workforce plan to support transition to closer working.
- Capacity to connect into local communities, services and assets.
- It is not envisaged that this approach needs a change in employment or establishment of a new organisation, indeed this may be a distraction in the first instance. The aim would be to network providers to coordinate care but not to merge organisations shifting to the bottom right quadrant in figure four.

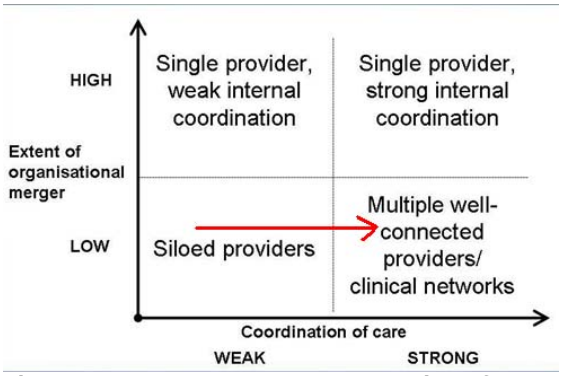


Figure Four: Boston group – Integration of care

Geography

This should be a form follows function approach but existing geographies should be considered e.g. Early years, CCG locality/patch arrangements, hospital catchment areas.

f. Benefits

The one team approach will be the means by which improvements to health and wellbeing outcomes for the population can be achieved due to the following features of the approach.

- Care which is locally focussed to the diverse populations within Manchester and targeted better to need and cultures.
- Right care, right place, right time – first time. This will mean more joined up care and support functions ensuring that people receive the interventions which will have the best effect in the timeliest way.
- Simplified navigation of the system for professionals and residents.
- Common outcome and output goals across the team with a shared performance framework focussing efforts towards shared outcome measures linked to LLLB.

- The opportunity for professionals to work together and to innovate how they deliver care
- Shared infrastructure including buildings and information systems enabling better joint working, improving quality of infrastructure and creating cost efficiencies.
- Productivity through shared resources, reduced duplication, simplified processes, fewer non value adding activities.

g. Challenges

- A key challenge will be to develop this approach in a way which works for residents of the city. The co-production workstream of the Living longer, living better programme would be used to ensure that the implementation is effective and the benefits to residents are realised.
- This is a significant workforce change both practically and culturally which will be challenging for front line staff and will certainly be a complex change programme. Development of organisational development, communications and engagement strategies will be essential.
- There are significant financial implications, positive and negative, but complex to model and there are financial risks for all organisations involved in the change. The change will require non recurrent resource, which may be accessible through the Better Care Fund but will need to be identified at the outset
- Estates and IMT/ICT are clear enablers for co-location and sharing information about patients. Strategic planning for estates has started to progress but there is progress still to be made in planning to support implementation. Shared electronic patient records and care plans are in place at for small proportion of the population but there is no clear strategy nor identified professional leadership through LLLB.
- The difference between registered and resident, fee versus free services and professional accountabilities will complicate implementation.
- Establishing the balance between allowing innovation and freedom amongst providers and front line staff and being assured of evidence based care, quality and value for money.
- Policy changes impacting upon how commissioning and provision need to take place e.g. the Care act, spending reviews etc. All potential outcomes of the 2015 General Election are likely to generate a shift in policy direction.

5. Implementing a One Team approach

Whilst simple in concept, implementing a one team approach requires reshaping community services, including primary care, within a five year period. This implementation will be complex in nature and will require implementation managed across multiple organisations. Implementation of One Team will rank amongst the largest scale changes ever made in our local health and care system. Whilst the city's joint working arrangements have been transformed for the better in recent years, this means a further advance in these arrangements is needed.

The principles behind both the governance and implementation approach is to use existing arrangements, strengthened where necessary, rather than establishing new structures. In addition implementation should be seen as core business from the outset rather than a programme of work done by others.

Each individual organisation will need to establish appropriate governance and implementation arrangements as they deem necessary. The following sections relate only to the multi-agency aspects.

a. Implementation

This timeline shown in figure five shows implementation over three phases which will require detailed scoping. As each phase commences a very detailed and tightly managed project plan and associated capacity will be required.

It is important that post implementation learning continues within the new arrangements to continually improve the new arrangements and to transfer learning to subsequent phases.

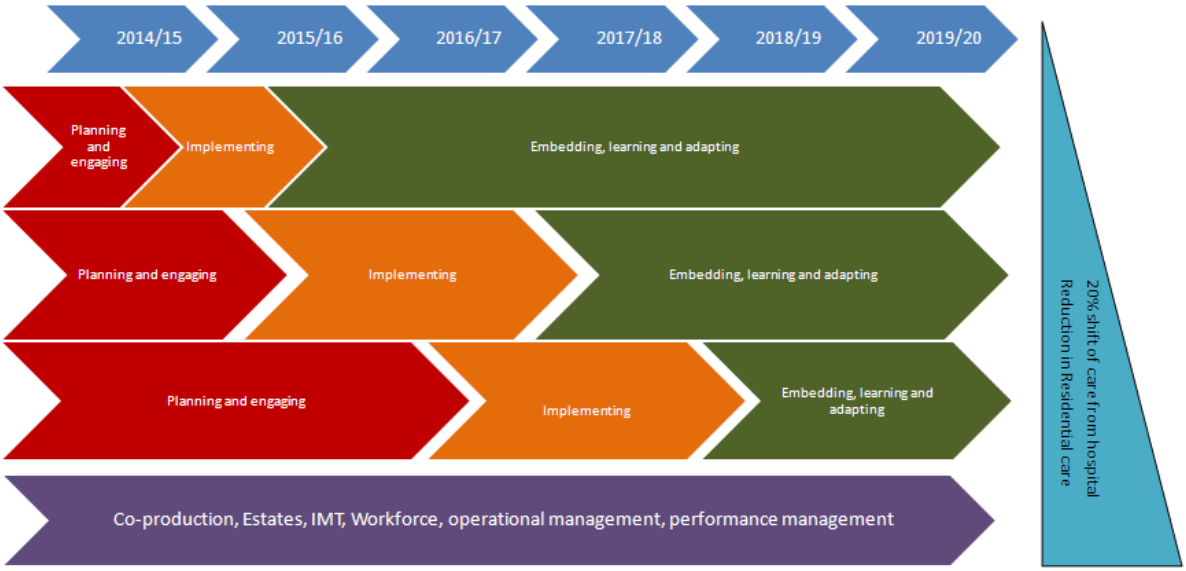


Figure five: Outline implementation plan - indicative

Areas of infrastructure development etc. (purple) need to meet the needs of the implementation of service change. They also need to plan to have developed overall infrastructure fit for 2020. Operationally the first phases will have estates needs for instance but strategic estates planning needs to work toward the needs of full implementation.

b. Governance

Governance will work at three levels. Ultimately accountability will be to the Manchester Health and Wellbeing Board and its Executive Group. The citywide leadership group (CWLG) will oversee the implementation over the five year period and the outline implementation plan (figure five) will form its broad work programme until 2020. In addition to overseeing the programme the CWLG will ensure the right balance between citywide integrity of the One Team model and the pace of implementation and local innovation that the three localities in the city can bring. Ultimately the One Team approach needs to enable seamless working across the city and a consistency of offer to residents.

Localities will focus upon design and implementation within the local context but will need to implement in such a way that ensures the integrity and consistency outlined above. Local systems will implement provision and, therefore, providers must have network arrangements.

A governance chart of collaborative working arrangements is shown in figure six below:-

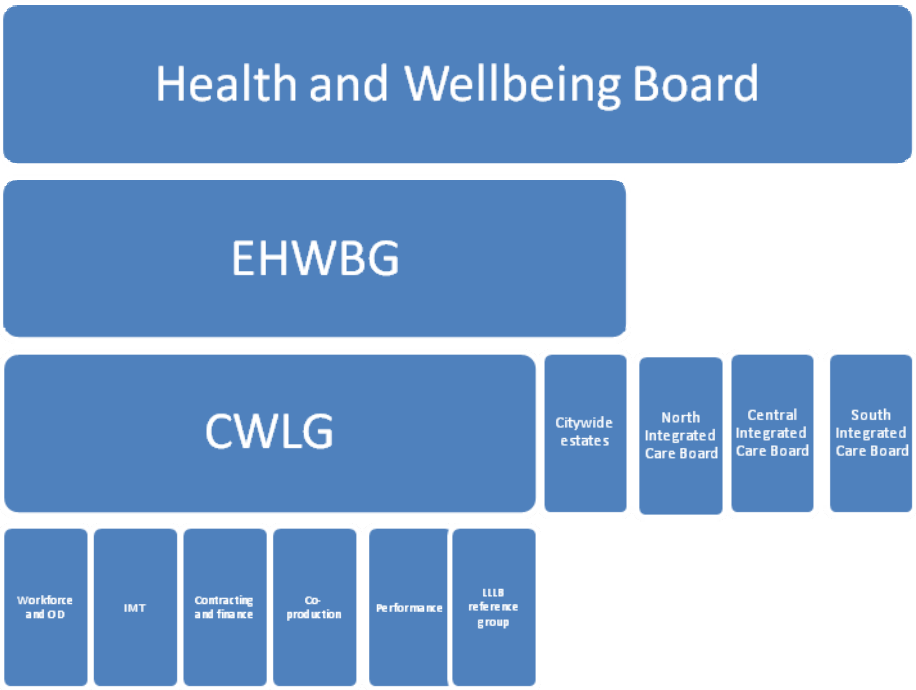


Figure Six Governance chart for One Team.

c. Resources

Financial planning should work to existing financial and contracting strategies. These strategies are aimed toward supporting the desired service model through effective contracting and funding methods. The key strategic approaches are outlined in the following sections.

i. The virtuous circle

This approach shows how a shift in resource can take place through targeted investments. An investment is made in out of hospital care which is evidenced to reduce activity in secondary/nursing and residential care. This in turn releases funding to sustain the service model on an ongoing basis.

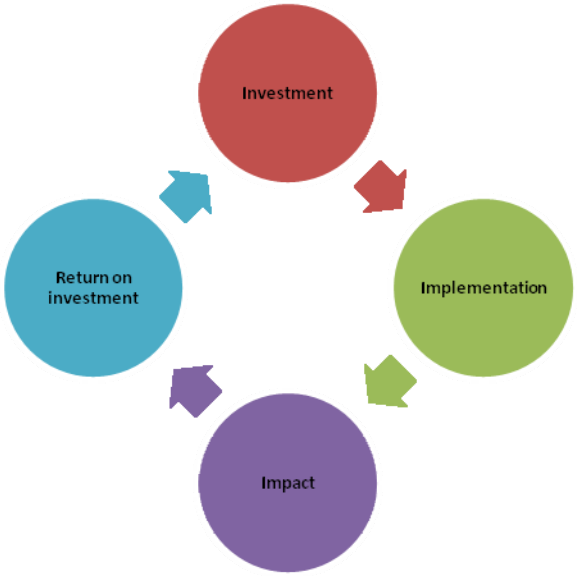


Figure seven: Virtuous circle of investment

ii. Public sector reform

PSR is a key Manchester and Greater Manchester approach. It takes the principle of the virtuous circle but recognises that the organisation making the investment may not be the organisation receiving the return on investment e.g. increased social care reducing emergency admissions. This philosophy will be important in building the One Team approach.

iii. Contracting reform

It has been shown that different contracting models such as Alliance or Prime contractor can act as an enabler for service change and to incentivise achievement of shared outcome goals. Again, options for the appropriate contracting model will need to follow the final design and implementation plan of the teams and may evolve over time.

iv. Funding

1. Recurrent

Ultimately public services will need to operate within increasingly tight financial constraints. Developments within community based care will need to be generated through existing resources. This will either be adapting how current services work to deliver better care, releasing resources through productivity or by reduction in secondary care/nursing and residential care to fund new service models. Improving quality of care and more proactive interventions will generate this shift. Experience to date in managing this release of resources has been by reducing exacerbation or the acuity of need through keeping people well rather than the same care being delivered out of hospital at lower cost.

2. Non recurrent

In the short term the main source of investment funding will come from the Better Care Fund (BCF). Whilst this is not new money and much of it is already committed it is a useful source of working funds to grow the capacity and skills within the team.

Consideration should also be given to the OD requirements of developing effective multidisciplinary/multiagency teams and leadership skills.

3. Capital

Fundamental changes will be required to the public estate in order to promote joint working with a clear emphasis on co-location, quality, productivity of estate and sufficient physical space to deliver a greater portfolio of community based care. Similarly IMT/ICT systems will need to be connected so front line professionals can share information and effectively plan care. Estates and IMT/ICT are inextricably linked and connected strategies and capital plans are required.

6. Roles and responsibilities

a. Commissioning for Place based teams

For the purposes of this paper commissioners in Manchester are:-

- Manchester City Council
- North, Central and South Manchester CCGs

Relationships will be needed with other commissioners e.g. NHS England through co-commissioning arrangements and other public sector functions e.g. housing, employment and regeneration.

Commissioners in Manchester will need to adapt in order to commission for a more integrated model of provision. This will include a number of aspects which will need to be explored in more detail by the relevant commissioners.

- To work together to shape and scope the One Team model further
- Developing a unified set of outcomes goals, service standards and performance management arrangements.
- To ensure effective public engagement in the development of the ‘One Team’ model.
- To work as system leaders to coordinate the overall health and care system bringing providers together to deliver the new system as well as to coordinate developing infrastructure such as estates and IT.
- To assess the value of more integrated commissioning activities to most effectively commission for the new system. This will include developing a common set of outcome goals and working more closely to avoid duplication and maximise opportunity.
- To continue to develop the optimum funding and contracting models to support development of the new community based care system.
- To commission and decommission within the One Team approach on an ongoing basis to ensure the most effective care to our population.

b. Provider arrangements

We need to engage with providers to establish the options for putting such a system in place. The key to this will be the provider partnerships within Manchester. However, a more active discussion with primary care will be required so that core

primary care services are embedded within the new arrangements from the outset as they are currently not represented fully within provider partnerships. Providers will need to:-

- Self organise to put together a collective proposal to commissioners to implement the One Team approach against outcome measures within the available resource.
- To establish effective implementation plans.
- To put in place the necessary systems of governance and good practice.

c. The leadership challenge

Putting in place a new community based care system will raise significant challenges and leadership needs to work across the system as well as within organisations. It is important that leadership rises to that challenge at all levels and across disciplines. There are strong leaders in the city already working across agencies. However, consideration should be given to how this can be strengthened still further and increased in depth. These leadership arrangements need to be underpinned by strengthened governance arrangements to support the development of this work.

d. Joint programmes of work between providers and commissioners

There are clear distinctions between the roles of providers and commissioners. However, there is value in a continuous dialogue from development through into implementation. There are specific pieces of work where there should be clear joint working between provider and commissioners. Key areas such as estates and IMT/ICT will require collective effort, skills and resources.

The areas listed below are proposed areas of joint working. They are key to the success of this proposal. They each need strengthened leadership and/or capacity arrangements establishing.

- Workforce and organisational development
- Estates
- Information Management and Technology
- Contracting and funding/financial planning
- Performance management and outcome development
- Co-production and public engagement

7. Next steps

The next steps to take this forward are as follows:-

- Strong engagement to communicate, develop the model and seek wider buy in.
- Establish governance arrangements including building capacity where necessary.
- More detailed scoping of model, outcome goals and means of implementation.