Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 17 December 2015

Subject: Manchester's Locality Plan - Update

Report of: Lorraine Butcher – Joint Director of Health and Social Care

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Summary

The following paper provides Committee members with an update on Manchester's Locality Plan and the health and social care transformation work planned in the city.

Recommendations

The Committee is asked to note, and discuss, the progress made in developing Manchester's locality plan as outlined in this report and the presentation provided at the Committee meeting.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

1. Introduction

As reported previously, health and social care commissioners and providers in Manchester are working on the development of the city's Locality Plan for health and care integration (see Appendix A for the current version). Over time this Plan has evolved to become a commissioner-led whole system strategic document which outlines the strategic approach to improving the health outcomes of residents whilst also moving towards financial and clinical sustainability of health and care services. The key purpose of the Plan is explicitly:

- To contribute towards the overall Greater Manchester 'ask' of Central Government to help deliver effective and sustainable integration;
- To articulate Manchester's proposals and provide a shared blueprint for the City's health and social care integration;
- To make clear the impact upon health and social care services if an appropriate settlement is not achieved through the forthcoming Comprehensive Spending Review

1.1 The Manchester Locality Plan

Since the previous report to the Committee in July 2015, significant discussions have been undertaken among commissioner and provider organisations regarding the scale of ambition and vision for the future health and wellbeing of the residents of the City and what actions are required to ensure future health needs are addressed through provision that is both clinically and financially sustainable.

What has emerged over this period is the strengthened view that the Plan is the Commissioning Plan for health and care integration, and that it contains 3 pillars which together will drive the radical transformation of health and care services in the City. These pillars are mutually dependent and are:

- A **single commissioning system** ('One Commissioning Voice') ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services;
- **'One Team'** delivering integrated and accessible out of hospital community based health, primary and social care services; and
- A **'Single Manchester Hospital Service'** delivering consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the City.

A Single Commissioning System

The bulk of health and care services in Manchester are commissioned by the following bodies:

- North Manchester NHS Clinical Commissioning Group
- Central Manchester NHS Clinical Commissioning Group
- South Manchester NHS Clinical Commissioning Group

- Manchester City Council
- NHS England

NHS England is responsible for the commissioning of 'specialist health' services.

For 'non-specialist' services, the 3 Manchester Clinical Commissioning Groups (CCGs) and City Council hold the resources for health and care services provided for Manchester residents and patients on GP registers. Increasingly it has become evident that the functions of commissioning have been fragmented across the commissioning organisations resulting in a multiplicity of transactional arrangements but more importantly a fragmentation of care provision and inefficient use of resources.

Over recent months a programme has been launched by the Commissioners, 'Working Better Together', undertaking a review of current commissioning arrangements and strengthening the focus and role of commissioners which is:

- To define the desired outcomes;
- To create the environment for change to happen;
- To ensure health and care standards are met and improvements are made.

What has emerged from this work is the intention of partners to commission with 'one voice', agreeing joint strategic priorities across all of the organisations; agreeing accountability and delegated authority arrangements across each of the partners; adopting an integrated way of staff working, combining where appropriate resources in line with agreed programmes; and jointly managing market provision. Development work is underway to shape this programme further.

Parallel to this work has been the development of a single specification for out of hospital care – 'One Team – Place Based Care'.

One Team

Over the preceding 6 months, the 4 commissioning organisations (3 CCGs and Council) have developed a specification for 'One Team – A Place Based Model of Care' for community based care in the City. This model of care is the means by which the commissioners intend to grow community based care and make the shift from a current system which has too much reactive, expensive and institutional care to one which enables, encourages and promotes health and wellbeing through place based, integrated working that prevents ill health and keeps people living well in their community.

Within scope of the 'One Team' will be:

- All community health services for children and adults (from the Council and including identified services from the District General Hospitals in the City);
- All adult social care services including assessment and care management;
- Residential, nursing and home care;

- Public health wellbeing and screening services;
- Commissioned services from the voluntary, community and faith sectors;
- Adult community mental health services;
- Primary care mental health and IAPT
- Primary care (including over time and subject to a separate development work stream GPs)
- Urgent care and first response services

The 'One Team' specification was approved by the Health and Wellbeing Board on 10th June 2015. With this specification came an invitation to providers to:

- Respond to how they would put this service model into practice with an initial focus upon primary care, community health, adult social care and community mental health services; and
- Describe how they would organise themselves collectively to deliver this.

A partnership of 11 providers gave a joint response to this specification which was a major step forward in the City. There is widespread support for the service model, and the providers are currently considering how they will need to collaborate to make this vision for the model of care out of hospital a reality.

Work is now underway by commissioners to develop a further iteration of the specification with more granular details to be more prescriptive about what is required, the scope of the services to be included, and details of how success will be measured. The basis for delivery is built from the 12 neighbourhood teams.

The intention by commissioners is to develop a **single contract** for Manchester which will be used to commission to this specification. The details of the type of contract and the term of the contract will be explored further but it will be with a single contract holder and it will need the means to actively shift resource out of the acute component in the out of hospital care component of the contract. The intention is that existing providers of the services actively collaborate to determine how they will together deliver the services required by the contract.

A Single Manchester Hospital Service

The hospital services in Manchester include some of the best and most highly regarded teams in the UK, with real areas of excellence in clinical care. However, there are also significant inconsistencies and variations in the way that acute hospital services are provided at present. Standards of care can be variable, best practice is not consistently adopted or adhered to, and there are important gaps in services alongside areas of service duplication. The existing arrangements also fail to provide a clear Manchester focus for acute hospital care, or for the relationship between providers and commissioners.

A 'Single Manchester Hospital Service' would be a partnership working approach which would aim to deliver consistent and complementary arrangements for providing acute hospital services across Manchester, with the aim of eventually achieving a

fully-aligned hospital model. This would encompass a range of clinical single services, and optimised arrangements for support services, estates utilisation, and back office functions.

It is proposed that the project would be developed through a two stage process. Firstly, reviewing the service portfolios of the 3 Trusts and developing a detailed exposition of the potential benefits of a fully aligned hospital service model. Secondly, undertaking a detailed appraisal of the most appropriate governance arrangement.

Clearly providers will need to consider governance arrangements and specifically determine how they will organise themselves to optimum effect to ensure delivery of the single contract specified by commissioners.

An action plan describing this process is attached in Appendix B.

Financial Position

In total Manchester spends £1.1bn on health and social care services, excluding specialist services. The strategies and priorities described in this Plan represent Manchester's health and care partners' agreed approach to managing a predicted 'do nothing' deficit of £284m by 2020/21. A summary financial plan for the 5 years to 2020/21 has been projected for Manchester, taking account of pressures and demographic changes over the period, together with the estimated changes in resources for health and social care. The deficit originates from net estimated challenges across health and social care of £163m and £121m respectively.

It is recognised that a deficit of this magnitude will only be avoided through strong commissioning across the 5 commissioning organisations, and by strong partnership working by providers. Providers have agreed to the principle that the delivery of the transformation programmes will enable a shift in resources between hospital and community settings.

Applying the Greater Manchester savings opportunities identified within the draft CSR submission to Manchester, indicates that Manchester has a potential position (Scenario 1) which converts the significant 'do nothing' deficit of £284m to an approximate break even position. However, the alternative scenario 2 to date (and subject to further review) currently indicates a potential deficit of £149m remaining.

Benefits Analysis Summary by Scenario by 2020/21	**Scenario 1**	**Scenario 2**
	£m	**£m**
Do nothing gap 2020/21	**284**	**284**
Additional Funding	-154	-44
Net Locality Transformation Plans	-81	-81
Provider Cost Improvement	-94	-34
Estate and Back Office Transformation	-34	-34
Other	58	58
Closing position (Surplus) / Deficit	**-21**	**149**

Proposed Next Steps

Work is ongoing among partner organisations to continue to strengthen and refine the Locality Plan. This will involve a focus upon quantifying the impact upon the population and anticipated improvements in health outcomes, underpinned by a clear performance and accountability framework.

Development work continues to implement the first phase of the Neighbourhood Teams scheduled for 2016.

Work is also underway reviewing the Governance and Accountability arrangements for the Locality Plan with a report scheduled to be presented at the next meeting of the Health and Well Being Board in January 2016.

Additionally work continues to be undertaken in identifying and agreeing the financial gap to inform the 'investment ask' of central Government for both Manchester and Greater Manchester.

Communications and Engagement

The Locality Plan provides us with a great opportunity to communicate, and engage upon, our vision and plans as a whole. It also sets an overarching narrative to support programme-specific communications and engagement. In line with the 'listening period' for the Greater Manchester Strategic Plan, a programme of public communications and engagement work around our Locality Plan is planned to start in the middle of January and run until the end of March. The aims for this exercise are:

- To raise awareness of Manchester's Locality Plan
- To receive feedback on the plan and the transformation programmes
- To receive comments and suggestions on how the health and social care system in Manchester could be more efficient and effective
- To receive feedback on what can be done to support people to live healthier lives and 'self care' where appropriate
- To support the GM Strategic Plan 'listening period'

Materials to support the work are currently being developed and will be brought to the Committee when ready.

Recommendations

The Committee is asked to note, and discuss, the progress made in developing Manchester's locality plan as outlined in this report and the presentation provided at the Committee meeting.

Appendix A: Manchester's Locality Plan

Manchester Locality Plan

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1.0 Executive Summary

1.1 The Manchester Locality Plan – A Healthier Manchester - details the strategic approach to improving the health outcomes of residents of the City, while also moving towards financial and clinical sustainability of health and care services. It supports the development and delivery of the Greater Manchester Devolution Programme. The Programme offers opportunities for Manchester to invest in transforming service, it protects social care funding, without which there would be a wholesale reduction in the level of care provided to vulnerable residents.

1.2 This is an ambitious and demanding Plan which reflects the shared commitment and vision of the Manchester Clinical Commissioning Groups, Manchester City Council, with the acute trusts, Central Manchester Foundation Trust, University Hospital of South Manchester, Pennine Acute Hospital Trust and Manchester Mental Health and Social Care Trust. The Plan continues to form and will be subject to review as further work by commissioners, and with stakeholders, the VCFS, Health Watch informs the safe and good quality delivery of services.

1.3 The Locality Plan is the ***commissioning plan*** for health and care integration for Manchester. It contains ***3 key pillars*** which together will drive the radical transformation of health and care services to the residents of Manchester. These are mutually dependent and are:

- ***A single commissioning system*** ('One Commissioning Voice') ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services. This approach will integrate spending across health and social care on high cost/high risk cohort, reducing duplication of service delivery and fragmentation of care;
- ***'One Team'*** delivering integrated and accessible out of hospital community based health, primary and social care services within neighbourhoods. Through the combining of resources residents will get integrated services, resulting in improved outcomes (holistic needs addressed) at reduced cost;
- ***A 'Single Manchester Hospital Service'*** delivering cost efficiencies and strengthened clinical services, with consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the City.

1.4 Manchester's ask of GM Devolution and the Comprehensive Settlement Review is to release investment funds to drive the progress towards devolution that is now happening on the ground. The early adopter of the Community Assessment and Support Service in North Manchester is already demonstrating early progress of the benefits for residents of integrated care. The use of the Cost Benefit Analysis methodology and it's adoption across GM localities is evidence of the strong approach being applied to drive this programme.

1.5 The Manchester approach will ensure that:

- There is a clear focus on place, the needs of residents, and not organisational interest;
- Manchester continues to be at the fore of clinical excellence and continue to attract world leading clinicians;
- A stronger service offer to residents ensuring their health and care needs are addressed earlier, that they are encouraged to take responsibility for their own well being, and that, when they need access to more specialist care that that is available to them and affordable; and

- Front line health and care staff are professionally fulfilled in the demanding roles that they undertake.

1.6 Importantly the commissioners and providers of health and care will come together to ensure duplication and fragmentation of service provision is removed, that unnecessary costs are avoided, and that our clinical leaders shape the model of delivery most suited to meet the needs of residents in Manchester ensuring that in future they get the ***right care, at the right time, in the right place***.

1.7 This Plan demonstrates the continued commitment of partners to continue to deliver the highest levels of clinical excellence, and to be a City which continues to attract investment in health sciences as part of its growth strategy.

Why do we need this Plan?

1.8 It is clear that the sustainable future of health and social care depends on ***partnerships, collaboration and working together***. The way forward is clearly one of 'connecting care' across the different sectors of health and care: between family doctors and hospitals, physical and mental health and health and social care. Clinical and financial sustainability will be secured through more innovative commissioner and provider arrangements, where the commitment to 'place' rather than organisation takes primacy. Locally the main aim is the 'one team' philosophy and ethos that all Manchester partners support.

1.9 Although there have been some local successes in changing the way services are delivered, more needs to be done to ensure services consistently meet the needs of local people, are ***clinically safe*** and are ***affordable***. Often services are fragmented, reactive and difficult to access. Staff can sometimes find it difficult to meet the needs of the people they support in the way they would like.

1.10 Importantly, health outcomes for Manchester's residents remain among the worst in England. Whilst the City has transformed in terms of economic growth and infrastructure people's health and wellbeing have not prospered. Good health is key to ensuring residents achieve their full potential and benefit from the economic growth and transformation taking place in the City. It is key to reducing dependency and ***unlocking the potential of the community*** to live well and contribute towards the City's growth.

1.11 High rates of smoking, drinking and poor diet are key factors in a cycle of ill health that compares unfavourably to other major cities. Manchester is the 4th most deprived area in the UK with over 36% of children living in poverty and life expectancy for men and women is lower than the national average. The levels of adult and child obesity, teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery, smoking related deaths, hip fractures, sexually transmitted infections and TB are all worse than the national average. Manchester has some of the worst outcomes for stroke, cancer and heart disease.

1.12 Specifically:

- The City has the lowest life expectancy at birth for women and the second lowest life expectancy at birth for men in England;
- Premature deaths from cancer, heart disease and stroke and respiratory disease account for most of the life expectancy gap between Manchester and the rest of the country;
- Adults in the city have much higher rates of obesity, alcohol misuse and smoking related conditions and the average of 750 smoking related deaths in Manchester each year is the highest in the country;
- The latest national GP Survey shows that around 19% of patients in North Manchester, 15% in Central, and 15% in South, report moderate or

extreme anxiety or depression compared to 12% nationally, with a high number of adults prescribed antidepressant medication;
- Higher % of children classified as obese in Reception and Year 6 compared to national levels;
- Higher levels of dental decay for 5 year olds, with 40.8% having one or more decayed, missing or filled teeth compared to the national average of 27.9%;
- Significantly higher rates of hospital admission for chronic ambulatory care sensitive conditions per 100,000 of the registered population in each of the three Manchester CCGs (1,523.3 in central, 1,568.8 in North, and 1,407.5 in South, compared to the national average of 808.5); and
- Higher rates of hospital stays for self harm and alcohol related harm and emergency admissions for hip fracture (65+).

Our Services are Under Pressure

1.13 Importantly our local services are experiencing levels of demand that are unsustainable and the whole system is not working well together to better meet those demands. Critically:

- Primary care and specifically GPs are under pressure and over the next 5 years a number are expected to retire;
- Compared to other regions of England, the North West Ambulance Service takes the highest percentage of patients to A & E and the second lowest percentage of calls are resolved with phone advice;
- Approximately 80% of A & E attendances are walk in presentations;
- Even though Manchester has a relatively young population, the over 65s make up a disproportionately high percentage of non-elective admissions to hospital;
- Compared to the national picture, emergency admissions of patients are high. Over the past 3 years there has been an 11% increase in admissions to Central Manchester University Hospitals, and a 13% increase in admissions to the University Hospital of South Manchester.
- There are high levels of admissions to residential and nursing homes;
- The wider urgent care system in Manchester is not functioning effectively leading to huge demand and pressure on the acute hospitals.

Financial Challenges

1.14 Alongside these major challenges locally there will be less resources available to commission the services required to address these health and care challenges. In total Manchester spends £1.1bn on health and social care services, excluding specialist services. The strategies and priorities described in this Plan represent Manchester's health and care partners' agreed approach to managing a predicted 'do nothing' deficit of £284m by 2020/21. A summary financial plan for the 5 years to 2020/21 has been projected for Manchester, taking account of pressures and demographic changes over the period, together with the estimated changes in resources for health and social care. The deficit originates from net estimated challenges across health and social care of £163m and £121m respectively.

1.15 It is recognised that a deficit of this magnitude will only be avoided through strong commissioning across the 5 commissioning organisations, and by strong partnership working by providers. Providers have agreed to the principle that the delivery of the transformation programmes will enable a shift in resources between hospital and community settings.

1.16 Applying the Greater Manchester savings opportunities identified within the draft CSR submission to Manchester, indicates that Manchester has a potential position (scenario 1) which converts the significant 'do nothing' deficit of £284m to an approximate break even position. However, the alternative scenario 2 to date ***(and subject to further review)*** currently indicates a deficit of £149m remains.

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Ambition

1.17 Our ambition is that by 2021 residents of Manchester will:

- Benefit from a transformed, integrated health and social care system, in which they receive health and care interventions which are joined up, of high quality, and are affordable;
- Be supported and encouraged to do what they can to remain healthy;
- Live in a City which encourages them to make the right choices;
- Ensure that when they need access to more specialist support they receive it in the right place at the right time appropriate to their needs and wishes;

How will this be achieved?

1.18 This will be achieved by transforming how health and care services are currently delivered. The integrated commissioning and delivery of services will shape a model of care which:

- Helps to achieve better and health and wellbeing outcomes for the residents of Manchester;
- Promotes independence and champion prevention;
- Works with the local communities in the places we deliver services;
- Works more closely with carers, voluntary and community sector groups recognising the valuable contribution to care that they make;
- Delivers effective and responsive services as close to a person's home as possible;
- Ensures that residents have access to high quality specialist services when they need it;
- Be clinically and financially sustainable.

1.19 A transformed service will result in a shift of resources from the acute sector (reacting to poor health) to investment in community based (and preventative focussed) health and care support.

What will be different?

1.20 **Firstly**, there will be a stronger emphasis upon ***prevention*** and ***self care*** with support being mobilised to focus upon promoting well being. The people of Manchester will be supported to live well and stay well through a stronger approach to the public's health.

1.21 **Secondl**y, those sections of the population most at risk of needing care will have access to more ***proactive care***, available in their ***local communities***, and delivered through one of the 12 Integrated Neighbourhood Teams that are currently being formed. These teams will include professionals working in social care, community health, primary care, mental health and some of the functions currently delivered by the District General Hospitals. The teams will be inclusive of GP practices, and enable care to be co-ordinated across the range of professionals involved in the care of an individual. A significant transformation programme for primary care is already underway. The aim of these teams is to work together to prevent those 'at risk' of developing ill health requiring specialist support. This approach will shift health and care interventions from being reactive to proactive, ensuring Importantly this will reduce duplication, fragmentation of care, poor use of resources, and improve the quality of care received ,

1.22 **Thirdly**, for those residents who need access to more specialist acute care, this will be available through ***A single Manchester Hospital Service***, shaped by clinicians within the hospitals, enabling resources across the hospital sector to be more effectively deployed. Critically, no medical services will be lost to Manchester. Rather, delivery of hospital services will be strengthened, through more effective commissioning and delivery arrangements.

1.23 Underpinning this approach is a unified commissioning system, with the 3 Clinical Commissioning Groups and City Council combining their resources and more effectively ***commissioning for the outcomes*** that they wish to see delivered. In other words, rather than purchasing individual episodic care and treatments from particular providers, the focus is on the providers to collaborate, combine their own resources to deliver services which will more effectively address the holistic needs of the individual and improve the health outcomes for the residents of the City.

1.24 Key components therefore to this Plan are 10 Transformation Initiatives:

- Public Health
- Cancer Care
- Primary Care
- Living Longer Living Better – One Team
- Mental Health
- Learning Disability
- Children and Young People
- Housing and Assistive Living Technology

Proceeding towards implementation

1.25 Work is progressing to establish a strong governance and accountability framework across the range of health and social care partners – commissioners and providers – to ensure a strong focus on delivery of this Plan. Finally it will be subject to regular review and be . underpinned by a clear performance framework which will involve regular reporting on progress towards its implementation.

2.0 Context: Manchester Place Based Plan for Devolution

2.1 The Manchester Locality Plan sets out the five year vision for improving health and care outcomes across Manchester. It is place based plan that supports the growth of the City and identifies how sustainable change will be delivered.

2.2 The plan sets out the vision for Health and Care across Manchester to achieve a clinically and financially sustainable future. It builds on the Manchester Strategy which sets a long term 10 year vision for Manchester's future and how it will be achieved. The Manchester Strategy is underpinned by the Joint Health and Well Being Strategy, the city's overarching plan for reducing health inequalities and improving health outcomes for Manchester residents. The Locality Plan sets out how the transformation will be delivered. The plan will be supported by growth, development of skills, education, early years, improved housing and employment. Partners working across Manchester, in the public sector, in businesses, in the voluntary sector and communities, all have a role to play in making Manchester the best it can be.

2.3 The ambition is to continue to grow, build and invest in the City through increasing productivity, getting more people into work and taking advantage of all the opportunities offered by Manchester's transformation to a world class city. Through this Manchester will:

- Create 43,000 new jobs accessible to Manchester residents. Health and social care services will both benefit as more Manchester people get good jobs and become healthier and continue as major employers.
- Ensure that everyone is paid at least a real Living Wage. This will be particularly important in social care where many jobs in home care and residential care are currently paid at or near the minimum wage.
- Reduce the gap between residents' wages and the average earned in the City.
- Increase school results so that they are significantly higher than the UK average. Proposals in this plan to improve the health of Manchester's children will support this ambition.
- Improve the health of the people who live in the City and have more active adults and children. The Locality Plan and the Health and Wellbeing Strategy which it fits into, encapsulates the way this ambition will be realised.
- Build 25,000 well designed and sustainable homes constructed with a diverse mix of ownership and rent options that meet the needs of the people who live in the City. Housing for those who require health and social care at home will be key to this.
- Be a City recognised for its high quality of life with improved green spaces and access to world class sports, leisure and cultural facilities. This will be a key contribution to Manchester peopling living longer, healthier lives and so making fewer demands on health and social care services.
- Encourage a strong sense of citizenship and pride in the City. The social movement for change, Age Friendly Manchester and plans for more are described in section 5.8 of this Plan will contribute to this.
- Increase productivity for the benefit of the City and the UK as a whole. Increasing the proportion of lives lived in good health will have a direct impact on productivity because more will stay healthy enough to stay in jobs for longer as they get older.

2.4 The ambitions for Manchester set out above have to be achieved within the financial reality of reductions in public spending which will continue over the next five years. Simply continuing with business as usual is not an option as the system will face increased demand. Coupled with the increases in demand associated with an ageing population, it is clear that the City's health and social care system will not be financially sustainable over the next five years unless radical and urgent action is taken. The Locality Plan aims to manage and control increased demand by identifying deliverable and sustainable change. The devolution of health and social care to GM as part of the wider growth and public service reform priorities for GM is the opportunity to make the radical and urgent changes happen.

2.5 The Manchester health and social care system will be unable to achieve financial sustainability to continue to operate within the standard national framework. Being part of GM Health and Social Care Devolution fundamentally alters the prospects for Manchester closing the gap, and over the next 5 years Manchester will fully engage with all of the opportunities that Devolution will offer. Devolution will enable the delivery of the Locality Plan at scale and at pace. The 'asks' and opportunities that devolution will bring are wide ranging covering regulation, finance, estate, GM population health, a flavour of which are summarised in Box 1.

2.6 The Locality Plan is the commissioning plan for health and social care integration for Manchester. It contains 3 key pillars which together will drive the radical transformation of health and care services for the residents of Manchester. These are mutually dependent and are:

- A single commissioning system ('One Commissioning Voice') ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services;
- 'One Team' delivering integrated and accessible out of hospital community based health, primary and social care services within neighbourhoods; and
- A 'Single Manchester Hospital Service' delivering consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the City.

2.7 Together, these elements will ensure that

- There is a clear focus on place, the needs of residents, and not organisational interest;
- Manchester continues to be at the fore of clinical excellence and continue to attract world leading clinicians;
- A stronger service offer to residents ensuring their health and care needs are addressed earlier, that they are encouraged to take responsibility for their own well being, and that when they need access to more specialist care that that is available to them and affordable; and
- Front line health and care staff are professionally fulfilled in the demanding roles that they undertake.

Box 1
The Devolution 'Asks'
Finance and contracting

- Capital investment and transitional funding
- Ability to plan capital and revenue spend across a CSR settlement period of 5 years
- More flexible financial rules and regulations in key areas, for example, council tax and business rates, or a reduced need to deliver annual surpluses

- Pooled budget flexibilities
- Greater freedom from national arrangements and flexibility's requiring changes to legislation – i.e. ability to contract for and price services in a different way and support for different models of contracting
- Significant flexibilities with possible changes to legislation / formal guidance needed (contracting and funding mechanisms) to move from commissioning on a tariff-based or block contracting approach to commissioning for outcomes
- Greater flexibility on payment schemes and support for different models of contracting

Regulation

- Influencing current regulation e.g.competition and choice. This is required to enable GM to take bold decisions on decommissioning services as demand is reduced or met in new ways.
- Development of local targets, responsive to local need

Capital and estate

- Ability to own and transfer assets locally
- Capital flexibilities and bringing ownership of Estate back

Public Health

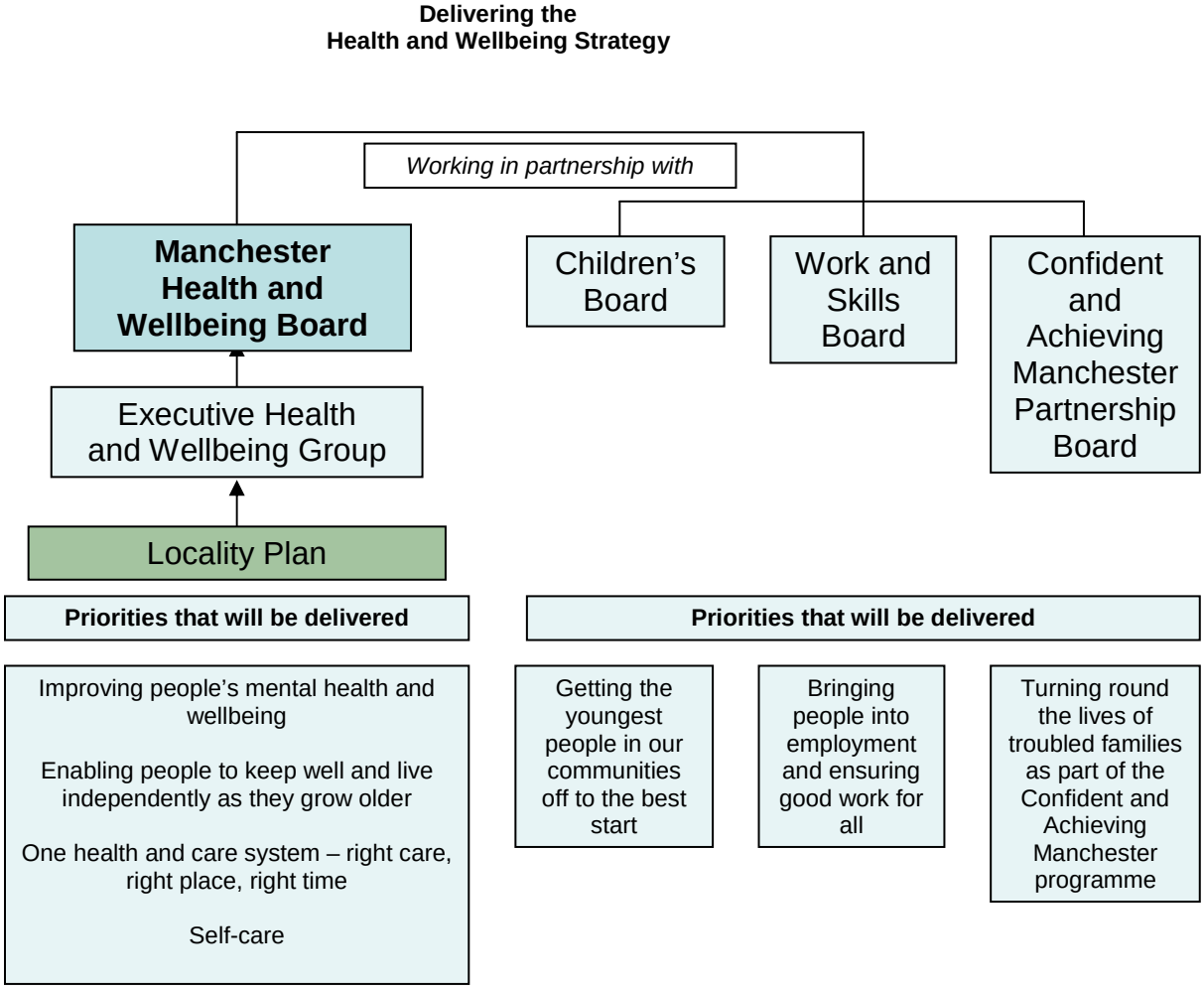
- Implementation of the GM wide framework for action and new leadership

2.8 As part wider GM devolution, there are a series of programmes being driven the GM level, with which we are engaging and will continue to do so fully as they develop. These include:

- Primary Care transformation- development of a GM primary care strategy
- GM Dementa Health and Social Care provision
- Focus on Mental Health and work
- GM Specialised Services Transformation programme
- Early Intervention and Prevention Strategy building on the themes of; Public Health, reform and growth, Social Movement and co-production, Starting Well: early years, Living Well: work and health, Ageing Well.
- Early Years: development of a single programme across GM
- Learning Disabilities: Development of GM vision and Fast Track implementation
- GM wide Capital and Estates programme

2.9 The problem of additional health and social care costs as people live longer is well known. On current estimates by 2020/21, there will be a funding gap of £284m in Manchester's health and social care system. Using assumptions developed as part of the GM Strategic Framework delivers a small surplus by 20/21 but it should be noted that these assumptions are ambitiousThis Plan sets out how we will go further than the existing efficiency programmes to radically transform the system as a whole over the next five years using the opportunity of GM Devolution. Section 7 of the Plan sets out the financial analysis of where we will be if nothing changes together with initial proposals for investment in the transformation programmes set out in this Plan which will reduce costs by meeting needs differently.

2.10 This Locality Plan describes how the transformed system will be achieved. The Health and Wellbeing Strategy will provide the vision for the health and wellbeing in the City. The Locality Plan outlines how we will deliver aspects of the H&WB strategy as well as links to other programmes of work. The Plan will be owned by Manchester's Health and Wellbeing Board. The relationship of this Plan to the Health and Wellbeing Strategy is shown below:



2.11 Through the delivery of the Locality Plan, by 2020, people in Manchester will have a transformed integrated health and social care system with:

- Improved health and wellbeing outcomes
- High quality, safe and clinically effective services meeting NHS constitutional standards
- A balanced budget during the five years to 2020 and a strong footing for long term financial sustainability
- A social movement to self-care

2.12 Seven principles of change underpin the Locality Plan:

Principle one - People and place of Manchester will have priority above organisational interests.
Principle two - Commissioners and providers will work together on reform and strategic change.
Principle three – Costs will be reduced by better co-ordinated proactive care which keeps people well enough not to need acute or long term care.
Principle four – Waste will be reduced, duplication avoided and activities stopped which have limited or no value.
Principle five – The health and social care system is made up of many independent and interdependent parts which can positively or adversely affect each other. Strong working relationships will be developed within the system with clear aims and a shared vision for the future
Principle six- There will be partnership with the people of Manchester, the workforce, voluntary and community organisations.
Principle seven- The partnership will work to safeguard children, young people and adults, enhancing their health and well-being and protecting the rights of those in the most vulnerable situations.
2.13 Manchester has embraced the approach of preventative measures, recognising complex dependencies, offering early intervention at the right time. Many families in Manchester have a range of complex dependencies which complicates the services provided to them. Manchester partners are increasingly working together to ensure that services are integrated and that the intervention is provided at the right time. By streamlining services and encouraging greater reliance and self-help interventions will be more appropriate, timely and cost effective. More understanding within the community of ways of ensuring good health and preventing illness will be strengthened and supported to help reduce the need for interventions. Using Health Visitors to assess all childcare at different stages between 0-5 is at the heart of prevention and early intervention. This will identify these children and families who most need the evidence based interventions we know to work. Similar approaches to prevention and early intervention are embedded throughout the Plan. This will ensure that when children, young people, adults and their families face challenges and need help, they can easily access the support before the issue escalates.
2.14 The engagement and involvement of patients, carers and the public will be regularly reviewed. The voluntary sector and social enterprise organisations will need to be involved in co-designing the transformations described in this Plan. This should include members of the Manchester Provider Group. The voluntary and community sector will be central to this. There will be links to GM Devolution programme to exploit the benefits, and use the results, of GM-wide engagement work when relevant.

3. Context: Growth and Place

3.1 Over the last decade Manchester has been the fastest-growing City in the UK. The City Councils forecasting model predicts population growth in Manchester to rise to between 543,100 and 577,800 by 2021.
3.2 In contrast to the national picture, Manchester has a comparatively young population. Currently, nearly two-fifths (39%) of the population are aged under 25 compared with around 31% in England as a whole. In contrast, just 10% of the population is aged 65 and over compared with 17% in England. Data from the 2011

Census also shows that the population of Manchester has become more diverse in the last decade, with a reduction in the proportion of residents classifying themselves as coming from a 'White' ethnic group (from 81% in 2001 to 66.6% in 2011).

3.3 Although Manchester has recovered faster than most places from the economic downturn, it started from a low base following decades of decline in the previous century and continues to suffer from deprivation with a disproportionately large number of residents in low paid and part-time jobs. Manchester also has one of the highest rates of child poverty in the country with over 30% of children aged under 16 living in poverty. Although the trend is reversing, with a decrease in child poverty while the population of children is increasing, there remain significant numbers of families that are dependent on public services.

3.4 The NHS and social care providers have a key role to play as employers of Manchester residents and families. The scale and value of employment offered by the sector is wide ranging and expansive – ranging from highly skilled roles in research and academia to apprenticeships. Multi disciplinary teams with more flexible roles will provide opportunities for frontline staff, for example in homecare and residential care, to develop new skills and to find new career ladders.

3.5 Health and social care services and the role of health sciences and academia are hugely important to economic growth in Manchester and indeed GM. The development of Medipark in Wythenshawe and City Labs on the Oxford Road corridor and the partnership between CMFT, UHSM and Manchester University will be a significant driver of growth and new jobs.

3.6 The UHSM, CMFT and North Manchester General Hospital (NMGH) sites are very significant features in the physical fabric of the City. Investment has taken place in CMFT, YHSM and Withington. This has been key to improving the structure of the buildings, as well as enhancing the ability to deliver different systems from the estate. Investment into the NMGH site is a key gap which needs to be addressed .The physical development of the City will need to accommodate new models of delivery, such as extra care housing and supported accommodation incorporating telehealth and telecare to transform productivity.

4. Context: Partnership with Manchester people

4.1 Manchester is becoming a world class City with an even more competitive economy. Manchester people will become increasingly highly skilled, aspirational, resilient, connected to growth and therefore increasingly productive. Encouraging and supporting Manchester residents to be resilient and active is central to this Plan. The strengths of our sporting legacy will enable the City to be a place where making the healthy choice is an easy choice. People will be able to look after their own health and be active. By bringing together health providers, the City Council, community and voluntary sectors, the experience and outcomes of people will be transformed by putting them at the centre of the services.

4.2 Manchester is committed to maintaining its successful approach to ensuring equality for its citizens. The ongoing commitment to Communities of Interest including Lesbian, Gay, Bisexual and Transgender will remain as part of ensuring that the health and social care integration respects the needs and wishes of all parts of the Manchester Community. Manchester has one of the most ethnically diverse populations in the Country. Health and social care delivery will respect the variety in peoples care needs and cultural differences. The voluntary and community sector will be central to this commitment.

4.3 Keeping people safe is intrinsic to the six principles of the Locality Plan. Living a life that is free from harm and abuse is a fundamental right of every person. Consequently, the emphasis is an integrated, partnership response for all the people who use our services, their families and carers. We will work in partnership to safeguard children, young people and adults, enhancing their health and well-being and protecting the rights of those in the most vulnerable situations.
4.4 Within Manchester there is an absolute commitment to ensure that common processes and thresholds are applied and that they are robust and consistently quality assured across the partnership.
4.5 Manchester has embraced the approach of preventative measures, recognising complex dependencies, offering early Intervention at the right time and Making Safeguarding Personal to our population. This will ensure that when children, young people, adults and their families face challenges and need help; they can easily access the support before the issue escalates. The focus and new approaches are embedded throughout the Locality Plan.
4.6 With an expanding and youthful population, Manchester has enormous potential to create clear routes for young people to develop the right skills to take up key employment and education as well as being able to lead safe, healthy and fulfilled lives.
4.7 The Age-friendly Manchester programme recognises the importance of supporting people to live healthy, active and independent lives as they move into older age. The city's voluntary and community sector and local networks are an important element of enabling older people to play a full part in the life of the city.
4.8 A key aim of Manchester's Locality Plan is to 'add years to life and life to years'. Work is needed to bridge the gap between our vision for a healthy, self-reliant population and the existing health of Manchester's population. The Care Act will enable individuals, families and carers to make the right decisions which suit them best. By planning for the future, they will be in a strong position to become increasingly independent.
4.9 Statistics relating to Manchester population's life expectancy are stark. Healthy Life Expectancy in Manchester is significantly lower than the England average for both men and women. Approximately two-thirds of the life expectancy gap between Manchester and England as a whole is due to three broad causes of death: circulatory diseases, cancers and respiratory diseases. These, in turn, can be linked in part to poor lifestyle. The role of the voluntary and community sector in providing opportunities for activity and support within communities is central to reducing reliance on statutory services health outcomes
4.10 Poor mental health and wellbeing has a significant impact on individuals, families and communities in the City. Low mental wellbeing among people living in Manchester is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. Suicide rates in Manchester remain higher than the national average.

5. Context: Public service reform

5.1 The level and scale of public services will shrink over the next five years. The cost and extent of services currently provided will no longer be sustainable or deliverable. We can and will make services, particularly hospital services, more efficient. But, on its own this will be insufficient. It will also be necessary for the public to be more informed about their health and to take a greater responsibility for their own health care. It will also be necessary to reduce or deflect demand on

expensive hospital and residential care services by integrating services in the community. This is why health and social care services are at the heart of public service reform. Greater emphasis will be placed on prevention and ensuring that the right intervention is made as early as possible to minimise the call on public services.

5.2 Public service reform in Manchester is based on the following principles:

- Using evidence-based interventions to improve outcomes
- Integration and coordination of public services
- Whole-family / whole-person approach to changing behaviour
- Developing new approaches to investing and aligning resources from a range of partners on joint priorities, and
- Robust evaluation of what works to reduce demand on public services

5.3 The Healthier Together initiative has made a start on making the provision of health and social care more effieicnt and meeting the changing needs of residents. We now need to go much further. The Devolution Agreement is a significant opportunity to overcome some of the barriers to integrating public services in the City, particularly for those groups of residents and communities who can most benefit from an integrated reponse from public services. Devolution is enabling us to drive reform at greater pace and scale to reduce the demand for expensive, reactive services. Health and Social Care integration in Manchester is based on better integration of public services for those cohorts of people who place the greatest pressure on the health and social care systems.

5.4 The three reform priorities for Manchester are:

- complex dependency to employment, 'Confident and Achieving Manchester'
- health and social care integration
- improving early years and school readiness

5.5 The fundamental review of services to children announced as part of the latest package of devolution to GM in the summer 2015 budget creates the platform to transform health and social care services (e.g. Child and Adolescent Mental Health Services).

5.6 The purpose of this Plan is not only to show how the priority of health and social care integration will be delivered, it is also to connect that reform to the reforms to reduce complex dependency (including low skills and worklessness) and the reform of services to children and early years.

5.7 The financial challenge facing Manchester will only be met if we reform to meet rising demand in radically different ways. Efficiency programmes are necessary, but on their own will be insufficient. This plan therefore focuses on taking reform into the transformation of how services are delivered.

6. Transformation: Sustainable future for NHS and Social care services

6.1 The family is the primary context in which health and care takes place. Strengthening all generations of the family, leading to active residents with responsibility for their own health needs is central to a sustainable future for the NHS. Our ambition is for the people of Manchester to keep themselves as happy and healthy as possible so that they get full benefit from the opportunities provided by the City's growth.

6.2 When health needs arise we aim to provide the highest quality care as efficiently as possible. Whilst most people do not regularly use services, those with long term, complex conditions do frequently need care, and ensuring that these

people receive the right interventions, in the right order, at the right time is central to the integration health and social care.

6.3 Services will be integrated to enable people to become, and remain, healthy. This Locality Plan outlines the major programmes of change that will deliver the four types of sustainability: outcomes for Manchester People, high quality services, a balanced budget and movement towards self-care.

6.4 These programmes, incorporating children and adults, focus on public health, cancer, primary care, integrated community based care (Living longer living better), mental health, learning disability shared services across the acute sector, and housing and assistive living technology.

6.5 Each of the programmes is accompanied by a 'Logic Chain' which is set out in a table (or for some programmes a series of tables) at the end of each programme section. The purpose of the logic chains is to set out the theory of change underpinning each of the transformation Programmes, i.e. the underlying theory as to why we think that the activities we are undertaking will lead to certain outputs and thence to the intended outcomes and impacts for the people of Manchester. The logic chains are not a performance framework in themselves but they will help us to build a robust performance monitoring framework that tests the key assumptions and hypotheses that the Locality Plan is built on.

Transformation 1: Public Health

6.6 A key element of the public health focus throughout the Locality Plan will be to provide leadership, advocacy and expertise in areas that underpin each of the Locality Plan transformation programmes. Those public health commissioned services that are being redesigned in a way that specifically supports this agenda i.e. enable a financially sustainable, place based, integrated health and social care service, are described in this plan. The content for the Locality Plan is not intended to be a comprehensive description of all public health activity.

6.6 The Manchester Public health Team will also be working collaboratively with public health professionals across Greater Manchester as part of the unified public health leadership system. As part of the Greater Manchester Devolution agenda, a memorandum of understanding has outlined key priorities for this system which are;

- Public health, growth and reform and alignment with the Spending Review –detailing the economic case for place based integration of public health, employment and early intervention strategies and the benefits that can be achieved.
- Nurturing a social movement for change – creating new platforms for full engagement of Greater Manchester residents.
- Starting well (early years) -scaled implementation of the GM early years model to improve school readiness and addressing long term determinants of public service demand.
- Living well (work and health) -aligning public health intervention to wider public service reform, tackling complex dependency and supporting residents to be in sustainable and good quality work
- Ageing well – setting up a Greater Manchester Ageing Hub to support age-friendly communities and environments and scaling up work on dementia friendly communities

6.7 The public health team at Manchester City Council is organised around the life course themes; starting well, living and working well and ageing well. The early years delivery model, work and health and Age Friendly Manchester are

established, well developed programmes of work in Manchester, and are well placed to lead the work at Greater Manchester level.

6.8 The annual public health report set out a vision for the people of Manchester where;

- Every child is offered the support he or she needs through a framework of "progressive universalism". Children are enabled to meet developmental goals, supported by a loving family and secure attachments, so that they enter school ready and able to learn, make friends and flourish. Services promote positive health behaviours such as breastfeeding, immunisation and a healthy diet.
- Adults are able to support themselves and live healthy lifestyles in gainful employment and in stable households. People are living in strong, supportive social networks in areas of high social capital. Where people have specific needs for support, these should be understood and services should be established to provide the relevant support based on clear needs assessments.
- People have a healthier older age, live in age friendly environments, and are able to continue to contribute to society in the ways they wish.

6.9 The role of public health in addressing the underlying causes of ill health is increasingly important as the scale of public services reduce. Lifestyle factors such as poor diet, physical activity, smoking and excess alcohol need to be tackled in the context of socioeconomic determinants of health, such as, employment, income and housing. There is also a need to develop the social networks and connectedness (social capital), that have benefits for health and wellbeing and economic growth.

Public health leadership, advocacy and expertise

6.10 Public health is providing leadership on self-care and the evolving work on creating a social movement. These areas of work will drive a change in approach from a deficit focus on illness and problems to an assets focus on strengths and abilities; this includes the skills, knowledge, resources and support available within individuals and the community. The broad aims of this are to promote personal and community resilience, to increase social connectedness and to empower people to take greater responsibility for their health and wellbeing.

6.11 A transformational self-care strategy for Manchester is being developed as part of Living Longer, Living Better (Transformation Programme 4). This will outline and influence the organisational approach required, across the system, to enable greater personal responsibility for health and wellbeing. It will encompass actions related to workforce development, public education and community asset building for health and raising awareness and understanding of the principles of self-care.

6.12 The creation of a social movement will be informed by the considerable experience and evidence gained from the Age Friendly Manchester programme. For example the work on age friendly environments, involved working with older people to create an environment that supports them to maintain social networks, build physical activity and contribute to the local community.

6.13 Public health is formalising partnerships with national organisations and charities in order to explore opportunities for joint work and potential investments in Manchester. Partnerships with the voluntary and community sector both nationally and locally will be essential for integrating community assets into health and social care pathways and addressing the wider determinants of health. Partnerships with

academic institutions, Public Health England (PHE) and Health Education North West (HENW) will also enable this work.

6.14 The public health knowledge and intelligence function will provide the data, information and evidence that allow interventions to be targeted in the most effective way, maximising health gain from services, policies and interventions. An example is the work on identifying people at high risk of emergency hospital admission. Through analysing data on those people who have experienced higher numbers of emergency admissions, we have improved our understanding of the socio-economic and behavioural factors that influence this. These findings have been fed into the Living Longer Living Better programme. We also have a responsibility to ensure that services are taken up consistently across all sections of our community. If all groups accessed these at the rates of the best, we would see big improvements in population health.

Public health commissioned services for transformation

6.15 Wellbeing service transformation - community asset building and prevention

Preventative services have a key role in reducing ill health, worklessness and dependency in the city. The expertise in the public health commissioned wellbeing service for facilitating behaviour change for improved health outcomes willl be retained. The service is being redesigned within a reduced financial envelope. The new service will be based on a community asset building model with a small element of one to one support for those who are unable to access community provision. This will link with the LLLB One Team in the 12 neighbourhoods, and the three Early Help Hubs to ensure that the limited service is targeted for maximum impact.

6.16 *Children's health service transformation - Integrated Children's Public Health Service*

An integrated children's public health service with health visiting, family nurse partnership and school health services along side other children's services is being considered. These services are currently commissioned separately and fragmented. Potential models will be reviewed to determine which shows the most evidence of effectiveness as well as best value for money before finalising the approach for Manchester.

6.17 *Alcohol and drug service transformation: Integrated alcohol and drug early intervention and treatment service for adults*

Alcohol and drug services are currently commissioned and provided separately, and are weighted in favour of drug treatment despite levels of alcohol misuse and dependence being significantly higher in the city. An open tender process is currently underway to identify a suitable provider for an integrated alcohol and drug service for adults. Outcomes of the redesign and re-commissioning will include more focus on prevention and early intervention for a wider range of substances, an increased focus on recovery and reintegration for those in treatment, increased capacity for alcohol treatment, and stronger links and partnership delivery with the Confident and Achieving Manchester, Early Help and LLLB/One Team programmes.

Transformation programme	**Public Health – Children and Young People**
Nature of problem	Large numbers of children living in poverty with subsequent poor health outcomes or risk factors for poor health including lack of

	school readiness, obesity and accidental injuries.
Proposed Solution	Ensure public health commissioned services (health visiting, school nursing, family nurse partnership) are linked into the Early Help Hubs in order to provide health support in multiagency teams. To roll out the early years delivery model to all children in Manchester.
Key Programmes	Early Help Strategy Early Years Delivery Model
Outputs	Increase in number of: • Workers working across multiagency teams. • Children and families helped to access universal services through targeted support. • Early Help assessments carried out. • Children identified for intervention pathways. • Children and families accessing parenting skills courses.
Outcomes	Increase in number of: • Children that are assessed as being school ready. • Children experiencing co-ordinated, effective local offer. • Children aged 0-19 years (25 for SEN) accessing early help and support. Significant and sustained progress for children, young people and their families. *Against what metrics?*
Impact	Narrow gap in key health and wellbeing outcomes for children. Improve emotional wellbeing of young children. Reduction in emergency hospital admissions for children. Reduction in accidents for children. Reduction in childhood obesity. More children aged 5 years achieve a good level of development that is at least in line with national average.

Transformation programme	**Public Health – Adults of Working Age**
Nature of problem	High prevalence of mental ill health prevents individuals from getting back into, and sustaining work.
Proposed Solution	Embed fit for work programme as part of the scale up of GM health and work programme and build on incentives to encourage referrals from mental health services and primary care.

Key Programmes	GM health and work programme
Outputs	Increase in number of people engaged in health and work programmes in Manchester. Increase in number of people referred by GP practices and mental health providers into health and work programmes.
Outcomes	Increase in number of people referred into health and work programmes by GP practices and mental health providers who meet agreed programme outcomes[1]. Increase in appropriate referrals to health and work services by GP practices. Increase in people with mental health issues employed by HWBB member organisations.
Impact	Reduction in people claiming any ill-health related benefit. Reduction in adults suffering mood and anxiety disorders. Improved health and wellbeing status among people participating in health and work programmes.

Transformation programme	**Public Health – Older People**
Nature of problem	High numbers of older people in Manchester are socially isolated and/or lonely with consequent impact on their mental and physical health and wellbeing.
Proposed Solution	Develop Age Friendly Neighbourhoods and teams and improve communication and engagement with older people.
Key Programmes	Age Friendly Manchester
Outputs	Increase in number of people aged 50-64 years in employment. Increase in number of older people engaged in Age Friendly Manchester networks.
Outcomes	Reduction in unemployment rate among people aged 50-64 years.

[1] Increased confidence levels in relation to obtaining employment; improvements in activation and self-care (incl. managing condition/symptoms, lifestyle, mental wellbeing); increased engagement in learning or skills activity and volunteering; securing and sustaining employment for 12 months.

Impact	Increase in life expectancy at age 65. Increase in number of years of life lived free from disability (disability free life expectancy). Increase in number of older people living independently and in good health. Reduction in social exclusion among older people.

Transformation 2: Cancer Care across Manchester

6.18 Manchester has some of the worst cancer outcome indicators when compared to rest of the UK. Unhealthy lifestyles, low screening uptake and late stage at diagnosis contribute to high premature mortality rates. Also with improved survival, more people are living with and beyond their cancer diagnosis, living with consequences of their cancer and side effects of treatment requiring surveillance and monitoring, and therefore the support required for this. To address these challenges, an increased emphasis on prevention and early detection of cancer, alongside the development of new models of aftercare and palliative/end of life care is required.6.19 The Macmillan Cancer Improvement Partnership (MCIP) is the key transformational programme across Manchester to improve cancer outcomes £3.45m has been committed from Macmillan Cancer Support for investment in two phases (1) , targeted improvements in primary, community and palliative care across all tumour groups, and(2) focused improvements in breast and lung cancer pathways.

6.20 Building on the new National Cancer Strategy and the local Manchester CCGs Cancer Commissioning Strategy has identified several priorities for delivery:

- Patient Experience: Improving the use of high quality information for patients and carers to ensure that patients can report good experience of their care.
- Prevention: Working with public health in the commissioning of primary prevention programmes e.g. for cancer and other long term conditions (smoking cessation, healthy eating, physical activity, alcohol consumption, exposure to UV radiation) to support the reduction in premature mortality, by reducing the number of people diagnosed with cancer.
- Early Detection: Commissioning of cancer services in Manchester will focus on prevention and early detection in order to reduce incidence, detect cancer at an earlier stage through symptom recognition and take up of the national cancer screening programmes.
- Diagnostics: Meeting the new standard of diagnosis within 4 weeks of GP referral for suspected cancer
- Treatment: Co-ordinated timed pathways to meet Cancer Waiting Times Standards.
- Survivorship: The provision of high quality cost effective supportive services for patients to improve wellbeing, reduce the risk of recurrence or manage consequences of treatment or disease progression.
- End of Life Care**:** Better co-ordination of care for people at end of life.

Transformation programme	**Cancer Care across Manchester**
Nature of problem	Unhealthy lifestyles, low screening uptake and late stage at diagnosis contribute to high premature mortality from cancer. Improved survival meaning more people living with and beyond their cancer diagnosis, living with consequences of their cancer and side effects of treatment requiring surveillance and monitoring Cancer now considered a long term condition
Proposed Solution	Increased emphasis on prevention and early detection of cancer, alongside the development of new models of aftercare and palliative/end of life care.
Key Programmes	Manchester Macmillan Cancer Improvement Partnership Programme National ACE programme (NHSE, Macmillan & CRUK) – Wave 1 and 2 Living Longer Living Better (LLLB) / One Team
Outputs	Increase in number of people attending health and wellbeing events and physical activity programmes Increase in number of eligible patients attending cancer screening appointments Reduction in number of eligible patients not attending cancer screening appointments Increase in number of patients with written care plans Increased in number of patients on a stratified care pathway Increase in number of patients receiving targeted investigations for early identification of risk of lung cancer Increase in numbers of cancer champions in primary care and community services Increase in number of patients seen as part of MCIP project
Outcomes	Increased awareness of impact of healthy lifestyles and smoking cessation on cancer Increase in screening uptake rate Increase in proportion of cancers diagnosed at an early stage (especially lung and bowel cancers) Reduction in number of routine hospital based follow up appointments Increase in number of cancer patents receiving palliative and end of life care
Impact	Improved survival from cancer Improved support for patients post diagnosis Reduce premature mortality from cancer Improved health related quality of life for patients with cancer / long term conditions

	Improved patient and care experience of end of life care More patients empowered to self-manage their recovery and seek advice for new symptoms or problems More efficient use of diagnostic resources and time to diagnosis improved

Transformation 3: Primary Care

6.21 The vision for Primary Care in Manchester is 'Consistent, high quality care for all'. The strategy is to improve the health and well-being of Manchester people through the provision of excellent and continually improving primary care

6.22 Whilst Manchester's Primary care services are generally of high quality, with many examples of excellent practice, there is variation in capacity and practice, and the current primary care system is facing significant challenges and pressures. The existing model of primary care needs to be more integrated, both within itself and in terms of how it links to other parts of the health and social care system. Currently Primary Medical Care is delivered by 92 GP Practices across the City; with variations in quality, capacity and size.

6.23 The primary care system is generally underfunded and fragmented resulting in a lack of resilience across the system. In Manchester the funding for Primary Care is amongst the lowest in the country, at around £102 per head of population, against an average of £116 in Greater Manchester and £136 in the country as a whole. There are major workforce pressures as increasing numbers of Primary care professionals approach retirement. The quality and provision of our estates for primary care is also variable across the City, with some areas of significant need.

6.24 Further challenges to transforming the system are presented by the current commissioning arrangements; the responsibility for primary care commissioning is split across NHS England, CCGs and Public Health and national contracting arrangements. These arrangements can restrict the ability to innovate and develop local solutions.

6.25 There is however commitment across the system both at the Greater Manchester level and within the city of Manchester to drive the transformation of primary care. This will deliver a system which can provide the co-ordinated and proactive care in the community which is required to deliver the 20% shift of care out of hospital by 2020.

6.26 In particular, the primary care of the future will be working as a whole sector of care, greater than the sum of its individual constituent parts or practices. Primary care will be an integral part of 'One Team' - community place based care which is outlined in Living Longer Living Better (LLLB); GPs will provide the leadership and co-ordination needed to enable lead workers with integrated teams to integrate services around the bespoke needs of individual patients and their families and careers.

6.27 The ambition is for all practices to work to explicit agreed standards. including keeping people well and avoiding ill-health , diagnosing people sooner that have a condition or an illness to identify their treatment plans, using the LLLB programme and supporting palliative care poor quality care will be decommissioned to ensure that resources are focused on the most effective interventions which have the maximum impact.

6.28 Key elements of the offer include the following:-

- **Access** – The highest priority for patients and the public. Patients will be able to access their GP practice in core hours, and be seen on the same day if needed, and access local primary care services in extended hours into the evenings and at weekends.

- **Proactive care for patients with Long term conditions** - Vulnerable and at risk patients will be identified and their conditions effectively managed services which are integrated by the LLLB programme. In this way, unplanned attendance and admission to hospital will be reduced, and health outcomes improved.

- **Patient voice** – Primary care will ensure that patients are at the heart of their care, that they are involved in every stage and in key decisions. Patients will have access to their care records, and be supported to self-care where they can. Patients nearing the end of life will also be supported to die in the place they choose.

- **Specialist services in primary care** –The range and scope of services provided in primary care will be increased. The establishment of federations and increased collective working by practices working in localities and neighbourhoods provides for enhanced opportunities to use and develop the skill mix and competencies required to meet the changing level and needs of care outside hospital.

6.29 Over the next 5 years, resources will be shifted into primary care; with an understanding that this increased resource is focussed on the standards, resulting in quality improvement and consistent offer.

6.30 The development of GP Federations across Manchester has given the opportunity to commission differently, and for primary care to operate more as a collective integrated and unified sector of provision .This will enhance delivery of LLLB.

6.31 Integrated services will be commissioned for priority cohorts on a neighbourhood basis; through services working together as 'One Team' in new integrated models. Options for organisational form across all provider organisations will be assessed over the next six months. Detailed risk stratification will take place to ensure that the integrated services are provided for those who are most likely to be diverted from acute and residential services.

6.32 Similarly, to deliver the transformation required, investment in estate is needed. Much of the primary and community based estate is no longer fit for purpose, and does not support our plans for transformed primary and community based care. There are major opportunities for improved utilisation of the estate, and for co-location to support more integrated ways of working

6.33 Devolution will enable us to commission primary care on a population basis, improving access, proactively managing long term conditions, and eliminating variation across the City through the implementation of standards and an integrated whole system model of care. The flexibility and freedom through Devolution should to enable us to:

- Make decisions locally on use of capital priorities, and use of asset disposals across all public services.
- Use locally all primary care resources over and above core contract to deliver the at scale transformation which our plans require. (Drafting note: not clear what this means.)

Transformation programme	**Primary Care**[2]
Nature of problem	Existing model of primary care does not always work as a system of care, and could be more integrated, both within itself and in terms of how it links to other parts of the health and social care system. Responsibility for primary care commissioning is split across NHS England, CCGs and Public Health and national contracting arrangements restrict ability to innovate and develop local solutions. The primary care system is generally underfunded and fragmented resulting in a lack of resilience across the system. Federated models of provision are relatively underdeveloped and the existing workforce is under threat from impending retirements and ongoing difficulties in recruitment and retention. Existing estates and facilities provide a poor infrastructure and there are known variations in the quality of services provided and the standards of delivery.
Proposed Solution	Investigate new models of care, based around commissioning for population as well as more integrated provision of primary care as part of the LLLB/One Team strategy. Implement estates and workforce strategies to improve infrastructure. Deliver Enhanced Primary Care standards to address variation in quality of services provided.[3]
Key Programmes	Living Longer Living Better (LLLB)/One Team, Healthier Together Primary care 7 day access, Primary care standards[1]
Outputs	Increase in number of: • GP practices offering extended opening hours. • Patients accessing primary care out of hours. • GP practices assessed against Enhanced Primary Care standards. • Patients receiving proactive care for long term conditions. • People referred by GP practices into health and work programmes. • GP practices routinely recording and reporting employment status of patients. • Primary care professionals working as part of an integrated team. • Lifestyle interventions delivered in primary care. • Patients signposted towards health and wellbeing and

[2] Primary care here covering Medical care (GPs), Pharmacy, Dentistry and Optometry; although the initial focus is on primary medical care.
[3] Available at http://www.centralmanchesterccg.nhs.uk/download.cfm?doc=docm93jijm4n2246.pdf&ver=2923

	screening services.
Outcomes	Reduction in: • A&E attendances. • Avoidable admissions to hospital. • Number of delayed discharges. • Length of stay. Increase in the: • Number of GP practices compliant with Enhanced Primary Care standards. • Uptake of childhood vaccination and flu immunisation. • Appropriate referrals to health and work services by GP practices. • Number of people referred into health and work programmes by GP practices who meet agreed programme outcomes. • Number of GP patients with a valid recorded employment status in primary care. • Uptake of funded health and wellbeing and screening services.
Impact	Earlier identification of people at risk of ill health. More people accessing prevention, intervention and screening services and at earlier stages. Patients more engaged in managing their own conditions and self care. Improvements in the quality of care provided in primary care. More appropriate use of health care services. Better patient experience and expectations. Reduction in worklessness and improved productivity through reduction in ill health and absenteeism.

Transformation 4: Living Longer Living Better

6.34 The current health and care system is focused on reactive care at the expense of prevention and early intervention. The delivery of health and social care is not sufficiently integrated and the workforce that provides it is fragmented and lacking in capacity and capability. This, combined with high levels of ill health in the population, has an impact on the quality and length of life for local people and draws resources away from more preventative approaches.

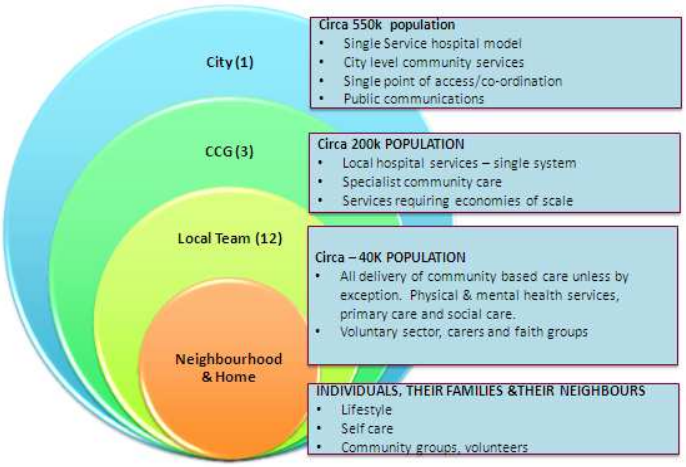
6.35 To address this challenge, we need to ensure that health and social care providers work as a more integrated system within the city and across GM as a whole, with a greater focus on prevention, early identification of ill health and more proactive, joined-up care. This will be through services delivered primarily in the community by a more confident workforce with appropriate skills and competencies in collaboration with voluntary and community sector providers.

6.36 The Living longer, living better (LLLB) is Manchester's transformation of community based care to address this challenge. It is an ambitious programme for implementation by 2020 which has in scope all health and care services that are, and could be delivered in the community. This includes in the first instance, local district general hospital services, community health services, social care services, GP primary care services, community mental health services and ambulance

services. As the programme is rolls out over the next 6 years and beyond, other elements such as wider primary care and services provided by the third sector will be incorporated.

6.37 The delivery of LLLB will be through 'One Team – Place Based Care Model'. All services will be based upon a 12/3/1 model of provision. Most services should be delivered at the place based neighbourhood level (12) unless they require economies of scale at a specialist local level (3), or a single Citywide level (1).

One Team – Place Based Care



Neighbourhood Team (12)

6.38 The key transformation will be the establishment of 12 Neighbourhood Teams across the City. These teams will be based on geographical area as opposed to organisation, and formed through existing services, populated with existing practitioners. The teams will focus on the place and people that they serve, centred around the ethos that 'The best bed is your own bed' where ever possible and care should be closer to home rather than delivered within a hospital or care home.

6.39 Working in this way, One Team will enable shift the focus from:-

- Organisation to place
- Disease to person
- Service to system
- Reactive to proactive care
- An unaffordable system to progressive upstream investment

6.40 Commissioners in Manchester have worked collectively to build the One Team Specification. In response, the 11 NHS and social care statutory providers (including all GP organisations in the City, all acute and integrated community trusts in the City, the Mental Health Trust, the Council and the ambulance service) have come together as a Manchester Provider Group to provide a collective provider response to the One Team Placed Based Care Model.

6.41 A wide range of services will be delivered in the future in a place based model in either 12 hubs, three localities or across the City. These include intermediate care and reablement, care management, urgent care first response, DGH functions, Community mental health, primary care, residential, nursing and home care.

6.42 For mental health, plans which are in the process of implementation are at a neighbourhood, locality and city-wide level. The opportunities arising from the Devolution Agreement add a new dimension and could allow us to make even greater improvement for our citizens and ensure that Manchester can contribute more fully to the Greater Manchester conurbation.

6.43 The LLLB programme operates at the community level with 'One team, Place Based Care' which has mental health services fully integrated in the future arrangements for the provision of community services. It is a key programme for delivering change to mental health provision and encouraging a more integrated approach to service delivery. Currently there is a multiplicity of providers and this fragmentation in the mental health system impacts negatively for people. Therefore, commissioners and providers wish to be bold in order to change the reactive way of working and to focus on prevention and early intervention

6.44 Integrated working across North, Central and South Manchester localities has already improved patients' experience of their care. For example an integrated health and social care discharge team (including those from neighbouring authorities) working under single management has been in place at North Manchester General Hospital for over two years. The team has been effective in reducing hospital lengths of stay, particularly for patients with complex needs.

6.45 North Manchester is an early implementer site for integrated community health and social care services beginning with intermediate care and reablement services. Reablement services (including bed and patients' own home based intermediate care, crisis response and reablement) have been integrated into a new Community Assessment and Support Service from September 2015.

6.46 A fundamental element of the One Team approach is the integration of social care within the 12 neighbourhood teams. This will integrate social care with:-
Home care will be more integrated into the new delivery models, combining elements of the current social care service with health support.

- Wraparound service offers for mitigating and responding to crises.
- 7 day working to support current models such as reablement.
- Online offer for self assessment.
- A fresh approach to support.
- Stronger links between adult services and wider City services providing an integrated whole family offer Manchester people.
- More innovative use of ICT to share data between providers and to facilitate new ways of working such as a telemedicine and shared records.
- Better integration of physical and mental services assisting a wide range of patients including those with dementia.

6.47 The LLLB programme will work with public health, linking with the Early Years strategies and other relevant programmes (such as complex dependency) to align and integrate where appropriate. This will include a focus on the three populations identified within LLLB that focus on children:

- Children with long term conditions
- Children at the end of life and palliative care
- Early Years implementation

6.48 The initial priorities are to integrate the following services from early 2016/17:

- Reablement and intermediate care, using the North Manchester Community Support and Ambulatory Services as a model.
- A single point of access to adult social care and community health services.
- Staff from adult social care and community health integrated into neighbourhood teams to jointly run assessment, case panning and case management.

- Urgent Care First Response

6.49 Urgent Care First response (UCFR) is a citywide approach, in response to the One Team specification, designed to reform the whole urgent care system in Manchester. It will bring together the different components of urgent care into a single unified system, which will operate with three core components (1) First Contact - people with a need for urgent care will be directed to the most appropriate part of the urgent care system, (2) providing urgent care to patients with complex needs through the 12 neighbourhood teams, and (3) developing Urgent Day Care hospital / ambulatory care facilities.

6.50 The integration of homecare and residential care will be delivered by commissioning these services on the basis of providers who share the values and priorities of this Plan. We will seek partnerships with providers who can not only provide value for money, but also staff and services able to be part of the integrated teams of the LLLB One Team approach. This will also provide an opportunity to create new skill mixes and new career ladders for front line staff linked to the move towards a Living Wage.

Dementia Care through LLLB

6.51 Dementia care in Manchester continues to be a high priority. Manchester is proud to be the 1st Age-Friendly city in the UK. The Devolution Agreement provides a unique opportunity to significant transform the health and care landscape around the GM Dementia priorities including:

- More people with dementia helped to remain living well at home
- Unnecessary delay and poor treatment avoided and stress reduced for the people living with dementia and their carers
- Preventable admission to hospital reduced and safe, sustainable and quick discharge to care and home increased
- Create England's best evidence base for dementia care, by bringing together data on the financial benefits to the acute sector of better and more integrated services for people with dementia in the community
- New innovative relationships with the digital, media and assistive technology industries

6.52 Building on this opportunity, a city wide transformational programme on dementia is being developed and will be implemented over the next 5 years. This will incorporate the range of existing programmes through LLLB, including the provision of Age friendly housing and the work that is ongoing with MHSCT about the redevelopment of all of their later life services. The ambition is to standardise care and keep people living at home as independently as possible.

6.53 There is a Greater Manchester work programme focusing on Dementa Health and Social care. This sets out clearly the vision for dementa care by 2021 across GM as *'the go to place for the best in dementia care, treatment and support'.*, and recognises that the dementia challenge in GM is one of standardisation, care pathway re-design and implementation. We will work with the GM Team in the achievement of this vision.

Transformation of District General Hospital Services

6.54 The implementation of LLLB, and the wider system changes across Greater Manchester through devolution, will drive the significant shift in emphasis and activity out of acute hospitals and into the community. In Manchester, we want a system which keeps patients well in the community, ideally at home, and only admits them to hospital when absolutely essential to receive care which can only be delivered in an

acute hospital. To this end, through LLLB, District General Hospital services will be transformed for our population.

6.55 With the exception of some independent sector hospitals, integrated hospital and community care for adults in Manchester is mainly provided by three NHS trusts, operating from four main sites:

Trust	**Site**
Pennine Acute Hospitals NHS Trust	North Manchester General Hospital
Central Manchester University Hospitals NHS Foundation Trust	Oxford Road Campus
University Hospital of South Manchester NHS Foundation Trust	Wythenshawe Hospital Withington Community Hospital

6.56 Many district general hospital services, particularly those related to urgent care and management of long term conditions will be part of LLLB and integrated into One Team, facilitating seamless transfer of care between hospital, community, primary and social care.

6.57 Radically different models of care will focus on providing safe and effective care without admission to hospital; e.g. emphasis on ambulatory care, outpatient and day case treatments, and “one-stop shop”. Services will be provided 7 days a week.

6.58 DGH services for children will be provided through a linked up system in which the secondary care offer to the Manchester population Royal Manchester Children’s Hospital and Wythenshawe Hospital’s paediatric service is clearly defined. It will be supported by a network of children’s community nurses and primary care providers, skilled in paediatric care.

6.59 Key enablers of this approach will be:

- Workforce: able to move between settings and organisations, recognising the wider contribution of volunteers, carers and the third sector.
- improved estate utilisation: community teams operating from a single location in each locality.
- interoperable IT systems: enabling DGH services to share electronic information with primary care, community and social services securely.

6.60 Two significant hospital programmes, focusing on LLLB integration and the transformation of community/DGH services are in Withington (The Withington Strategy) and North Manchester General hospitals.

The Withington Strategy

Withington Hospital, in the North part of South Manchester, currently provides a range of services including daycase surgery, cataract surgery, audiology, sexual health, therapies and outpatient clinics. It is co-located with Buccleuch Lodge which provides intermediate care beds, a day hospital and a base for community services staff. The hospital is under-utilised and currently does not generate enough income to be financial viable in its own right'. UHSM has developed a new strategy for Withington to create an integrated care campus in 3 phases (with some elements delivered in parallel): increasing outpatients and diagnostic activity; co-locating primary, community and acute services; and developing fully integrated services. Once complete Withington Hospital will provide integrated services in which organisational boundaries are broken down and the patient becomes the focus. To cater for busy, time-poor workers and families, patient pathways will be highly efficient with clear referral guidelines, GP access to consultant advice, one-stop shops and extended opening hours. Services at Withington will be closely integrated with primary care and focus on secondary care and long-term conditions. The intention is to co-locate general practice into Withington Hospital and, in the longer term, potentially build a new primary care centre on the site in which general practice, dentistry, optometry, pharmacy and wellness services could be brought together. The site also offers an ideal location for the One Team integrated health and social care neighbourhood team for this part of South Manchester to be based. Building on the recent partnership agreement with CMFT, the two trusts will explore the potential to both offer complementary services from Withington.

North Manchester General Hospital

NMGH is based in the community, surrounded by houses, with a main bus route through its grounds. Under" Healthier Together "it is a District General or Local Hospital site. Given the population growth predicted in North Manchester area of over 20,000 predominantly young people with young children over the coming 7 years, the need to keep a DGH site is vital. The age of some of the estate means that much of this is not fit for purpose in the 21st century. Hence capital is required to remove these, re-provide facilities for support services, construct a new energy centre and alterations to the site infrastructure. Plans are to make this a local hospital that provides A&E services, maternity and paediatric services, a range of outpatient services (ideally around Long term condition management) (making better use of the good building stock and co-locating relevant services), along with diagnostics that all operate 24/7. Plans are in development to establish a neighbourhood centre as part of the redevelopment of the site that will contain as a minimum a GP practice, a pharmacy, a base for social workers and rehabilitation teams as well as voluntary groups, that can assist in reducing A&E admissions. NMGH capital work on a 24 bedded intermediate care centre will commence in September 2015. This will allow step up and step down from EMA, hospital wards and primary care to allow better flow through and less dependency on hospital beds stock. As part of this work, the need for extra care housing to be based nearby this intermediate care centre will allow patients to gain independence in a

safe environment before returning home or remain as a tenant. This could be extended to provide dementia based services as the population is living longer and to an older age in	North Manchester and this facility would allow residents to stay close to their families in a safe and supported environment.

Transformation programme	**Living Longer Living Better – One Team (Intermediate Care and Reablement/Integrated Neighbourhood Teams)**
Nature of problem	The health and care system is focused on reactive care at the expense of prevention and early intervention. The delivery of health and social care is not sufficiently integrated and the workforce that provides it is fragmented and lacking in capacity and capability. This, combined with high levels of ill health in the population, has an impact on the quality and length of life for local people and draws resources away from more preventative approaches.
Proposed Solution	Ensure that health and social care providers work as a more integrated system within the city and across GM as a whole, with a greater focus on prevention, early identification of ill health and more proactive, joined-up care through services delivered primarily in the community by a more confident workforce with appropriate skills and competencies in collaboration with voluntary and community sector providers.
Key Programmes	Integrated intermediate care and reablement services Integrated Neighbourhood Teams
Outputs	Increase in the number of: • People having an agreed shared care plan. • Patients receiving appropriate care through an integrated team. • Health and care professionals working as part of an integrated team. • People receiving a multi-disciplinary assessment using an appropriately validated tool. • Patients appropriately referred to IC&R service. • People appropriately discharged from IC&R service. • Referrals dealt with within agreed response times. • Appropriate people screened using frailty tool. • Events or services delivered in partnership with voluntary and community sector providers. • People reporting as ‘self caring’ in the city.
Outcomes	Reduction in: • Avoidable emergency hospital admissions. • A&E attendances. • Length of stay in hospital. • Number of delayed discharges. • Number of people able to live at home following discharge from IC&R.

	• Permanent admissions to nursing care and residential care. • Readmissions to hospital. • Patient waiting times for non-urgent care (diagnostic tests etc.). • Safety incidents linked to uncoordinated multidisciplinary working. Improvement in level of independence based on validated frailty tool scores. Increased amount of health and social care activity delivered in the community Increase in staff satisfaction and reduction in staff turnover. Increase in the number of people supported to die in their place of choice.
Impact	Reduction in: • Mortality from causes considered amenable to healthcare. • Spend on acute hospital care. • Residential/nursing provision. Increase in: • Health-related quality of life for people with long term conditions (LTCs) and their carers. • People feeling independent and able to manage their LTCs in their own homes. • Proportion of spend on services delivered in the community. • Participation of patients, carers, family and local people in the care assessment and planning process. • Effectiveness satisfaction of the workforce. Improvement in patient and carer experience of community-based services. Improvement in quality and safety of community-based services. Improved experience of palliative/end of life care.

Transformation programme	**Living Longer Living Better – Urgent Care First Response**[4]
Nature of problem	The urgent care system is characterised by duplication, overlap and high use of expensive care. There have been numerous initiatives over the years seeking the dual "holy grails" of reducing non elective admissions and A&E attendances.
Proposed Solution	Develop a new model of urgent carer to ensure that the system is simple for patients and referrers to navigate, remove duplication and overlap and reduce the use of high cost reactive services.
Key Programmes	Living Longer Living Better (LLLB)/One Team
Outputs	Increase in number of people treated in line with commonly agreed standards for urgent care. Increase in the number of patients whose care is managed over the telephone. Increase in the number of patients accessing urgent primary care. All Manchester urgent care services and pathways are included in 111 directory of service.
Outcomes	Reduction in serious and untoward errors in urgent care. Reduction in non-elective admissions and other high cost interventions. Reduction in healthcare acquired infections (HCAI). Reduction in A&E attendances.
Impact	More efficient commissioning and provision of urgent care services. Improved patient and referrer satisfaction. Increase in people in control of their own condition. Increased self reliance. Reduction in disability and mortality from causes considered amenable to healthcare. Improved equity of access for people with protected characteristics and other groups. Reduction in overall cost of urgent care. Reduction in duplication of urgent care services.

[4] Urgent Care First Response (UCFR) is the urgent care component of One Team

Transformation programme	**Living Longer Living Better – Dementia Care**
Nature of problem	The number of people with dementia in Manchester is increasing but specialist service provision in Manchester varies across the city and some 'general' services are not geared up to cater for people with dementia. Diagnosis rates vary across the city as does the level of post diagnosis support and support for carers.
Proposed Solution	Refresh the Dementia Strategy for Manchester. Redesign Later Life and Dementia services to reintroduce Dementia Support Advisor roles. Work with the Alzheimer's Society to map dementia services and improve access and awareness. (Dementia Journey Roadmap) Roll out Dementia Friends training to all GP practices and social care assessors. Review medicines management and prescribing to ensure appropriate use of anti-psychotic drugs. Carry out cost benefit analysis on MHIP dementia care pathway to inform gaps in provision. Develop a performance management template for dementia services across MCC and CCG commissioned services. Further expand GP clinical advice line to the Acute Trust.
Key Programmes	Living Longer Living Better/One Team Age Friendly Manchester
Outputs	Increase in the number of: • patients screened for dementia by GP practices. • people from BME communities screened for dementia by GP practices. • patients seen by primary, community, voluntary and specialist services. • Health Care Professionals working in the community. • Dementia Advisors working as part of the Dementia Community Service. • patients being prescribed anti-psychotic medications receiving a medicines review. • staff performing health and social care duties attending dementia awareness training.
Outcomes	Increase in the: • number of people receiving a timely diagnosis of dementia. • dementia diagnosis rate among BME communities. • number of carers accessing local voluntary and community groups • number of staff equipped with the skills to support people with dementia effectively. Reduction in the: • waiting time from referral to diagnosis. • number of avoidable hospital admissions among people with dementia.

	• number of avoidable residential care placements among people with dementia. • length of stay in hospital for people with dementia. • number of patients with dementia being prescribed inappropriate anti-psychotic medications.
Impact	Improved access to treatment, support and services. Improved access to dementia services for BME communities. Reduced variation in dementia diagnosis between GP practices. Improved health and wellbeing of people with dementia and their carers enabling them to self care and maintain the carer relationship. More people able to continue living in the community supported by appropriate services. Fewer people reaching crisis point such that they need for secondary/ residential care services. Improved patient/carer experience of dementia care. More patients with dementia receiving appropriate medication. Reduced spend on residential and hospital care for people with dementia. Improved quality of health and social care delivery for people with dementia by appropriately trained staff.

Transformation 5: Mental Health

6.61 The mental health of citizens in Manchester is integral to its success as the effects of poor mental health and wellbeing are to the detriment of individuals, the social cohesion of their communities and the economic growth of the city.
6.62 Mental health is a significant issue for Manchester – for residents affected by, and living with, mental health problems as well as organisations delivering services. Manchester has a clear vision of improving services and by 2020 aims to have acute and serious episodes of mental illness treated more safely and providing a substantially improved service for Manchester residents. The ambition is to deliver a safer and more effective management of acute and serious episodes of mental illness. As the link between mental illness and unemployment is established, the intention is to increase the number of people who can regain skills after serious mental illness
6.63 A key driver for improvement is to help people maintain the best quality of life when they have severe and persistent depression
6.64 The overarching approach to good mental health and wellbeing must take account of the needs of people, at their different stages of life and ensure that the services and support available to them is:

- Preventative, ideally avoiding the need for intervention form specialist practitioners by effective public health programmes in communities and workplaces
- Accessible at the times needed to prevent worsening of symptoms and especially to intervene early in crises.
- Integrated into the needs arising from and affecting physical health
- Responsive to need and 'recovery' focussed ensuring people are supported and encouraged to return to active working lives, where relevant
- Clear in its pathways of care for all users of services through children's transition to adult services and pathways to more intensive and restrictive settings where necessary

6.65 The 'system' then, needs to ensure that it is effective, efficient, based on 'best practice' and outcome focussed so that services are sustainable and provided as close to the users community as possible. These principles drive the ambition of the city in its development of mental health services which require close collaboration between all stakeholders including health and social care providers, the third sector, Police services, housing and the Department of Work and Pensions (DWP). The role of carers cannot be underestimated and their full engagement in all our plans is crucial to their success.
6.66 The costs to the health care system of our current approaches are significant – poor mental health makes physical illness worse and raises total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12 per cent and 18 per cent of all NHS or GM expenditure, between £420m and £1.08bn. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.
6.67 Current mental health services in Manchester do not provide the best value for money nor generate the best outcomes for patients with long waiting lists and high use of "out of area" beds. By outlining care pathways, the current fragmentation between services will be reduced with improved access to integrated delivery.

6.68 The "One Team" approach proposes that mental health services will be fully integrated in the future arrangements for the provision of community services. It will be key for delivering integrated mental health provision, as described in Transformation 4.

Neighbourhood, Locality and City

6.69 Many people with physical health conditions also have mental health problems. Currently physical and mental health treatments tend to be delivered, as separate health services. Care for large numbers of people with long-term conditions will be improved by integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. This will also allow us to provide MH training and awareness to all neighbourhood teams and community services to ensure the chance of stigma is reduced.

Supporting Complex Dependency and Worklessness

6.70 We are supporting people with a range of complex needs by working collaboratively across local services to deliver the right support at the right time. The provision of mental health support as part of packages of support through the expansion of Working Well, the Troubled Families Programme and complex dependency will strengthen our ability to ensure all residents are able to benefit from the conurbation's economic potential.

6.71 The links between employment, wellbeing and mental health are well established therefore, access to therapeutic interventions at the right time are critical to keep people in or return to work. The urgent care response for young people in crisis is an area for further development and improvement in Manchester. This applies too for those with learning disability where there are associated mental health problems.

Children and Young People's Mental Health

6.72 The numbers of children in the UK affected by mental illness has risen particularly fast in the past 10 years. An estimated one in 10 children and young people suffer from a diagnosable mental health disorder. These problems are a significant personal, social and economic burden not only on the children and young people themselves, but also their families, carers and the community.

6.73 The early detection of mental health problems through all stages of a child's life is crucial. The antenatal period and early years represent vital development stages when problems with child development, speech and behaviour can arise. We will ensure that there is:

- Intervention to make a difference both for individuals and populations at this time will help to avoid social and health problems in later years.
- Access to appropriate support in teenage years is a priority, with access to appropriately resourced and trained staff in education settings and wherever young people may seek help.
- Development of pathways of care through a common point of access for all agencies supporting children and young people in Manchester will help all children access the right support in the quickest way possible.

6.74 The emphasis will be on the prevention and emergence or escalation of mental ill health by

- active health promotion/support and early intervention within the community
- access to the right age appropriate support in the right place at the right time by an appropriately skilled and informed workforce delivering evidence-based interventions
- ensure the early detection and on-going treatment of physical health problems, through GP screening; in addition to the mental health support available to all our children and young people

6.75 For those young people already in receipt of CAMHS services and approaching adulthood we must ensure a timely appropriate and planned transition to adult mental health services through integrated pathways. Bringing the parts of peoples care together without them noticing the join.

The Greater Manchester opportunities

6.76 There are great benefit to be achieved by looking beyond the city boundaries for future change and improvement to mental health services. These relate largely to:

- the ability to collaborate between organisations and agencies, providing for example GM wide AMHP services and crisis response
- the integration of services which are highly specialised and require greater critical mass than available in separate economies. This could apply to:
    - CAMHS
    - Learning disability services
    - Psychosexual services
    - Autistic Spectrum Disorder (ASD) services
    - Crisis response
- It is recognised that there is also opportunity to re-consider the 'footprints of delivery' for NHS Trusts across greater Manchester which could result in a reduced number of organisations and a greater economy of scale for corporate and support services, allowing a higher proportion of spend to be directed to direct patient care.
- The offer to be developed for the city through the Mental Health Improvement programme (MHIP) will be rooted firmly in the emergent GM Mental Health Strategy, Greater Manchester will develop a Specialist Mental Health Provision System that can combine critical mass, expertise and development opportunity with the ability to be flexible in local delivery to address the differing needs of local populations in relation to health and social care integration. This may lead to the restructuring of the current "footprints of delivery" of the 4 existing Trusts and/or organisational change that reduces the number of organisations. To ensure these are provided on a cost effective and sustainable basis. At a GM Level we will ensure that the devolvement of NHS England budgets relating to Specialist Mental Health Services be used to break the current paralysis of strategic planning and opportunities. We will also tap into our academic assets through the MAHSC and AHSN to support the spread of evidence based practice.

6.78 At a GM Level we will also ensure that the devolvement of NHS England budgets relating to Specialist Mental Health Services be used to break the current paralysis of strategic planning and opportunities. We will also tap into our academic assets through the MAHSC and AHSN to support the spread of evidence based practice. The Greater Manchester Devolution will play an essential role in transforming acute and hospital care. By realigning investment to early intervention and proactive care, there will be a positive impact on the quality of life of people with

mental health issues. The number of people entering and completing IAPT should increase, with a higher recovery rate. By 2020 there should be a reduction in mortality rate from suicide and undetermined injury and more people living in appropriate accommodation.

Transformation programme	**Mental Health Improvement Programme: Common mental health problem pathway**
Nature of problem	Need to develop a robust community offer through the work of LLLB and One Team There is a need to reduce Fragmentation of providers across the city, which can result in difficulty for patients in easily accessing the right help. Long waiting lists in some services and thus limited access in a timely way can impact on the patients journey outcome and experiences there is a need to ensure that services deliver improved outcomes for people – that they recover and have an improved quality of life. Care offered and majority of investment sits with reactive care and intensive provision, investment needs to be realigned to proactive care – evidence based care and early intervention. Re distribution of resources required, though this will only be enabled if acute and rehabilitation care pathways are effective and if early intervention is resourced
Proposed Solution	Development and implementation of common mental health problem pathway (one of 17 proposed MHIP care pathways).
Key Programmes	MMHSCT transaction process (TDA led) GM Devolution programme (for acute and hospital care) Living Longer, Living Better (LLLB)/One Team (for community provision) IAPT Integrated service offer from all CCG commissioned third sector
Outputs	Increase in: • spend on psychological therapies required. • the number of psychological therapy interventions available for different levels of severity. • the number of people assessed and referred to an appropriate intervention. • the number of referrals to IAPT entering treatment. • the number of people accessing psychological therapies who are also in receipt of an employment support package. • the number of people entering therapy who have waited less than 18 weeks. • the number (and %) of people referred to IAPT finishing a course of treatment. • the number of patients treated in line with an appropriate PbR tariff. • the number of people seen as part of One Team model

	referred to appropriate psychological and MH interventions. Expected number of people entering psychological therapy completing therapy. Average number of contacts by people in receipt of psychological therapies. Reduction in number of people dropping out of treatment.
Outcomes	Increase in the proportion of referrals to IAPT that moved to recovery at the end of treatment. Reduction in re-referrals to psych therapies. Reduction in hospital admission/readmissions. Increase in people offered least intensive but effective intervention. Increase in proportion of people with common mental health disorders in employment. Increased utilisation of full service capacity (e.g. reduction in vacant posts).
Impact	Reduced spend on intensive (Step 4) interventions (inpatients and community). Improved quality of life among people with common mental health problems and their families. Increase in people with common mental health problems in stable employment. Increase in number of people with common mental health problems treated in the community. Reduction in time spent in hospital by people with a common mental health problem. Improved patient, carer and family experience of community mental health services Increased value for money.

Transformation programme	**Mental Health Improvement Programme: First episode of psychosis pathway**
Nature of problem	As described in Common mental health problem pathway above
Proposed Solution	Development and implementation of first episode of psychosis pathway (one of 17 proposed MHIP care pathways).
Key Programmes	Development of service offer to meet new standard – MMHSCT and RDASH One team
Outputs	Increase in number of people experiencing a first episode of: • psychosis entering the MHIP pathway. • psychosis accessing EIP service with MCC commissioned employment support services. • psychosis accessing physical health screening and treatment services (primary care/neighbourhood teams).

	• psychosis accessing CBT in line with standard. • psychosis accessing family interventions in line with standard. • psychosis accessing well-being interventions such as smoking cessation and physical exercise.
Outcomes	Increase in: • people recovering from a first episode of psychosis showing a reduction in symptoms. • people offered least intensive but effective intervention. • people with a first episode psychosis treated with a NICE approved care package within two weeks. • proportion of adults in contact with secondary care MH services in paid employment. • proportion of adults in contact with secondary mental health services living in stable and appropriate accommodation. • average health status score on assessment and on discharge (based on EQ-5D score). • people with MH illness feeling supported to manage their condition. Reduction in people experiencing an escalation of need and crisis requiring MH inpatient care or crisis community care. Reduction in mental health readmissions within 30 days. Reduction in smoking status among people experiencing a first episode of psychosis. Reduction in obesity among people experiencing a first episode of psychosis.
Impact	Reduction in excess premature (<75) mortality rate for people experiencing a first episode of psychosis in contact with mental health services. Improved physical health of people experiencing a first episode of psychosis. Improved quality of life for people experiencing a first episode of psychosis. Improved patient, carer and family experience of mental health services. Reduced spend on out of area treatment. Increased value for money.

Transformation programme	**Mental Health Improvement Programme: Integrated community rehabilitation from psychosis pathway**
Nature of problem	As described in Common mental health problem pathway above
Proposed Solution	Development and implementation of integrated community rehab from psychosis pathway (one of 17 proposed MHIP care pathways).

Key Programmes	MH QIPP programme
Outputs	Number of people receiving an appropriate clinical assessment in acute and rehabilitation wards.
Outcomes	Increase in number of patients in an out of area placement returning to local services. Reduction in LOS in out of area placements. Increase in average health status score on assessment and on discharge (based on EQ-5D score). Reduction in smoking status among people experiencing an episode of psychosis. Reduction in obesity among people experiencing an episode of psychosis.
Impact	Improved physical health of people experiencing an episode of psychosis. Improved quality of life for people experiencing an episode of psychosis. Improved patient, carer and family experience of mental health rehabilitation services. Reduced spend on out of area placements. Increased value for money of community rehabilitation services.

Transformation programme	**Mental Health Improvement Programme: Acute mental health care pathway**
Nature of problem	As described in Common mental health problem pathway above
Proposed Solution	Development and implementation of acute mental health care pathway (one of 17 proposed MHIP care pathways). Increase investment in development of acute care and community home treatment care.
Key Programmes	Risk share in MMHSCT National programme for MH liaison services in acute hospitals TDA sustainability process Greater Manchester Devolution programme
Outputs	Number of people with an acute or serious episode of mental illness receiving a clear intervention offer based on evidence based treatment. Increase in number of people with an acute or serious episode of mental illness receiving an effective discharge plan.
Outcomes	Reduction in: • the number of out of area acute care placements for patients with an acute or serious episode of mental illness. • average length of stay for people with an acute or serious episode of mental illness. • delayed transfers of care within acute wards and community home treatment teams for people with an acute or serious episode of mental illness. • acute hospital readmissions within 30 days for people with an acute or serious episode of mental illness. • the number of mixed Sex Accommodation (MSA) Breaches. • the number of people with an acute or serious episode of mental illness experiencing a 12 hour wait in A&E for admission. Increase in number of for people with an acute or serious episode of mental illness discharged to their own homes. Increase in number of people with an acute or serious episode of mental illness receiving a Care Programme Approach (CPA) 7 day follow-up. Increase in number of for people with an acute or serious episode of mental illness reporting improved outcomes (PROMs).

Impact	Reduction in mortality from suicide and undetermined injury. Safer and more effective management of acute and serious episodes of mental illness. Improved physical health of people with a severe mental illness. Increase in people with a severe mental illness feeling supported to manage their condition in their own home. Improved quality of life for people with a severe mental illness. Improved patient, carer and family experience of acute mental health care. Reduced spend on private, out of area, acute and rehabilitation beds. Increased value for money of acute mental health care.

Transformation 6: Learning Disability

6.79 A transformation of services for LD people is required to reduce reliance on inpatient and hospital care by reducing the factors that lead to emergency and crisis admissions and prevent unnecessary admissions. This will require the development of a new delivery model for specialist care, universal service and community support and a new approach to what should be developed at GM level and what should be delivered locally. This will be across GM, citywide and at a local level. The priority is to support people to live independently in the community with appropriate step up and step down wrap around health and social care services and investment will be required to develop a new residential estate.

6.80 The targets for learning disability are to

a) Through commissioning mechanisms, map the national service model against current pathways and service footprints and agree a local plan to close the gaps
b) Work with Manchester City Council & other partners in stimulating the supported living sector to provide appropriate accommodation stock & resettlement pathways for those leaving institutional care.
c) Integrate diagnostics and interventions for those with autism into the existing local community service offer.
d) Build robust transition pathways for young people identified with learning disabilities so that they remain within a supportive system.
e) Prevent premature deaths by promoting health & wellbeing for those with learning disabilities through regular health screening, support & access to targeted training & employment.
f) To develop a new Resource Allocation System (RAS) for LD people to demonstrate an equitable and transparent allocation of social care resources, support consistent decision making, provide a new way of measuring severity of need and support transparent care package decision making
g) To develop a new conversation with service users which is based around the individual and their family
h) To increase the number of people with learning disabilities on a coherent, coordinated and fully integrated Care Pathway

6.81 *Universal Offer*

- Strengthen and develop community learning disabilities health & social care teams to be responsive in supporting mainstream provision to manage those with mild & moderate learning disabilities and conditions, as

well as supporting those with complex & challenging behaviours through tailored community support. The number of people who are in good quality accommodation will be increased.

- Build integrated pathways between health, social care, accommodation, education, vocation & employment agencies so that bespoke rehabilitation programmes are a fundamental element of care and support plans and people with LD are actively encouraged, trained and supported.
- Work with Manchester City Council and other GM CCG/Local Authority footprints to build robust transition and early intervention pathways with appropriate services for Children & Young People identified with learning difficulties and burgeoning disabilities, including looked after children, so that a life-course approach can be developed for each child, to reduce crises and acute episodes developing in the future.
- The ambition is to improve the quality of life for people with learning disabilities and their carers. By increasing the participation of people with learning disabilities, and their carers, in the design of health and care services, by 2020 there should be a reduction of crisis hospital stays and reduction in the duration of stays

6.82 *Primary Care Strategy*

- Develop and train clinical "champions" for LD across the primary care sector developing subject matter expertise across professional footprints, including GPs, practice nurses, school nurses, dentistry, and sexual health services.
- Ensure LD register information is correct and up to date and people with LD as well as their carers receive a full annual health assessment and review.
- Work with IAPT providers to develop a specific intervention for those with LD experiencing anxiety, depression and phobias.
- Train staff from the Community Health LD team in IAPT compliant interventions for those with mild/moderate LD
- Integrate diagnostics and interventions for those with autism into the existing local community service offer.

6.83 *Community Offer*

- Redesign & reshape the Community Health LD team (formerly known as MLDP) for compliance with the national service specification including establishing specialist consultants to provide clinical leadership.
- Integrate LD social care staff including forensic staff to form a Community Health & Social Care LD team as a core element of the new national service delivery model.
- Build an on-call liaison service for Accident and Emergency presentations to support Emergency Department and Mental Health liaison staff, reduce breaches and prevent unnecessary admissions, but where admission is required, it is timely and appropriately managed.
- Develop a crisis management and outreach service as part of the redesigned integrated community team that works closely with GPs, community mental health services, and social care.
- To develop a community assets approach to service delivery

6.84 *Residential offer*

- Commission a specialist residential crisis intervention service that provides respite for people with LD in order at an earlier stage and as part of an integrated community package.
- Manchester City Council and CCGs to work together to stimulate the accommodation market in Manchester to develop “step-down” residential rehabilitation for those coming out of hospital supported by community staff. Resultant increase in the number of people in good quality provision.
- Ensure all care plans and support plans include recovery and rehabilitation as part of the drive towards independent living for people with LD
- To replace the supported accommodation estate across the City for people with a learning disability so they can live independent, supported lives in a locality of their choice in good quality apartment style provision
- To develop a new estate for young people with a learning disability in transition from children’s to adults status, supported to live as independent life as possible to the maximum of their own ability. To promote choice about where this is located and to build a wrap around health and care model that is community based, light touch with step up levels of support when required
- To develop more shared lives schemes and extra care facilities for people with a learning disability

Transformation programme	Learning Disability
Nature of problem	Recognition that the current configuration of care pathways across Manchester is disparate and fragmented. This does not match the national requirements or the aspirations for Manchester set out in the Locality Plan.
Proposed Solution	Develop more coordinated and sequenced care pathways for people with learning disabilities across health and social care in Manchester based on the national specification and service model.
Key Programmes	Living Longer, Living Better/One Team GM LD Fast Track Programme Transforming Care for People with Learning Disabilities, Next Steps
Outputs	Increase in number of Manchester patients repatriated from healthcare facilities in line GM LD Fast Track Targets (25 people). Increase in number of people with learning disabilities on a coherent, coordinated and fully integrated Care Pathway. Increase in number of people with learning disabilities receiving an annual health screening. Increase in number of people with learning disabilities referred onwards to mainstream services for support. Increase in number of people with learning disabilities on a pathway to access employment, skills and training.
Outcomes	Reduction in the number of people who require specialist inpatient admissions. Reduction in number of crisis/avoidable emergency hospital admissions among people with learning disabilities. Reduction in length of stay in hospital among people with learning disabilities. Reduction in number of delayed discharges among people with learning disabilities. Reduction in readmissions to hospital among people with learning disabilities. Increase in the number of people supported to live independently in the community and stepped down into good quality provision. Increase in the number of people in employment and actively accessing skills and training opportunities.
Impact	Improved health and quality of life for people with learning disabilities and their carers. Increased participation of people with learning disabilities and

their carers in the planning and design of health and care services.
Improved quality of provision for patients with learning disabilities and their carers.
Increased independence for patients with learning disabilities and their carers within community settings.
Improvements in ability of workforce across mainstream provision to respond to people with learning disabilities.
Improved availability of specialist clinical support for patients with learning disabilities and their carers.

Transformation 7: Co-ordinating the organisation and delivery of Acute Hospital Services in Manchester - A Single Manchester Hospital Service

6.85 The hospital services in Manchester include some of the best and highly regarded teams in the UK, with real areas of excellence in clinical care. However, there are also significant inconsistencies and variations in the way that acute hospital services are provided at present. Standards of care can be variable, best practice is not consistently adopted or adhered to, and there are important gaps in services alongside areas of service duplication. The existing arrangements also fail to provide a clear Manchester focus for acute hospital care, or for the relationship between providers and commissioners.

6.86 The partnership working approach, including Central Manchester University Hospitals NHS Foundation Trust (CMFT), University Hospitals of South Manchester NHS Foundation Trust (UHSM) and Pennine Acute Hospitals Trust (PAHT), would aim to deliver consistent and complementary arrangements for providing acute hospital services across Manchester. The aim is ultimately to achieve a fully-aligned hospital model.

6.87 It is proposed to create an appropriate mechanism to bring together the organisation and delivery of acute hospital services through a two stage process.

6.88 Firstly, it will involve reviewing the service portfolios of the three Trusts and developing a detailed exposition of the potential benefits of a fully aligned hospital service model, expressed in terms of clinical, patient, staff, financial, research and innovation aspects, and fully supporting integrated working.

6.89 Secondly undertaking a detailed appraisal of the most appropriate governance arrangements, including:

- The overall organisational governance which will bind all three acute providers in the City of Manchester into a set of formally agreed accountability arrangements, with devolved authority from each of the the three respective Boards;
- The structure and operation of any supporting governance structures, for example a Joint Hospitals Board;
- The key supporting workstreams (focussed on priority areas for developing clinical single services);
- The arrangements for management of operational services; and
- The contractual arrangements with commissioners, including the management of risks and benefits, which will need to provide assurance to commissioners that the delivery arrangements have a binding and accountable point of authority.

6.90 At the heart of the clinical service modelling would be the development of a series of 'single services' for acute hospital care in Manchester. This work will build on the approach utilised for Healthier Together, and would be driven by clinical standards developed through discussion and agreement amongst clinical teams. However, the service scope will be much more ambitious than Healthier Together, progressively encompassing all acute hospital services.
6.91 It would be expected that a fully aligned hospital service model could be progressively developed and implemented by April 2020, while recognising that any capital or estates development may also need to be considered..

Transformation 8: Health and Social Care for Children and Young People

6.92 Health and Social care for children and young people will put the individual and family at the heart of everything they do and provide health and social care support at the time when most needed, offering intervention at a local level to those children, young people and families with additional and complex needs. This will be is linked to a reduction in demand and a focus on early and earlier intervention and prevention to enable families, children and young people to become self-sustaining and to secure improved outcomes. Where interventions are necessary these will be based on three core principles:

- Use of evidence based interventions
- Integration and co-ordination of delivery of those interventions with all other public services so that families receive the right support in the most effective sequence based on the needs
- A family approach to changing behaviours

6.93 Continued investment in early and earlier intervention and prevention (including early years) will lead to reduced demand in later years. There is an opportunity to re-profile commissioning intentions and pathways to represent Manchester and Greater Manchester which will be consolidated in Manchester through our Early Help Strategy and locality hubs delivery model to get the youngest people in our communities to the best start and to turn round the lives of troubled families within the city.
6.94 The Council and it's partners have a shared ambition to ensure that children and young people in the City are safe and have the opportunity to thrive as they become adults. This is within a context of children in the City living in poverty, approximately 1200 children in the care of the Local Authority, and over 900 being subject to a child protection plan and over 5000 classified as being children in need.
6.95 In this context the focus of health and social care integration aligns with the Improvement Plan for childrens services. Key objectives are to reduce the dependency of families and children upon acute services, to safely reduce the numbers of looked after children in the City and to provide the right interventions at the right time . Specifically the Local Authority and it's partners need to ensure that early help is targeted and coordinated effectively, so that families receive support when need is first identified and the number of referrals to children's statutory social care services is reduced as a result.
6.96 Key features of this transformation priority are:

- Investment in social work services in order to reduce caseloads and improve the quality of support provided to those children in need of support and protection;

- Expansion of Multi-agency assessments to ensure an integrated and timely support;
- Early help to be targeted and coordinated ;
- Safe reduction in the numbers of children looked after by the Council; and
- Increases in the number of children benefitting from adoption and fostering

Transformation programme	**Children and Families: Looked After Children**
Nature of problem	High volume of LAC compared to comparators and core cities leading to high overall spend. NB Cost per LAC is average. Increasing flow of LAC (nationally and in Manchester but LAC population always volatile). Historically social work culture does not fit with focus on reduction in LAC (perceptions of risk). Historically partners too easily treat MCC as 'parent of last report'. Cannot reduce costs through reducing social workers.
Proposed Solution	CD work will reduce LAC flow. Better targeted interventions for 0-5s and 15-17s. Greater focus on: adoption; re-balancing from residential to foster care, placements in the City; decommissioning internal residential provision; work and skills; work with extended families. Focus on progression and exit through targets for reduction, emphasis on permanent outcomes, tracking outcomes. Strengthened performance management. Workforce development of social workers. Social worker caseloads reduced. Collaboration and co-commissioning of care services.
Key Programmes	Multi-agency LAC partnership group. Digital working strategy.
Outputs	Increased rates of adoption. Increased rates of fostering. More care leavers with skills. More care leavers in decent work. Good flow of performance management information. Changed attitudes of social workers to LAC reductions. Reduced social worker caseloads. Cost-effective care services in place. Plans with partners in place. Digital working strategy in place.
Outcomes	Reduced flow of LAC. Reduced rate of LAC admission. Reduced stock of LAC. Increased rate of LAC discharge. Reduced duration in care. Better outcomes for LAC and other children with potential to become LAC.
Impact	Residents more independent, resilient, school ready and economically active.

Transformation programme	**Children and Families: Safeguarding**
Nature of problem	Ofsted report of 1 September 2014 judged children's services as inadequate e.g.: children waiting a long time for social work assessment; quality assurance and management oversight not robust; high social work caseloads; poor partner understanding of thresholds; poor engagement in early help; too many children waiting for adoption; ineffective challenge of poor practice. Manchester's child population has grown by 2% (av.) over past decade. 37% live in poverty.
Proposed Solution	Review caseloads. Ensure correct staffing levels. Ensure robust management oversight. Improve collation, accuracy and reporting of performance data. Effective targeting and coordination of early help: scale up Troubled Families approach e.g. specialist CiN team, lead workers, Local Integration Team, triage, MASH, Public Service Hub. Prioritise the recruitment of adopters. Increased use of voluntary adoption agencies. Accelerate foster to adopt. Act on children's feedback – improve effectiveness of independent reviewing officer service.
Key Programmes	Children's Improvement Plan
Outputs	Manageable caseload levels. Timely assessments. Proper attendance at meetings/case conferences etc. Proper record-keeping. More accurate, timely information available. Better understanding of when to refer/offer other support. More appropriate interventions. More and more variety of adopters.
Outcomes	Improved safeguarding. Reduced referrals. More families in employment. Reduced mismatch of adopters and children. Quicker adoptions.
Impact	Reduced proportion of Manchester's children are in need i.e. reduced dependency.

Transformation programme	**Children and Families: Complex Dependency**
Nature of problem	Worklessness in Manchester above core city and national average. Higher than average number of residents with low skills levels. Higher than average number of LAC. High number of residents using targeted services.
Proposed Solution	Scaling up Troubled Families including those at risk of becoming complex. Sharper focus on employment as key route out of 'complexity'. Effective cohort analysis and neighbourhood intelligence. Controlling entry through integrated front door, MAPSH. Multi-agency assessment and case allocation. Coherent early help e.g. Early Help Coordinators. Tier 1 key workers – bespoke plan (family based approach). Tier 2 draw down specialist support. Prioritising cases e.g. 0-5, return to home, 15-17. Support for integrating services through Local Integration Teams. Negotiating with partners to elicit resources for new delivery model. Workforce development. Address ICT challenges.
Key Programmes	Troubled Families Programme Confident and Achieving Manchester Programme
Outputs	More accurate identifications of Troubled Families by MCC and partners. Greater uptake of Early Help offers. More key workers, including staff from partner organisations. Wider range of flexible Tier 2 services available.
Outcomes	Reduced stock of Troubled Families. Reduced flow of Troubled Families. Fewer workless households. Fewer ESA/IB claimants. Fewer working Tax Credit claimants. Lower youth offending. Improved skills levels. Fewer mental health service users. Reduced flow of LAC. Improved school readiness and attendance.
Impact	Residents more independent, resilient, school ready and economically active.

Transformation 9: Housing and Assistive Living Technology

6.94 Manchester is developing a strategic approach to meeting housing needs to maintain good health and extend independence.
6.95 The Housing for an Age Friendly Manchester Strategy links care and health services for our older population. Innovation, creativity and making best use of technology will increase housing provision and choices for older people. The plan is to offer older people the advice and guidance they need to make informed decisions. This is currently being tested in North Manchester. By offering Housing Options to residents approaching retirement they can be informed about lifestyle choices.
6.96 Extra Care housing is a type of housing for older people which offers an independent tenancy (or outright/shared ownership) within a communal setting. Onsite care is the critical feature of extra care and is strictly managed to ensure extra care housing remains a balanced community where the more active, independent older people help people who are more infirm. The ambition in Manchester is to scale up future provision from the current 297 units and to provide mixed tenure options across the City. A Housing Needs Assessment has compared the forecasts of numbers of older people across the City's neighbourhoods against the locations of our existing stock and numbers of units already in a funded development pipeline. This has helped us to identify where we need to locate new developments and the numbers we need to accommodate. Our ambitions are to develop an additional four new schemes over the next five years: two new schemes in the south of the City, one in the Newton Heath area and one in Gorton (already the subject of a funding bid). Subject to investment funding being available to deliver these schemes, this would provide approximately 400 additional units. We also intend to upscale some existing sheltered schemes to provide Extra Care Lite accommodation. This would bring our total extra care stock to over 1000 units. The benefits from this kind of accommodation are significant and include reduced hospital stays, reduced expenditure on adaptations in larger homes and employment and apprenticeship opportunities for the construction industry
6.97 The Council's Supported Accommodation Service looks after and supports learning disabled adults and learning disabled young people in transition to adulthood. The ambition is to replace or significantly improve the current estate. The design of new accommodation, tailored to the needs of each cohort will ensure better quality of care and improved lifestyle outcomes.
6.98 Advances in assistive technology, and tailored equipment packages will support greater independence and deliver more cost efficient packages of care. Assistive Living Technology (ALT) includes both telecare and telehealth/telemedicine. The ambition in Manchester is to roll out ALT across the whole City to other cohorts as a prevention tool to reduce unplanned hospital admissions and as a way of shifting the appropriate delivery of care from acute hospitals to community settings, particularly people's homes. There is a real opportunity to involve private sector expertise and investment.
6.99 There are clear advantages for supported living arrangements that offer choice and independence. This can also maximise opportunities to link to education and employment and to develop independent living skills. Investing in appropriate accommodation and services will enable young people to live inclusive lives within their communities. Ideally people will be able to live more independently without 24 hour support, reducing care costs further.

6.100 Improvements to the City's aids and adaptations services will be essential if our LLLB programme is to work. People need suitably adapted homes to return to following a stay in hospital. To improve these services, we will:

- Develop a social care cluster of equipment related services in one centre of excellence across local authority and health budgets
- Develop a partnership approach across the local authority, health, housing providers and the third sector for adaptations to people's homes so that they can continue to live in them for longer, delaying costly placements in residential and nursing homes.
- Develop a unified approach to rehousing people.

Transformation programme	**Housing and Assistive Living Technology**
Nature of problem	The type, volume and quality of accommodation in the city does not support independent living and results in too many residents moving to residential care. Excess admissions to A & E from residential and nursing homes when residents are unwell.
Proposed Solution	Ensure that accessible housing and financial advice and guidance is available for older people, carers and health and care professionals. Develop additional extra care housing units and re-commission sheltered schemes as extra care lite. Develop additional supported living schemes for learning disabled residents. Scale up provision of Assistive Living Technology to reduce hands on social and health care costs. Increase use of telemedicine to manage long term conditions more effectively in the community and deal with medical scenarios onsite within the home. Develop a social care cluster of equipment and related services to ensure consistent access to equipment and adaptations. Develop a more streamlined rehousing offer making best use of the city's adapted housing stock. Targeted reduction in use of residential and nursing care when alternative options are available.
Key Programmes	Living Homes Housing for an Age Friendly Manchester Residential Growth Programme Care Closer to Home Winterbourne Resettlement Programme LLLB All Age Disability Strategy
Outputs	Increase in number of older people and their carers accessing HOOP (Housing Options for Older People) and web based advice services. Increase number of Extra Care housing units providing long term independent living with care on-site. Step up step down units within extra care schemes. Increase in number of additional units of supported accommodation for people with LD. Increase in number of units of replacement accommodation. Increased usage of ALT equipment across health and care services. Increase in proportion of equipment and adaptation that is recycled.
Outcomes	More older people understand housing options for later life and move to appropriate accommodation in a timely manner. Reduction in admissions to residential and care homes.

	Reduction in falls and emergency hospital admissions. Reduction in number of care hours required. Best use made of adapted homes. Reduction in waiting times for equipment and adaptations. Improved co-ordination of re-let of specialist housing stock. Reduction in NWAS calls. Reduction in A & E attendances among care home residents.
Impact	Reduction in expenditure on residential care. Reduction in expenditure in health services. Release of large family homes to support economic growth. Improved health and wellbeing and quality of life. Sustained independence. Reduction in social isolation. More cost effective delivery of services.

7.0 Enablers

Health and social care estate transformation

7.1 A City wide estate strategy is crucial to deliver efficiencies, to provide the right buildings for integrated care and to enable the City to plan its wider land use to facilitate growth and housing for an expanding population. GM devolution of health and social care, coupled with the proposal for a GM Land Commission announced as part of the devolution package in the July 2015 budget create the opportunity for a radically different way of managing property and other assets. Within Manchester this will involve a portfolio of well located, high quality accommodation that could be coordinated and utilised more flexibly.

7.2 The current estates provision across health and social care is extremely complex. The complex nature of financial arrangements for NHS estates needs to be addressed at a GM and Citywide level. Key to this will be releasing resources from existing properties to re-invest in accommodation for the new hub based delivery of community services across Manchester.

7.3 A Citywide Integrated Estates Development Board is in place which comprises of members from the health and social care system across Manchester This board will develop the City wide estates strategy, assess current estates provision and develop an estates portfolio which will support the health and social care transformation programmes across the City.

7.4 In line with the delivery of One Team, the vision has been developed to provide 12 multi-disciplinary Place Based Hubs throughout Manchester. The hub and spoke model will be operated with the hubs being at the centre of a network of community assets or spokes. The hubs will provide accommodation for teams working beyond organisational boundaries to deliver public services designed around people and place not organisation and team, a focal point and facility for the community, increasing access to service provision, and having a role to improve health, wellbeing and quality of life within the area in which they are based.

7.5 There will need to be some investment in the community based estate, to support implementation of the model and some limited new build where required; but there are also major opportunities to develop efficiencies through better utilisation and more integrated working.

Information Management and Technology – Shared Records and digital wellbeing

7.6 To deliver the ambition set out in section 1.5, a radical approach to identifying patients and tracking them through the system, sharing electronic records and adopting a digital approach to wellbeing is essential. There are 5 key areas of work to be done:

- There are some immediate tactical solutions that are required to support the initial integration of community health and social care
- A longer term strategic approach to deflection from hospital admissions and residential care placements through the development of a citywide Patient Co-ordination Centre and electronic system
- To develop a wider Digital Wellbeing approach to integration with a scaling up of approaches such as telemedicine to deflect hospital and residential care admissions
- To develop significant IMT partnerships with the private sector including the promotion of Manchester as a centre for inward commercial development and a test bed for IMT innovation
- To scope out and recruit a delivery team for the work led by UHSM

7.8 Tactically, solutions are required for the three community health services to procure electronic case management systems that are interoperable with social care, primary care and other hospital sectors. The PDT requires solutions to enable them to share files across organisational systems and there is potential for teams to adopt the NHS email platform. Integrated estates require wifi options so staff can connect in as they work in between buildings and sites. North Manchester has developed a tactical approach to interoperability between Community Services and Social Care for referrals and workflow and there are similar requirements across the rest of the City.

7.9 The social care record system will be upgraded to enable further inter-operability and compliance with the Care Act which will include provision for a citizen portal, electronic marketplace, commissioning directory of services and resident facing electronic care accounts and social care support plans

7.10 Strategically, work is required to drive the urgent need to identify people early who are at risk from a hospital or residential care admission. An electronic patient co-ordination system to support risk stratification and patient tracking is required citywide which will work across all parts of the model including primary care, social care, community health, public health, hospitals and ambulances. This needs underpinning through access to electronic records and work is needed to decide whether to further develop the common feed into The Manchester Care Record or to look for a new solution. In the short term, we will incorporate into the MCR the mental health record, add an application to support end of life care and extend access to ambulance services and A&E departments in the event of emergency.

7.11 A wider Digital Wellbeing Strategy will be developed alongside the Self Care Strategy to include developing digital health solutions to deliver technology first services arising from the risk stratification work. For example, telemedicine hub for residential and nursing cohort, heart monitors for circulatory disease, gps locators for people with dementia, falls monitors for frail older people etc. The telemedicine work could be applied at scale across GM.

7.12 There are opportunities arsing to develop strategic relationships with private sector IMT companies who will see Manchester as a test bed site for new innovative solutions. Opportunities will be sounded out at the Sept Expo and trade fair supporting the Tory Conference in October. Early meetings with Cisco Systems have already taken place

7.13 To deliver such an ambitious programme of work, a delivery team will be required. UHSM have agreed to lead this and work is underway to scope out the business requirements and secondment requests from the Manchester providers.

Workforce Transformation

7.14 We have made significant progress against our ambitions for health and social care reform in recent years within Manchester. An increase in people benefiting from extended access to primary care, models of integrated neighbourhood working between health and social care are coming to life across all parts of Manchester.

7.15 We are re-imagining health and care and pursuing entirely new possibilities for specialist care, integrated care, primary care, early intervention, prevention and wellbeing services.

7.16 The scale of change we propose will impact significantly on our way of working, challenging traditional roles, introducing new relationships, new teams and indeed new professions. Whilst the vision for integrated care delivery is clear in Manchester through the Living longer Living better programme with early pilots generating confidence in the potential for the new models, delivery of the road map will require very significant cultural change and involvement of the workforce across many organisations.

Strategic Workforce Aims

7.17 Future care models such as those outlined on the NHS 5 Year Forward view and as described in recent King's Fund reports all emphasise the centrality of primary and community care, and a more adaptable and multidisciplinary work force. We need a workforce for the future that:

- Is empowered and flexible
- Will work across both organisational and geographical boundaries
- Is fit for purpose
- Is sufficient and capable of providing high quality care at the point of need

7.18 A strategic workforce plan for Manchester will be put in place providing the basis for specific long, medium and short term objectives in relation to:-

- Communication of strategic vision/intent.
- Education and commissioning to include the development of partnership working arrangements between Health Education Northwest, Skills for Health and Skills for Care and the GM Academic Health Science Network in order to ensure one Manchester health and social care workforce plan. This will inform the commissioning of new education programmes to support new models of care.
- Workforce profiling and future planning including role re-design and competency based planning within multiagency, multi-disciplinary environments with a focus on people, place and outcomes.
- Terms and Conditions of employment across partner organisations to:
  - increase recruitment from local communities and progress further work to ensure that workforces reflect the communities they serve

- incentivise employment conditions which promote good health e.g. payment of living wage opportunity for home care and residential care home staff, organisations providing a healthy workplace

- Cultural change and organisational development with programmes designed to shift control from doing to people and supporting them to be active participants in managing their own care.
- Development of joint working with NHS and City Council / trade unions and a single TU consultation and negotiation strategy to deliver Health and Social Care reform across Manchester
- Development of a Manchester Workforce Leadership Group to secure partnership working and system leadership across health and social care
- Alignment with other key NHS and Social care strategic organisational changes for example, Healthier Together, Placed Based Care, Primary Care Transformation

7.19 The scale of change within Manchester will impact significantly on the workforce. Workforce planning is important because of the complex skill-mix required. We need a workforce that is fit for purpose, able to adapt to changing demographics and the new models of care. Building a more flexible workforce with a breadth of skills and knowledge allows for greater adaptability.

7.20 Although it is vital to get the workforce of the future right, there also needs to be a clear plan for how the current workforce can meet the challenges ahead. This will involve a more integrated approach to managing the existing workforce.

8.0 Financial plan

8.1 The strategies described in this plan represent Manchester's health and care partners' agreed approach to managing a predicted 'do nothing' deficit of £284m by 2020/21 for the scope of services and responsibilities for Manchester listed in Tables 1 and 2 below.

8.2 The forecast deficit rises to £373m, an increase of £89m, if estimates for specialist services are included within the Manchester financial model.

8.3 A summary financial plan for the five years from 2016/17 to 2020/21 has been projected for Manchester, taking account of pressures and demographic changes over the period, together with estimated changes in resources for health and social care. The deficit originates from net estimated financial challenges across health and social care of £163m and £121m, respectively.

8.4 Modelling suggests that by 2020/21, Manchester will have:

- an increase in health and care expenditure of £297m (Figure 1 / Table 4).
- an aggregate total increase in health and social care resources of only £13m (Figure 1 / Table 4).

8.5 It is recognised that a deficit of this magnitude will only be avoided through strong partnership working and by jointly transforming the future of health and care commissioning and provision, to create a clinically and financially sustainable system.

8.6 Partners are committed to achieving and demonstrating clinical sustainability and improved quality outcomes from the future health and care system, whilst managing patient and resident needs within available resources. Partners have agreed to the principle that the delivery of transformation programmes will enable a shift in resources between hospital and community settings.

8.7 Applying the Greater Manchester savings opportunities indentified within the CSR submission to Manchester, indicates that Manchester has the ***potential*** to convert the significant 'do nothing' deficit of £284m to a £21m surplus (or contingency) by 2020/21 (see Table 5).

The Financial Model

8.8 Financial modelling has been undertaken to calculate a five year health and care financial plan for Manchester for the years 2016/17 to 2020/21, incorporating:

i) sources of pressures within the economy, analysed by sector, using:
   - a series of strategic financial planning assumptions derived from the 'Five Year Forward View'; and
   - health and social care expenditure baselines for the **Manchester population** within the scope of Manchester's local responsibility under GM Devolution, including:
     - £1.1 billion of 2015/16 commissioning budgets for the three Manchester Clinical Commissioning Groups, NHS England (for primary medical services) and Manchester City Council (children's and adults social care) – see Tables and 2; and
     - £0.6 billion of 2014/15 outturn income and expenditure, excluding estimates for specialist services, for the providers shown in Table 3.

ii) assumed funding commitments from the Treasury with respect to the protection of health and care in Manchester;

iii) potential commissioner benefits using GM wide assumptions or locally estimated benefits assumed to be achievable through the commissioner led strategies described in this plan

Table 1 – 2015/16 Commissioning Baseline Budgets by Commissioner	**Opening expenditure values 2015/16 £m**
North Manchester CCG	274.4
Central Manchester CCG	252.4
South Manchester CCG	223.2
Subtotal – CCGs	**750.0**
NHS England **(Note 1)**	70.9
Subtotal – Health	**820.9**
Manchester City Council	**301.1**
Total - Health and Care Resources in Scope	**1,122.0**

Note 1: *Reflecting medium term commissioning responsibilities, NHS England's Direct Commissioning budgets for the following services are* ***excluded*** *from Manchester's analysis and financial modelling: circa £67.8m for secondary care dental, primary care dental, primary care ophthalmic and primary care pharmacy services, in addition to an estimated £220.5m for specialist hospital services.*

Table 2 – 2015/16 Commissioning Baseline Budgets by Service Area	**Opening expenditure values 2015/16 £m**
Acute	374.4
Mental Health	104.3
Community Health	66.8
Continuing Care	36.7
Primary Care	8.8
Prescribing	91.0
Other Programme	50.4
Other	17.6
Total – CCGs	**750.0**
Primary medical services (assumed delegated to CCGs from 2016/17)	70.9
Total – NHS England	**70.9**
Total – Health	**820.9**
Adult Social Services	53.2
Learning Disability	49.9
Public Health	48.3
Mental Health	20.6
Children's Social Services	96.0
Complex Dependency	13.4
Other Commissioned Services	9.3
Administration	10.3
Total – Manchester City Council	**301.1**
Total – Health and Care Resources in Scope	**1,122.0**

Table 3 – 2014/15 Provider Baselines within the Financial Model (adjusted to exclude 'non-Manchester flows' and specialist services)	**Income 2014/15 £m**	**Expenditure 2014/15 £m**
Manchester Mental Health and Social Care Trust	85.8	86.9
Central Manchester University Hospitals Foundation Trust	205.4	206.8
Pennine Acute Hospitals Trust	108.2	107.0
University Hospital of South Manchester Foundation Trust	111.1	108.7
North West Ambulance Service	15.7	15.6
Other providers	50.9	50.8
Total	**577.1**	**575.9**

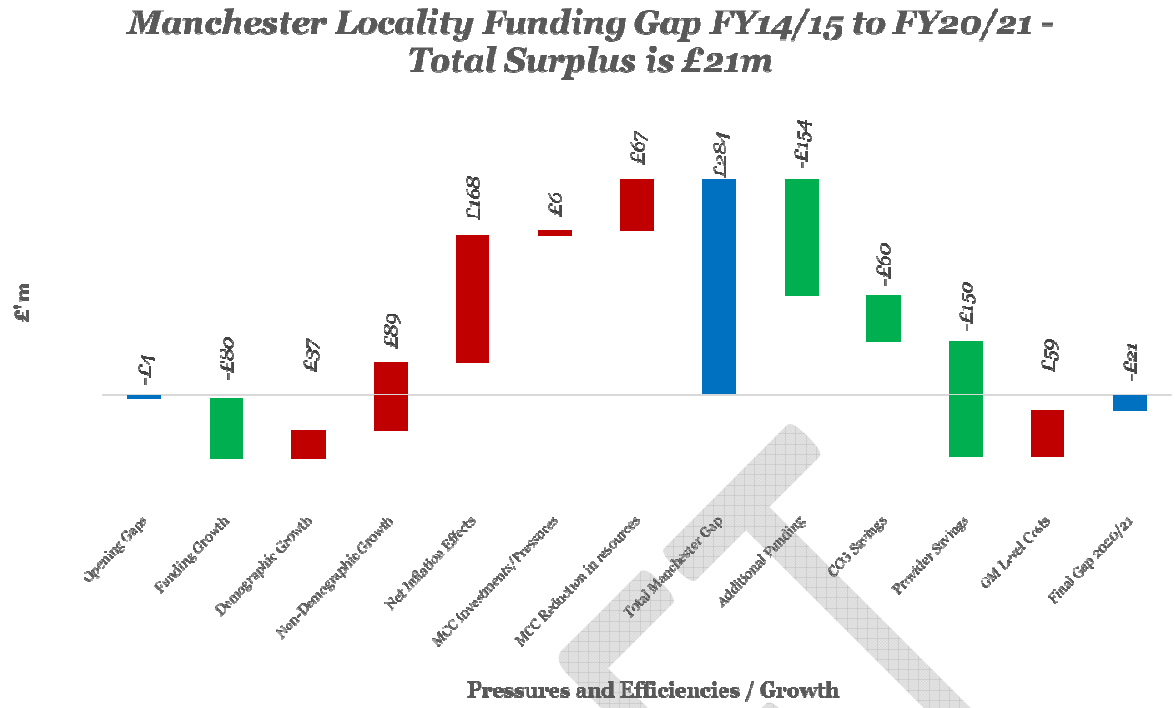
8.9 Using the baselines in Tables 1 to 3 and key assumptions about price and cost inflation, growth, and funding changes, variations of the financial gap and potential mitigating opportunities have been modelled and summarised in a series of 'bridge charts', the outputs of which are explained below.

The 'do nothing' deficit: £284m

8.10 Figure 1 illustrates Manchester's population based share of pressures arising from services and budgets within scope for the Manchester Locality under GM Devolution, i.e. **excluding specialist hospital and non-medical primary care services. The resulting gap of £284m is the local five year efficiency target for the purposes of this plan.**

8.11 The chart also summarises the impact of benefits modelling under the Upside Scenario (explained later).

Figure 1 – Manchester Pressures and Upside Benefits to 2020/21



8.12 Further analysis of the data in Figure 1 by sub-sector of the Manchester economy demonstrates that the forecast deficit relates to health and social care services over the five year period as shown in Table 4:

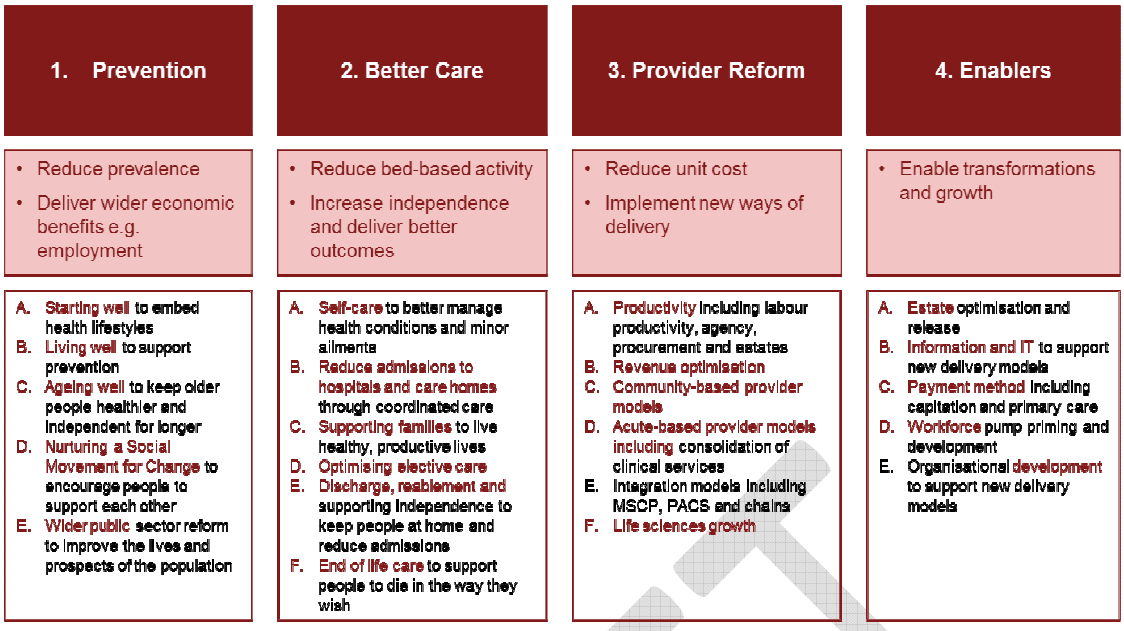
Table 4 – Analysis of 'do nothing' gap	**Total**	**Health**	**Care**
	£m	**£m**	**£m**
Opening position	-4	-4	
Net demographic pressures	37	26	11
Non-demographic pressures	89	52	37
Inflation	101	101	
Tariff deflation	68	68	
MCC Pressures	6	0	6
Net cost pressures	**297**	**243**	**54**
Increase in CCG funding	-80	-80	
Social care funding reduction	67	0	67
Funding change	**-13**	**-80**	**67**
Total do nothing gap	**284**	**163**	**121**

Achieving financial sustainability – benefits identification and quantification

8.13 Alongside the pressures illustrated in Figure 1, benefits have also been modelled to show the impact upon the deficit over the five year planning period.

8.14 A share of GM ***'potential opportunities'***, scaled to Manchester's population, has been calculated using the assumptions set out in the 'GM Strategic Financial Framework' which are designed to lead to financial sustainability for providers and commissioners by 2020/21 (see Table below for definitions).

GM Strategic Financial Framework definitions:



8.15 Benefits models are shown for two scenarios: A) Upside and B) Downside. The key differences between the two are (all other assumptions remain consistent):

GM Assumption	Upside	Downside
Share of £8bn NHS Funding	100%	50%
Protection of Social Care Funding - £67m	100%	0%
Provider Cost Improvement Plans	2.5% Year 1-2 2.0% Years 3-4	0.8% p.a.

A) Upside Scenario

8.16 The output of this model (Figure 2) identifies potential – **but highly ambitious** – benefits for both commissioners and providers:

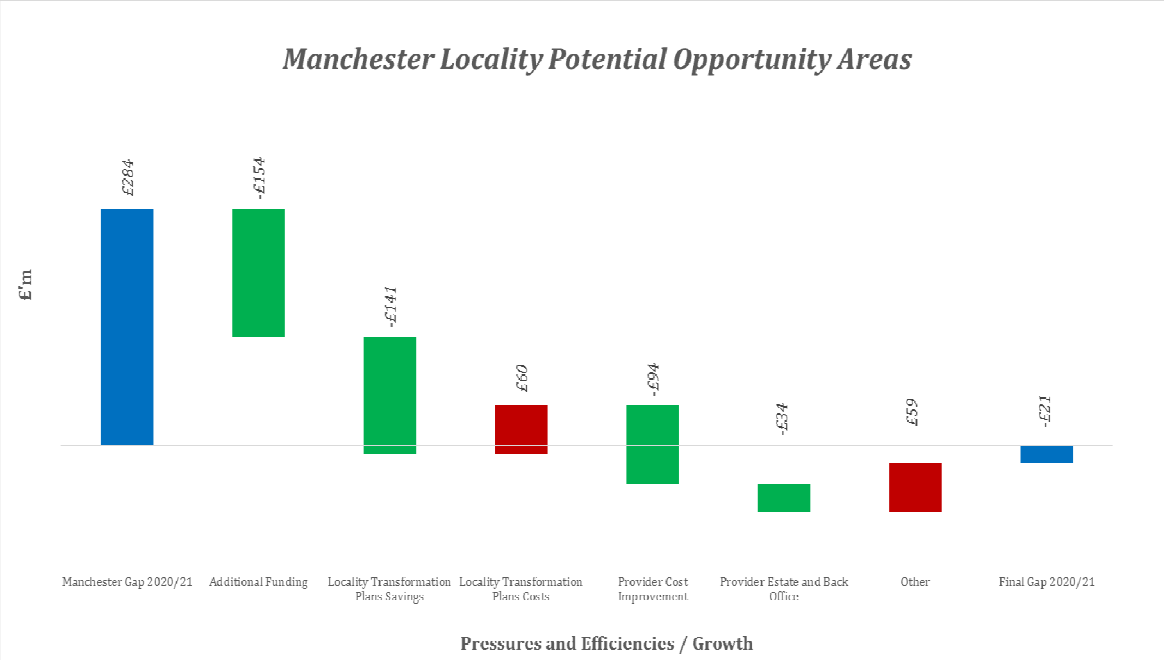
- £81m relating to Locality Plan Transformational Schemes net of re-provision costs; and
- £128m for other GM led programmes (see Table 5).

8.17 The model assumes £154m of additional funding over the five year period, reflecting:

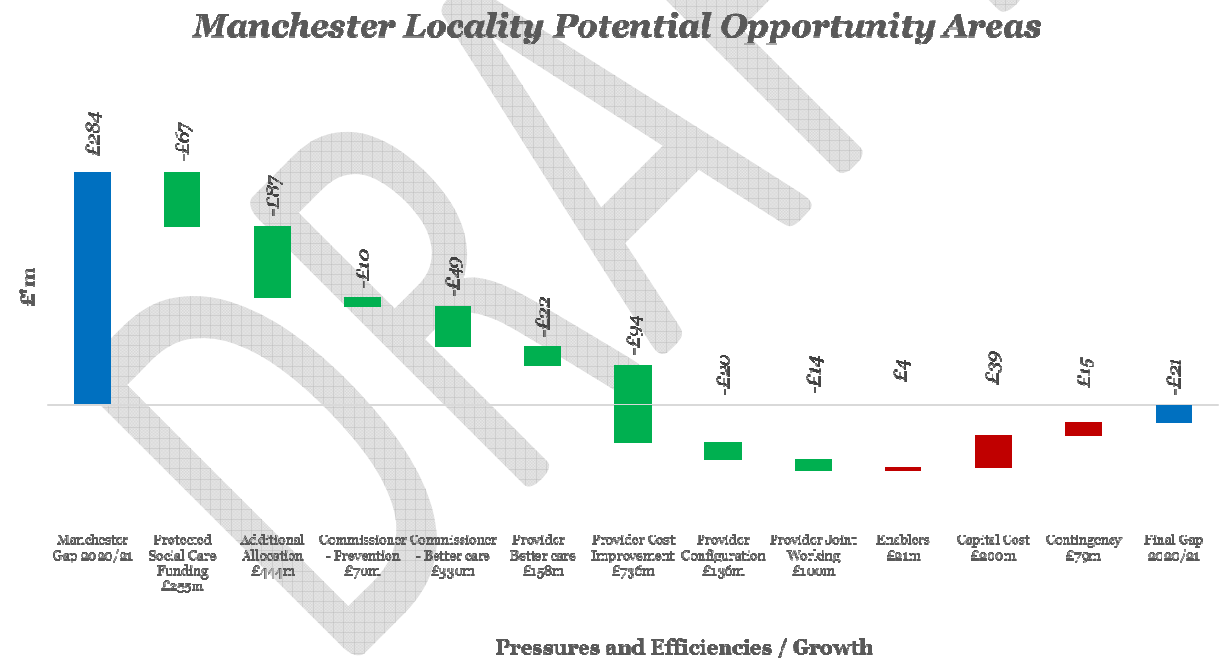
- £67m for the 'protection of social care' requested through GM Devolution; and
- £87m for the three Manchester CCGs, representing a share of the £8bn additional national funding announced through the Government's 2015 manifesto commitments to the NHS.

Figure 2 – GM assumptions of potential opportunities, scaled to Manchester

8.18 Manchester's population based shares of GM estimated opportunities are shown in the bridge chart below:



This is further analysed in the bridge chart below:



8.19 The assumptions in these charts indicate that the economy will be in overall surplus by £21m by 2020/21.

Table 5 – GM Benefits Analysis by 2020/21	**Total**
	£m
Do nothing gap 2020/21	**284**
Additional Funding	-154
Net Locality Transformation Plans	-81
Provider Cost Improvement	-94

Estate and Back Office Transformation	-34
Other	58
Closing surplus position	**-21**

8.20 Other than the material funding assumptions described in 7.16, key assumptions underpinning the estimated benefits in Figure 2 include:

- £94m of assumed provider savings, representing assumed **net efficiencies of 2.5% in 2016/17 and 2017/18 and 2.0% in the remaining three years** of the planning period. (This compares to an historic 0.8% efficiency actually delivered across the NHS.); and
- the costs of re-commissioning alternative care models will be 50% of amounts saved.

8.21 Further work will be carried out to verify the deliverability of the GM efficiency assumptions and reasonableness of re-commissioning costs across Manchester's partners by the end of November 2015.

B) <u>Downside Scenario</u>

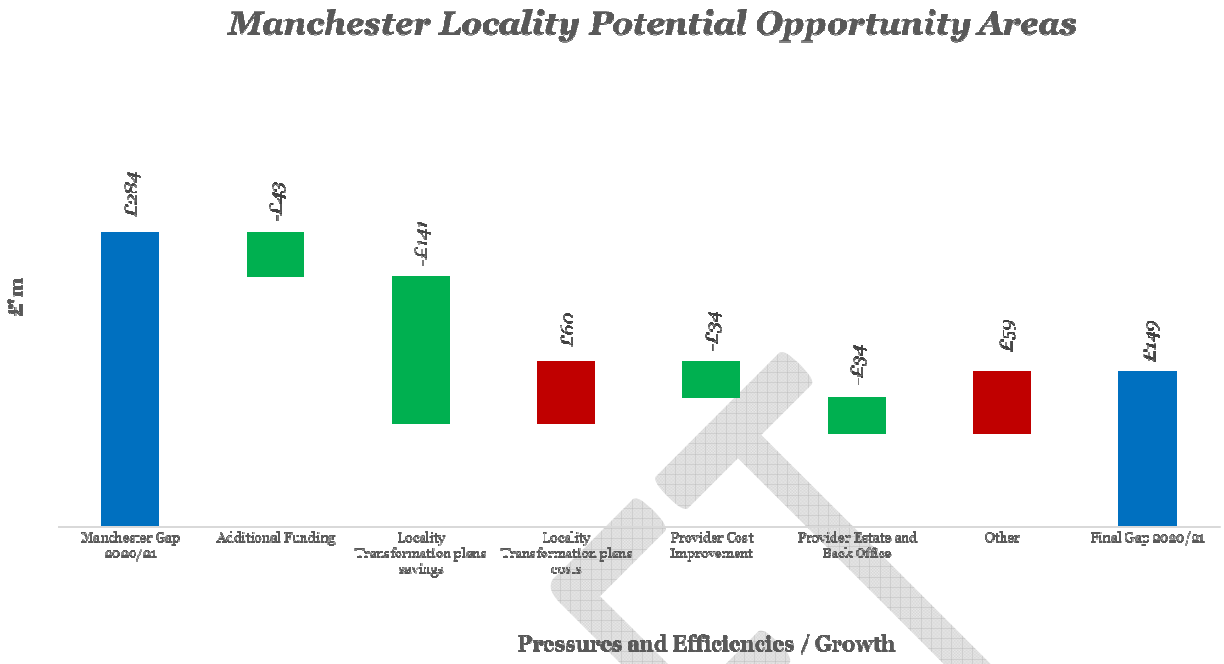
8.22 Local assumptions have been applied within this scenario to illustrate the risks associated with the optimistic GM upside scenario in Figure 2. The output of this model (see Figure 3) identifies potential benefits for commissioners and providers of:

- £81m relating to Locality Plan Transformational Schemes net of 50% re-provision costs; and
- £10m for all other GM led programmes (see Table 6).

8.23 Furthermore, this model assumes only £43.5m of additional funding over the five year period, reflecting:

- No 'protection of social care' funding requested through GM Devolution; and
- £43.5m for the three Manchester CCGs, representing only a 50% share of the £8bn additional national funding announced through the Government's 2015 manifesto commitments to the NHS.

Figure 3 - Potential opportunities - downside scenario



8.24 The downside scenario shows the impact associated with under-delivery against the GM modelled opportunities, as the economy's overall position converts to a deficit of £149m by 2020/21 (instead of a surplus of £21m under the 'Upside Scenario'):

Table 6 – GM Benefits Analysis by 2020/21	**Total £m**
Do nothing gap 2020/21	**284**
Additional Funding (partial NHS only)	-44
Net Locality Transformation Plans	-81
Provider Cost Improvement	-34
Estate and Back Office Transformation	-34
Other	58
Closing deficit position	**149**

Local planning

8.25 For the purposes of this plan and despite the delivery risks associated with the GM assumptions in the 'Upside Scenario', **the focus in Manchester for transformational savings is the £81m challenge relating to the 'Locality Transformation Plans'** estimates in Tables 5 and 6.

8.26 Similarly, although the range of savings within 'Provider Cost Improvement', 'Estate and Back Office Transformation' and 'Other' is materially different in each scenario, it is assumed for the purposes of this plan that solutions will be developed through other GM and provider channels to identify the remaining £128m of savings shown in the Upside Scenario.

8.27 Very early 'bottom up' analysis of the potential benefits relating to each of the transformational programmes included within the locality plan, shows that proposals are being developed which currently indicate that up to £48.6m of savings may be possible by 2020/21, falling £32.4m short of the £81m of savings required across Manchester by 2020/21. These are summarised in Table 7 (values are cumulative).

Table 7 – Benefits Realisation by Programme	**Cost**	**Benefit**	**Net**
	£m	**£m**	**£m**
Mental Health Improvement	0.0	-14.1	-14.1
Learning Disabilities	0.0	-7.4	-7.4
Community Intermediate Care and Reablement	37.9	-44.8	-6.9
Manchester Neighbourhood Care	19.1	-38.3	-19.1
Urgent Care First Response	1.8	-9.7	-7.9
Extra Care Housing	9.3	-10.6	-1.3
Primary Care	10.0	0.0	10.0
Cancer Improvement Programme	6.4	-8.3	-1.9
Totals	**84.5**	**-133.1**	**-48.6**

8.28 Local plans will be reviewed and adjusted accordingly because the financial affordability assessment in each financial year from 2016/17 to 2017/18 across the economy requires action to be taken to bring partners into balance.

8.29 Local strategic financial planning and analysis will be used to calculate target efficiency requirements for transformational plans to meet the efficiency requirement of £81m. When compared to the values estimated as possible through early bottom up modelling, this gives a level of stretch and / or additional savings targets across the programmes and broader health and care budgets (see Table 8).

Table 8 – Locality Plan Transformation	**Benefits estimates £m**
Mental Health Improvement	-14.1
Learning Disabilities	-7.4
One Team - Community Intermediate Care and Reablement	-6.9
One Team - Neighbourhood Care	-19.1
One Team - Urgent Care First Response	-7.9
Extra Care Housing	-1.3
Primary Care and Prescribing	10.0
Cancer Improvement Programme	-1.9
Sub-total	**-48.6**
Additional savings requirement to achieve assumed GM benefits	-32.4
TOTAL	**-81.0**
Potential other programmes / budgets:	

Care Closer to Home
Children and Young People
Continuing Care
Early Years
Public Health Review
Administration
Other hospital care

Cost Benefit Analysis

8.30 Further financial modelling is required to determine the costs and benefits of the above transformation plans which will be completed to support the next iteration of the locality plan by 30 November 2015. This will show the recurrent and non-recurrent investment requirement for new models of care and targeted impact from reductions in acute hospital and residential care home activity. This will be informed by the local CBA undertaken in Manchester based on emerging care models, learning from other GM localities, national and international evidence, and stretch targets from GM transformation initiatives.

8.31 To meet the efficiency targets identified in the bridge charts above, a significant amount of work is still required to define how Manchester's transformational plans and other programmes of work will deliver the savings required. This must focus upon describing, in financial terms, how the new models of care will be different to the current health and care model.

8.32 Providers and commissioners are working together to develop and implement a monitoring and evaluation process to track actual costs and financial benefits for the change programmes described in this plan. This will including tracing the impact of investments to reductions in activity levels (and hence cost drivers), including where and when those reductions lead to savings in other parts of the system. This monitoring and evaluation process will be used to manage risk and ensure that the agreed shifts in resources are achieved over the five year period.

8.33 The proposals being developed by providers will also include CBA requirements to set out clearly what interventions will be carried out, the activity and the expected outcome in the form of a reduction in demand. The CBA will require work-stream leads to estimate the cohort and likely outcomes so that it can be compared to what is being provided at the moment. The current position 'Business as usual' will be compared to the outcomes expected in the future 'New Delivery Models'.

8.34 The models must be shared and 'owned' by all partners in the economy. The work to deliver a robust financial model will therefore need to be jointly produced by both commissioners and providers. Assumptions must be agreed and replaced / validated as more experience of the new models becomes available.

8.35 Commissioners and providers will need to understand the changes proposed within the new models, including the health and care interventions and, fundamentally, the financial impact upon the finite resources within Manchester in the longer term.

Investment Requirements

8.36 The efficiency challenge is of such a magnitude that significant transitional, capital and revenue investment funds will be required to secure success, from any transformational funds secured by the Greater Manchester Devolution programme.
8.37 The complexities of the Manchester locality, comprising several distinct commissioners and providers, means that collaboration between partners will be essential to define the elements of investment funding needed to implement the programmes described in this plan.
8.38 Although financial modelling described above continues to develop, current estimates about the investment and phasing required to deliver benefits are incorporated within the bridge charts in Figures 1 and 2. Specific assumptions about transitional enabling costs are shown in Table 8 below.

TABLE 8 – Transitional Costs	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**TOTAL**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Non-recurrent transitional revenue costs:						
Double running costs					112.4	112.4
Support for Extra Care and LD Accommodation					2.8	2.8
Support redesign of hospital care	16.0	8.0	4.0			28.0
Subtotal - Non-Recurrent Revenue	**16.0**	**8.0**	**4.0**	**0.0**	**115.2**	**143.2**
Capital (Note 1):						
Capital - Extra Care Housing					36.3	36.3
Capital – Four new hubs (£4m each)		4.0	8.0	4.0		16.0
Capital – PAHT Crumpsall site		4.0				4.0
Capital – Refurbishment		2.0	6.0			8.0
Capital – Intermediate Care Beds	5.0	5.0				10.0
IT		1.0	3.0	2.0		6.0
Subtotal - Capital	**5.0**	**16.0**	**17.0**	**6.0**	**36.3**	**80.3**
Total cash requirement	**24.3**	**27.3**	**24.4**	**6**	**151.5**	**233.5**

8.39 Investment costs will be included within the CBA work for each strategy to ensure that only net benefits inform local considerations about the 'value' of investment decisions to Manchester. Positive CBA ratios – i.e. 1:1 or more – indicate a 'return on investment' (and vice versa) although decisions will not be taken necessarily entirely on the basis of this evidence.

Enablers – Single Integrated Commissioning System

8.40 Pooling of health and care budgets is the agreed approach to enable transformational change and the CCGs and Council have agreed in principle that budgets will be pooled where this makes sense.

8.41 In the medium term this will be a minimum of £168m from the City Council and £210m from CCGs, a total of £378m, based on identified indicative budgets for 2015/16. Priority areas for a shadow pool from April 2016 have also been agreed, including:

i) Single Point of Access
ii) Neighbourhood Teams (Integrated Health and Care Teams)
iii) Integrated Intermediate Care and Reablement

8.42 In order to support development of initiatives, pooled arrangements and shift of resources, progress with implementation and delivery will be analysed during each phase in order to establish:

- a definition of patient/client populations affected, together with detail of how people meeting that definition will be identified
- an estimate of the numbers of the people within the cohort across the City over the next five years
- a systematic evaluation of the costs and benefits of the new service models, in comparison to the existing arrangements
- an overall assessment of the financial implications of these changes for the various partner organisations and the supporting mechanisms required to move funding around the system

Dependencies – Greater Manchester Transformation Plans and Wider System Work-streams

8.43 Manchester's success in meeting its efficiency targets is co-dependent upon the success of several Greater Manchester and / or wider sector and system transformation plans, including for example:

- Healthier Together for GM - implementation of single service models for Manchester
- Provider reform, including expansion of single service care models and standardisation of clinical and back office services
- GM wide plans, including mental health , primary/ social care transformation, public service reform and public health programmes
- GM enabling work streams e.g. estates, workforce and IM&T

8.44 At this stage, the impact of these plans is assumed to be within the other GM benefits in Table 5 above. Further development and financial modelling is required however (at a Greater Manchester and / or wider system level, as well as locality) to provide further assurance about the deliverability of assumed savings.

Appendix B: Single Hospital Service for the City of Manchester

1. Background

The Manchester Oversight Group, working on behalf of the Health and Wellbeing Board, has developed a proposal for the establishment of a "single hospital service" for Manchester. This proposal is consistent with Manchester commissioners' aspirations for hospital services in the City of Manchester, and is a key theme within the Manchester Locality Plan.

The proposal has also been submitted as a Transformation Initiative within the GM Devolution arrangements (attached). The key commissioner and provider organisations confirmed their commitment to the proposal at a special meeting on 3 November 2015, and this agreement will be formally considered by the Manchester Health and Wellbeing Board at its meeting on Wednesday 11 November 2015.

This document provides a provisional plan for the range of actions that need to be undertaken to design the single hospital service agreement.

2. Current challenges

As other reports provided to the Health and Wellbeing Board demonstrate, whilst Manchester hosts a wide variety of very high quality hospital services, some with national and international reputations, it continues to be the case that the residents of Manchester generally have poor health outcomes compared to the rest of the country.

The main hospital services that are used by the residents of Manchester are provided by three different provider organisations (Pennine Acute NHS Trust (PAT), Central Manchester University Hospitals NHS FT (CMFT), and University Hospitals of South Manchester NHS FT (UHSM)). Previous national policy has encouraged provider organisations to compete, and the structure of contracts, payment mechanisms and competitive tendering processes has made it difficult for Trusts to behave in any other way.

This approach has resulted in duplication of services, and has created barriers that stop Trusts working together to improve services for local people. A variety of difficulties are encountered:

- For some services there is unproductive duplication (or triplication) of services, and in others there are service gaps that make it difficult for patient to access the care they need.
- Trusts find themselves competing with each other to attract staff with specialist skills, but these individuals are not always then deployed as effectively as they might be.
- Opportunities to work together to improve patient care or enhance research and innovation are missed
- Some clinical services run the risk of becoming unsustainable, and having to be discontinued in an unplanned or reactive way.

- There is no clear Manchester focus for acute hospital care, or for the relationship between providers and commissioners.
- Different operational protocols and patient pathways are used in the various provider organisations
- Different standards of care are provided to people in different parts of the city,

The proposal for a single hospital service for the City of Manchester seeks to create a mechanism for closer collaborative working and to deliver consistent and complementary arrangements for providing acute hospital services across Manchester, with the aim of eventually achieving a fully-aligned hospital model. This would encompass a comprehensive range of clinical single services, and optimised arrangements for support services, estates utilisation, and back office functions. Further, innovation is essential to drive the change necessary in health outcomes and care pathways. Integrating research and innovation, along with education of the workforce, will be fundamental to deliver a high quality service that will attract investment for research and innovation.

Manchester commissioners have given a very clear indication that the existing structures and arrangements for providing hospital services in Manchester are no longer acceptable. They have defined their minimum requirements as creating a single system with a unified focus for authority and accountability and a single contractual arrangement for hospital services in the city.

3. Review structure

It is proposed to progress the project through a two stage review. Firstly, this would review the service, research and innovation, and educational portfolios of the three Trusts and develop a detailed exposition of the potential benefits of a fully aligned hospital service model, including its alignment with the proposed structure for integrated care in Manchester based on Living Longer Living Better/One Team. Secondly, the review would then undertake a detailed appraisal of the most appropriate and effective governance and organisational arrangements to deliver the identified benefits.

The review structure will need to recognise the significant transformation programme currently being progressed by North East sector commissioners and Pennine Acute Hospitals NHS Trust and the Healthier Together programme.

4. High-level timeline

The high-level timeline for the two stages of the review is as follows:

Stage 1: 16 Nov 2015 – 6 March 2016
Stage 2: 10 March – 31 May 2016

This allows 16 weeks for the first stage, and 12 weeks for the second stage. Approval of the overall approach at the Health and Wellbeing Board meeting on 11 November 2015 would signal the commencement of the process. Regular updates would be provided to the Trust Boards and to the Health and Wellbeing Executive Group throughout Stage 1, and this would culminate in a Stage 1 report, previously

informed by the three Trust Boards[1], being received at the Health and Wellbeing Board meeting on Wednesday 9 March 2016. The three Trust Boards would also be invited to submit a statement detailing their support or otherwise for the stage 1 review and its recommendations.

Trust Boards and the Health and Wellbeing Executive Group would also receive regular updates through Stage 2 of the Review, and the final Stage 2 report, previously informed by the three Trust Boards[1], would be presented to the Health and Wellbeing Board on Wednesday 8 June 2016. The three Trust Boards would also be invited to submit a statement detailing their support or otherwise for the stage 2 review and its recommendations.

The longer period allowed for Stage 1 reflects the activities involved in the initial project set-up process, and the extent of clinician engagement that will be required.

5. Benefit themes

The benefits identified in Stage 1 of the review process will be clustered around a set of themes defined as follows:

1 For the avoidance of doubt, the provision for the Review Director's reports to be informed by the views of Trust Boards does not imply that the Boards have a power of veto over the content of the reports, in whole or in part.

Theme	**Scope**
Clinical	Patient safety, clinical effectiveness
Patient	Patient experience, patient satisfaction
Research	Research, innovation and biomedical infrastructure
Workforce	Recruitment and retention of staff, staff satisfaction, education and training
Operational	Performance, operational effectiveness, integration
Financial	Financial savings, productivity/efficiency, investment requirements

There will be a bespoke thematic action plan developed for each of these areas.

6. Actions

The key actions required to deliver the Review are described below. A summary action plan with provisional timescales is given in appendix A.

Stage 1 – Benefits assessment

- **Terms of Reference and Scope**

Terms of Reference for the Review will need to be developed and agreed. Sign-off of the Terms of Reference will be through the membership of the Health and Wellbeing Executive Group, and the Chairs and Chief Executives of the three Trusts, and their Boards of Directors (or with delegated authority).

The Terms of Reference will include an appendix that defines the Scope of the Review. In principle, this will include all of the hospital services provided by the three main hospital service providers in Manchester (UHSM, PAT, CMFT). It should also take into consideration how those services best align with integrated community based services. Some of these services may also be considered through other processes (eg GM Transformation Initiatives, Healthier Together, GM Specialised Services Strategy, North East Sector Transformation Programme) but it will be important for the Review to consider as broad a range of hospital services as possible.

A role description for the Review Director and a brief for the project analytical support will also be appended to the Terms of Reference document.

- **Appointment of Review Director**

An appropriate process will need to be undertaken to identify and appoint a suitable individual into the role of Review Director. The appointee will need to be independent, have substantial experience in the leadership of health services, and a track-record of achievement in a complex multi-agency environment. The appointment process will be agreed and managed through the membership of the Health and Wellbeing Executive Group, and the Chairs of the three Trusts on behalf of their Boards of Directors.

- **Identification of analytical support**

The Review will need to be supported by independent analytical and project management capacity. This will need to include a broad knowledge of clinical service models and competencies in engaging clinicians, facilitating dialogue, and synthesising service model proposals. To complete the review robustly in the timescales being proposed will require a significant level of resource (and funding) which will need to be agreed.

- **Establish Review Steering Group and supporting arrangements**

The Review Steering Group will oversee the Review process on behalf of the Health and Wellbeing Board and Trust Boards. The Steering Group will be chaired by the Review Director and the membership will include the Chief Executives, Medical Directors and one other nominee from each of the three hospital service providers in Manchester. Consideration will be given to commissioner and other Manchester stakeholder members. The group will meet on a fortnightly basis as a minimum, and more frequently if required.

The Steering Group will also have the option of convening a clinical “Star Chamber” to consider any key clinical issues that have not been resolved in the clinical workstream groups.

- **Establish reporting arrangements**

The reporting arrangement for the Review will be from the Review Steering Group through the Health and Wellbeing Executive Group to the Health and Wellbeing

Board. A reporting process will be established around the existing meeting cycle of Trust Boards and the Health and Wellbeing Board/Exec Group, with a standard reporting format.

- **Clinical service stock-take**

There will be an initial high-level exercise to define the full range of hospital services provided by each of the three Trusts, including details relating to scale and scope, and identifying areas of overlap and duplication. This information will be integrated into an overall baseline picture of hospital services in Manchester.

- **Clinical engagement and clinical workstreams**

Two Clinical Conferences will be undertaken as part of the stage 1 (Benefits Assessment) process. The first session will take place early in the review and will bring together hospital clinicians from across the city to explain the ambition and purpose of the review processes, and to discuss key themes around clinical, patient, research, workforce, operational and financial aspects. The second session will take place towards the end of the first stage review, and will allow the assessment of benefits to be shared as early and as widely as possible amongst the clinical community.

A series of clinical workstreams will be established, bringing together key clinicians from the three Trusts to look at particular areas of clinical service (specialties or groups of specialties). One of the initial tasks of the Steering Group will be to establish these workstreams with appropriate clinical leadership. A standard process for identifying and agreeing the clinical workstream leads and members will need to be developed. Where necessary the workstreams will include external expert clinical representatives. The objective will be for the workstreams to achieve reasonably comprehensive coverage of the hospital services provided within the city. The workstreams will have standard terms of reference and reporting requirements, and the output of the workstreams will feed directly into the overall assessment of benefits.

- **Establish benefits assessment themes**

As the thinking of the clinical workstreams develops, this will be brought together around the key benefits themes (clinical, patient, research, workforce, operational and financial). To facilitate this, thematic groups will be brought together, with representation from relevant corporate functions and, where appropriate, clinicians within the three Trusts. A similar process to that for the clinical workstreams will need to be developed to identify and agree the thematic workstream leads and members.

- **Communications**

As well as engaging the key clinical teams, there will be a requirement to communicate very widely, both within the three Trusts, and with key stakeholders and audiences in the wider community. Early and ongoing engagement with Monitor and TDA will be essential.

A communications plan will be developed to run throughout the Review process, ensuring communication of accurate and relevant messages to all appropriate audiences. This plan will also need to dovetail with constituent Trust communications plans.

This review will be a major piece of work with potentially wide ranging implications for the three trusts, the health and social care system in Manchester and most importantly the patients and population of Manchester. As such, the communications required to support it must not be underestimated. Consideration should be given to dedicated communications resources to support the review.

- **Report development and presentation**

The Stage 1 report will summarise the views of the Review Director, based on the ideas and proposals that have been produced during the Review process, and focusing on the key benefits themes (clinical, patient, research, workforce, operational and financial). The Review Director will be cognisant of any advice provided by the Review Steering Group, and there will be a process for sense-checking the report with the three Trusts.

The Trust Boards will be given an opportunity to inform the final draft report[2] and be invited to submit a statement detailing their support or otherwise for the report and its recommendations However, the final content of the Stage 1 report will be the sole responsibility of the Review Director.

Once the report has been accepted by the Health and Wellbeing Board, there will be a process to communicate the key findings to all relevant audiences.

Stage 2 – Governance and Organisational Arrangements

- **Generation of options for Governance and Organisational arrangements**

An early task in the second stage of the Review will be to start to generate a wide range of options for the governance and organisation of hospital services in Manchester. In the initial generation of options, no viable proposals will be discounted. A non-exhaustive list of options could include arrangements such as:

- Do nothing
- Partnership underpinned by multiple SLAs
- Strategic partnership/alliance contract
- Multiple lead providers (service specific)
- Single lead provider
- Organisational mergers

The options may include proposals which would evolve or develop over time.

- **Development of criteria for assessing options**

The purpose of the assessment of options is to determine what sort of governance and organisational arrangements can deliver the identified benefits most rapidly and

most reliably. Based on this overall objective, a set of assessment criteria will be developed.

2 For the avoidance of doubt, the provision for the Review Director's reports to be informed by the views of Trust Boards does not imply that the Boards have a power of veto over the content of the reports, in whole or in part.

In developing the assessment criteria, it will need to be borne in mind that the Commissioners' minimum requirement is for a solution that provides a binding single point of authority and accountability for hospital service provision, and that the Commissioners will seek to achieve this through a procurement process if it is not delivered through collaborative working.

- **Assessment of options**

Depending on the outcome of the initial process to generate options, and advice from the Review Steering Group, the assessment process may be undertaken in two stages (initial shortlist followed by full assessment) or as a one stage process, but the options involved in the final analysis will need to be developed in some detail.

The assessment process will draw on relevant evidence from elsewhere in the UK and internationally. Attention will be paid to how rapidly any alternative arrangements could be put in place, how rapidly benefits could be delivered, and how sustainable those arrangements would be in the longer term. Relevant considerations will include the need for any consultative processes, governance issues, the role of regulators, and aspects relating to competition law.

- **Report development and presentation**

The Stage 2 report will summarise the views of the Review Director, based on the assessment of options undertaken during the Review process.

The Review Director will be cognisant of any advice provided by the Review Steering Group, and there will be a process for sense-checking the report with the three Trusts. The Trust Boards will be given an opportunity to inform the final draft report[3] and be invited to submit a statement detailing their support or otherwise for the report and its recommendations. However, the final content of the Stage 2 report will be the sole responsibility of the Review Director.

Once the report has been accepted by the Health and Wellbeing Board, there will be a process to agree the next steps and communicate the key findings to all relevant audiences.

7. Conclusions

The key partnership organisations in Manchester have now given a commitment to develop a single hospital service, and this action plan proposes the arrangements required to undertake a two stage review to design this future service provision arrangement.

3 For the avoidance of doubt, the provision for the Review Director's reports to be informed by the views of Trust Boards does not imply that the Boards have a power of veto over the content of the reports, in whole or in part.

Immediate Actions Required

Meeting between constituent Chairs, Chief Executives, Directors of Strategy w/c 16.11.15 (SG)

Clarification of the funding stream for the Review Director

Clarification of the appointment process for the Review Director

Clarification of the funding stream for External Consultancy

Clarification of the procurement process for External Consultancy

- Piggy-back on current work e.g. Deloitte
- STW
- Limited
- Full
- Monitor/TDA approvals process dependent on funding stream

Meeting with commissioners

Development of MoU (SG)

Early engagement with Monitor/TDA

Appendix A

Stage 1 – Benefits Assessment Provisional Timetable

No	Task	Week ending
1.1	Develop and agree Terms of Reference and Scope of Review	20 Nov 2015
1.2	Develop role description for Review Director	20 Nov
1.3	Appointment of Review Director	20 Nov
1.4	Develop brief for project analytical support	20 Nov
1.5	Identify project analytical support	27 Nov
1.6	Develop membership for Review Steering Group	27 Nov
1.7	Establish meeting cycle for Review Steering Group	27 Nov
1.8	Establish format and cycle for reporting to Health and Wellbeing Board, Health and Wellbeing Executive Group, and Trust Boards	27 Nov
1.9	Develop and implement communications programme	27 Nov and On-going
1.10	Undertake clinical service stock-take	11 Dec
1.11	Establish clinical workstreams with appropriate participation and leadership, and standard reporting format	11 Dec
1.12	Undertake first clinical conference event	18 Dec
1.13	Review Director meets with Chairs of three Trusts for first interim review	8 Jan 2016
1.14	Identify thematic leads for benefits assessment	8 Jan
1.15	Establish benefits assessment work theme groups	8 Jan
1.16	Develop benefits assessment work plans	15 Jan
1.17	Undertake second clinical conference event	22 Jan
1.18	Completion of benefits assessment thematic reports	12 Feb
1.19	First draft report received by Review Steering Group	19 Feb
1.20	Second draft report received by Trust Boards for sense-checking and comments	29 Feb
1.21	Review Director meets with Chairs of three Trusts for second interim review	29 Feb
1.22	Report presented to Health and Wellbeing Board	11 Mar

Stage 2 – Governance and Organisational Arrangements Provisional Timetable

No	Task	Week ending
2.1	Governance arrangements	18 Mar
2.2	Development of criteria for assessing options	1 Apr
2.3	Generation of options for Governance and Organisational arrangements	29 Apr

2.4	Assessment of options	13 May
2.5	First draft report received by Review Steering Group	20 May
2.6	Second draft report received by Trust Boards for sense-checking and comments	27 May
2.7	Review Director meets with Chairs of three Trusts for third interim review	27 May
2.8	Report presented to Health and Wellbeing Board	8 Jun