Manchester City Council
Report for Information

Report to: Manchester Health and Wellbeing Board –4 July 2012

Subject: Integration of Health and Social Care in Manchester

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Summary

This report is in two sections. The first section provides an update on the work of the Health and Social Care Theme of the Greater Manchester Community Budgets programme. The second section provides a progress report on local work on integration across the Manchester Health and Social Care economy with some specific detailed examples from the central locality provided in Appendix 2. This report relates to a number of Board priorities, specifically:

- Moving more health provision into the community.
- Providing the best treatment we can to people in the right place and at the right time
- Improving people's mental health and wellbeing
- Enabling older people to keep well and live independently in their community

Recommendation

The Board is asked to note the report and comment on the progress being made in Manchester

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Section One: Health and Social Care Theme of the Greater Manchester Community Budgets programme

This full report the work of the Health and Social Care Theme of the GM Community Budgets programme, following the first three months of activity is attached as Appendix 1 and the key headlines from the report are summarised below:

In relation to health and social care integration the case for change, and the rationale for the Community Budget methodology, is clear:

1. We cannot afford the future elderly population to be anything other than healthier for longer.
2. Current models of service provision are not fit for the coming financial and quality challenge.
3. The aggregation of a host of small scale projects is not enough to meet the funding gap – pace and scale of reform is the only option.
4. We need a transformational reduction in demand for services, not just in the acute sector but across the health and social care system. This can only be achieved at scale through greater personal resilience, independence and well being.
5. Significant organisational efficiencies in themselves will not be enough. Only by exploiting the potential of Community Budgets, coupled with strong system leadership and a relentless drive for personalisation, can we tackle the challenges ahead.
6. Reform needs to happen at different spatial levels –the individual, community settings, districts, and GM wide.

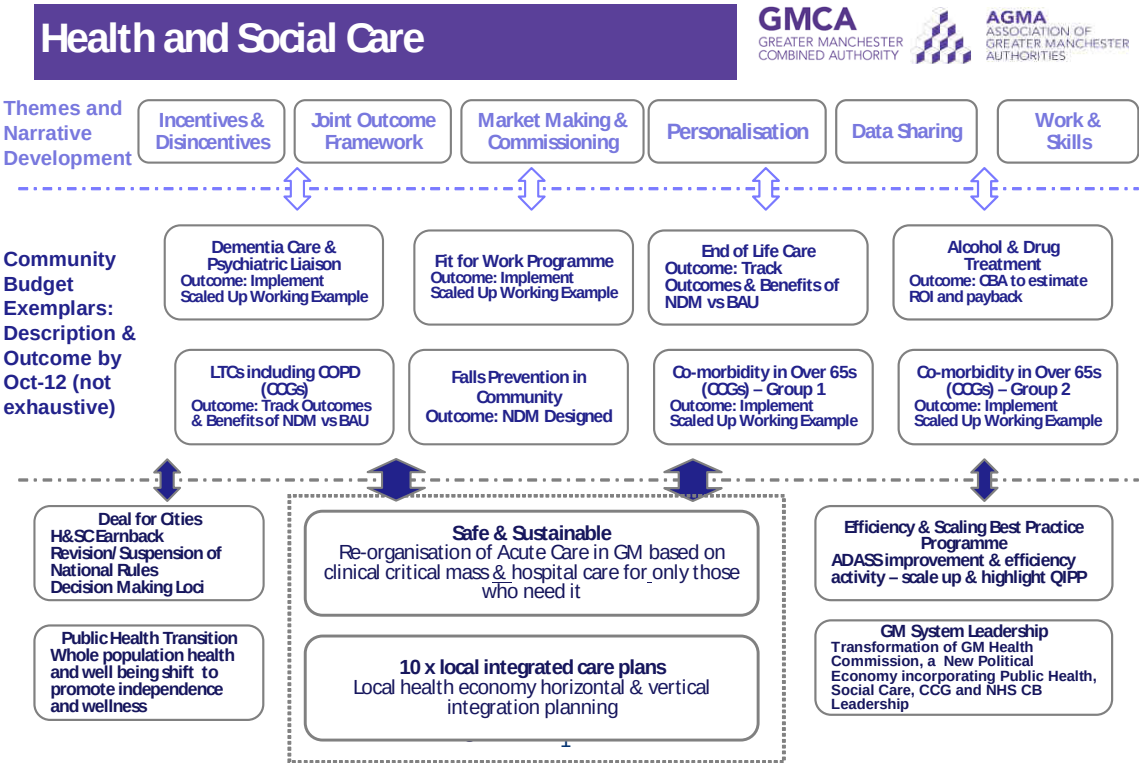
To respond to the case for change, the Health and Social Care Theme's work has developed at three levels:

1) **Building Blocks for Radical Reform** – as the case for change has been built, and the scale of the financial and quality challenge faced by the public sector has become clearer, wider building blocks of radical health and social care reform have been developed. A transformational reduction in cost of services, and reduced demand for services, requires not only new ways of service delivery, but the aggregation, scale and increased delivery pace of very many programmes or initiatives across Greater Manchester. This includes for example, the Safe and Sustainable programme tasked with the reconfiguration of the acute sector in GM.
2) **Community Budget Exemplars** – Work has progressed to test the community budget model, prioritising those areas where there is a need to get investment and return on investment flowing across organisational and sectoral boundaries. Exemplars include dementia care; end of life care; over 65 co-morbidity; disease/condition specific interventions such as COPD; and fitness for work. These are a mixture of exemplar projects at a GM and local level, at differing stages of the development lifecycle. Specifically the team is working with partners at a local and GM level to land technical expertise in cost benefit analysis, new delivery models, new investment models, and data sharing arrangements, to test the community budget methodology. This work

is continuing. The outline business cases attached provide a more in-depth view of the specifics of three of the exemplar projects, in different aspects of the health and social care theme.

3) **Emerging Themes –** The Theme's work, particularly in engaging a broad range of stakeholders from different levels across the health and social care spectrum, has produced a range of different emerging themes that will be taken forward as part of the Theme's work, including for example increasing the scale of personal budgets within health and social care's service delivery, and the importance of data sharing, particularly NHS data into Local Authority commissioners.

This is illustrated in the diagram below, including the Outline Business Cases selected at this stage:



Section two: Progress report for Manchester

1 Developing an Investment Model for Integrated Care

1.1 Manchester City Council and NHS Leaders across the Manchester health economy have agreed the development of a proof of concept to inform a new Investment Framework for integrated Health and Social Care using a Community Budget type approach. This is in line with other exemplars being developed through the Greater Manchester Whole Place Community Budget. The purpose of this work is to test changes from reactive to targeted investments – integration, personalisation, large scale adoption of new technologies – across urgent care, management of long-term conditions and mental health in order to manage demand and improve outcomes for Citizens.

1.2 Within Manchester' s exemplar we intend to manage the demand for urgent care by rebalancing reactive / unplanned spending on patients and customers identified as at risk of hospital admission, to planned and targeted investment to create a consistent, sustainable, affordable framework for investment in early intervention and prevention as well as supporting people in the most appropriate settings.

1.3 The three Manchester exemplars in the Manchester health economy (North, Central and South) are all initially targeting vulnerable patients and customers identified as at risk of hospital admission, commonly older people with multiple long term conditions and complex social care needs. This target group includes those with memory loss and dementia, and those who fall or are at risk of falls.

2. Principles of the New Delivery Model and Investment Model: Proof of concept.

2.1 We are in the process of developing an initial "proof of concept" where we can demonstrate the success of the New Delivery Model and Investment approach in improving outcomes for a particular group of customers, and to realigning costs / and budgets across the public sector.

2.2 In the first instance we are identifying a defined group of individuals (numbers and cost) in order to see whether they can be supported in different ways in the community and to work out the costs associated with the new delivery model.

This exercise needs to focus on both the resident and the GP registered population as this will assist both health colleagues and the Council.

2.3 There is no single source of joined-up data covering all three elements of this information at an individual level, such as would be found in an integrated care record. Consequently, information needs to be drawn from a range of different sources and data systems.

2.4 The PARR (Patients At Risk of Readmission) tool is being used at GP practice level across the City to generate lists of vulnerable patients which will be used to set the baseline of costs of the current health and social care system.

2.5 The three elements of hospital admissions, social care and community health will be determined for this group of patients to demonstrate the current cost and volume of the defined group across the Health and Social Care economy.

3. Manchester Health Economy Progress

3.1 The Central Manchester health economy has jointly signed up to the development of a proof of concept to test a new Investment Framework for integrated Health and Social Care using a Community Budget type approach. They have agreed to focus on the proof of concept for vulnerable patients and customers identified as at risk of hospital admission, commonly older people with multiple long term conditions, including mental health, and complex social care needs. The work is being supported through the Kings Fund and AQuA Integrated Care Discovery Community which provides expertise, insight and knowledge sharing to members. The Central Integrated Care Board agreed a project plan in March to implement integrated community teams based around four GP localities (where each locality equates to 2 to 3 Council Wards). The Project team, resources and implementation plan have been established with Central Clinical Commissioning Group, Central Manchester Foundation Trust and Manchester City Council. (More detailed information on the work in the central locality is provided in Appendix 2)

3.2 The North Manchester health economy has jointly signed up to the development of a proof of concept. They have agreed to focus on vulnerable patients / customers with co-morbidity (multiple long term conditions). A Project team, resources and implementation plan has been established with North Clinical

Commissioning Group, Pennine Acute Hospital Trust and Manchester City Council.

3.3 The South Manchester economy has agreed a strategic service model for the implementation of GP hub based health and social care neighbourhood teams. The transformation programme has now entered into phase 2 which is the planning and delivery of the model. A South Manchester Clinical Integration Delivery Board has been formed to direct and oversee the implementation of the neighbourhood teams. An IT strategy for South Manchester which will enable the neighbourhood teams to work more effectively and efficiently is currently being developed.

4. New Delivery Model

4.1 A suite of specific evidence based interventions will be agreed across health and social care that will drive improvement in service and outcomes. This improvement in service/outcomes should drive a reduction in demand for public services that could give rise to cashable savings across the health and social care economy.

4.2 A key element of the new operating model will be around working in an integrated, joined-up manner so as to minimise duplication and ensure access for the customers to the right service at the right time.

4.3 There are many strands to the new delivery model, which will require changes to services, care pathways and resources across all sectors and departments. The 3 local health economies (clinical commissioning groups, acute trusts, Manchester Mental Health and Social Care Trust) and Manchester City Council all aspire to integrating services around the needs of patients and customers that reflects different needs and provision of services locally. These approaches may include:

4.3.1 An integrated multidisciplinary discharge team working in each Acute Trust for Health and Social Care, working across the hospital and working across AGMA Local Authority boundaries (Manchester, Trafford and Stockport in South, Manchester, Bury, Oldham and Rochdale in the North; Manchester and Tameside in Central). The teams will expedite safe and timely discharge home using equipment and rehabilitation services to facilitate patient / customer recovery to maximum independence and reduce unnecessary admissions by

collaboratively working into Accident and Emergency, and Short Stay areas within the hospital.

4.3.2 Creation of out of hospital bed capacity (Intermediate Care), which is sustained and flexible to allow for surges in demand.

4.3.3 Increase in flexible capacity for home-based rehabilitation services, both health and social care (i.e. Reablement, Intermediate Care home pathway and increased access to equipment).

4.3.4 A community focused multi-disciplinary triage function to ensure patients/ customers are referred into the most appropriate service (health or social care) depending on assessed need, capacity and flow demands.

4.3.5 Social Workers linked in with GP Practices, District Nursing and Case Management teams. The teams will use risk stratification tools to support earlier, focused and needs based interventions for patients / customers with escalating needs. This involvement will be much earlier than currently provided and so prevent unnecessary hospital admissions.

4.3.6 When exacerbations occur, step up into more intensive community based services (intermediate care and reablement) will be utilized through a single multi-disciplinary triage process.

4.3.7 For patients who have been in hospital the integrated discharge service will work with multi-disciplinary ward based teams to support safe and timely discharge into community rehabilitation services to assess long term needs appropriately.

4.4 The new delivery model will use processes and systems that are built around patient / customer needs rather than organisational boundaries. Joint processes (for example Single Assessment and support planning across health and social care, including the Ambulance service) and protocols will be developed to reduce duplication, and create a person centred approach to care.

4.5 City wide collaboration across Clinical Commissioning Groups, Manchester City Council and Acute trusts will test the “proof of concept” and a new delivery model and provide the data, evidence and financial model for scaling up the whole system investment framework.

4.6 **Examples of Good Practice.** We are taking examples of good practice to inform design across exemplars.

4.6.1 In Central a new community based model has been piloted to tackle Falls through earlier referral to appropriate support services including Intermediate Care, Social Work and Community Alarm. The Central Manchester Integrated Care Board has agreed to invest in the rollout of this learning and model which is expected to deliver reductions in unplanned hospital admissions. We will be discussing the extension of this model with other Clinical Commissioning Groups in North and South localities.

4.6.2 The North Manchester Treatment Centre has been setup by Pennine Acute Hospital Trust as an ambulatory care service treating people with specific acute conditions as a day patient, rather than making a traditional hospital admission. Patients are either referred directly by GPs or streamed to the Treatment Centre from A&E for day case management. Social Work and Reablement services have been deployed to work within these new arrangements, ensuring people have access to support at home.

4.6.3 In South Manchester a pilot has been approved to provide enhanced levels of care for patients with a respiratory condition in a community setting. This will require greater integration of existing hospital and community respiratory teams in order to reduce lengths of stay in hospital and readmission rates.

4.6.4 In South Manchester, a pilot has commenced looking at anticipatory care for older people. Risk stratification in Primary Care is identifying citizens who are then supported through direct input from secondary care specialists, working alongside GPs and integrated neighbourhood teams supporting people in their own homes, preventing A&E attendances and admissions.

5 Collaborative Working Arrangements – Integrated Care Reference Group.

5.1 An Integrated Care Reference Group has been established with representatives from Manchester City Council, Mental Health, Manchester Clinical Commissioning Group's and Acute Hospital Trusts together with colleagues from the Greater Manchester Community Budgets team. The Group will support and steer development of the new Investment Model for Integrated Urgent Care across the City. A sub team composed of key Finance representatives from across all

organisations will be established to shape the detailed work required. Other themes which will be tackled collaboratively by the Group include ICT and Performance. It is planned to invite other key partners to join the group (for example, North West Ambulance Service) as the Investment Model development progresses.

5.2 The Reference Group will provide a forum for sharing knowledge across all project teams, with a key focus on managing issues arising across Clinical Commissioning Group boundaries and developing a consistent and coherent delivery model and investment framework for the City.

5.3 Governance arrangements for the Investment Model development are led through the three Clinical Boards. Links and communication with the Health and Wellbeing Board Executive in Manchester will continue to advise the Shadow Health and Wellbeing Board of progress.

6 Integrated Working across Local Authority boundaries

6.1 Manchester is working with surrounding local authority partners to tackle duplication of processes and standards. In each of the three hospital teams a single referral form and process is being developed, so that there will be a single point of contact for the integrated hospital teams. Each referral will be triaged by the duty workers in the team and assigned to the most appropriate health or social care key worker depending on patient / customer need. In the North East Sector, Bury Council has led a joint initiative to agree a single set of forms for Section 2 and Section 5 hospital referrals. The standard forms were implemented in September 2011 by all the local authorities (Bury, Oldham, Rochdale and Manchester) working within the Pennine Acute Hospital Trust.

6.2 A whole ward at North Manchester General Hospital has been converted to office space to co-locate all health and social care hospital staff supporting discharge and reducing admissions at the front door. The following teams are now co-located: Social Care staff (Manchester, Bury and Rochdale), Nursing Assessors, Intermediate Care, Patient Flow Co-ordinators, Navigator service, St Josephs befriending service and Late call District Nurses. The co-location of staff has already been noted as contributing to an improvement in hospital performance this Winter. It has now been agreed to further develop this model and implement

a fully integrated and jointly managed hospital service. Discussions are underway with Bury, Oldham and Rochdale regarding joining the fully integrated team approach with a single management post across all health and social care staff based at the hospital. The new management arrangements are planned to be implemented later this year.

6.3 At Wythenshawe hospital the following teams are now co-located: Social Care staff (Manchester and Trafford), Nursing Assessor and Patient Flow. The co-location of teams has already improved communication and hospital patient flow across health and local authority boundaries. The consultation to combine nursing teams with Social Care and establish a single integrated team management post has recently completed. The new single integrated discharge management post will manage all hospital nursing, Manchester and Trafford social care resources providing the opportunity to simplify and rationalise processes – creating a single referral and single assessment process and paperwork for example. The new management arrangements will be implemented later this year. Discussions are taking place with Stockport regarding the local authority social care resources joining the co-location and shared management arrangements in the future.

6.4 Discussions are underway at AGMA level, looking at the potential for shared social work arrangements to support patients / customers of the regions Neuroscience services. There are 4 specialist Neuroscience units in AGMA, which are in the scope of this review.

Appendix 1 : Greater Manchester Health and Social Care Theme Update Full Report (May 2012)

1. Background

The Health and Social Care Theme of the GM Community Budgets Programme commenced in early March and is intended to conclude in its current form by October 2012. By then it is expected that the health and social care theme (in common with the other 3 themes of transforming justice, early years, and troubled families) will be reporting on the progress towards implementation of new delivery models that prioritise investment in cross public sector cost reduction and quality improvement through a focus on targeted preventative intervention rather than unplanned reactive services.

While there is a strong focus on developing propositions for the deployment of the community budget methodology, the work of the theme has also been to influence and engage the wider system to lay the foundations for the pace and scale of reform required. There has been recognition that the health and social care theme is both quantitatively and qualitatively different to the other three themes of the GM programme.

The health and social care theme core team has been supported by the establishment of a multi-agency steering group meeting monthly comprising representatives from all parts of the GM system, including Local authorities, NHS Greater Manchester, GM Centre for voluntary Organisations, Acute Trusts, CCGs, Directors of Public Health, AQUA (a NW health improvement organisation) and the North West Ambulance Service.

The health and social care theme is strongly supported by the lead AGMA Chief Executive for Health – Steven Pleasant, and the Chief Executive of NHS Greater Manchester – Mike Burrows.

The community budgets health and social care team has deliberately sought to engage the mainstream work of the stakeholders in Greater Manchester, positioning the community budget proposition and principles as a core part of the solution to the necessary multi-agency lead Public Sector reform in Greater Manchester. The Community Budgets team have the opportunity to routinely report to

- The GM Health Commission (operating as effectively a GM Health and Well Being board)
- The GM Directors of Adult Social Services Group
- The GM Directors of Public Health Group
- The Council of GM Clinical Commissioning Groups
- GM Directors of Public Health Group
- GM Acute Trust Chief Executives Group

In particular a broader based leadership forum comprising 60 or so representatives from the above forums has been developed and supported to create space for the necessary consistency of narrative and development of leadership understanding and commitment across the conurbation.

The Health and Social Care Theme Group is comprised of the following:

- Warren Heppolette – NHS Greater Manchester
- Andy Bowie – Avanta UK
- David Jones – DH – Social Care
- John Crook – DH – Social Care
- Geoff Ashton – DWP
- Jack Sharp – Director, Salford Royal Foundation Trust

- Teri Byrne – GM Fire and Rescue Service
- Will Blandamer – NHS Greater Manchester (Director, Public Health Network)

2. Summary Case for Change

The early development phase of the community budget work highlighted the need for a coherent, consistent narrative, developed and shared by stakeholders in the health and social care system, that stated the case for change, and the rationale for changing the way things are done, in the short and long term, to better meet the financial and quality challenges facing the system.

Over the last two months, as well as building the evidence for the case for change (aggregating and analysing financial, demographic and activity data e.g. the level of direct payment take up), considerable progress has been made in engaging system leaders in the development of this narrative. As well as locality engagement and building consensus with key system commissioners and providers, the establishment of the Whole System Leadership Group has provided the forum for a wider debate on the case for change and importantly where we need to get to. A first draft of this narrative is now in circulation and will continue to be refined.

The fundamental underlying challenge of public sector reform and the focus of the Health and Social Care theme within a "community budgets" agenda is the economics of the next twenty years in the context of the budget deficit. This is the burning platform that sees the threat of the significant proportion of council funding being committed to social care and in the NHS an unsustainable model of health care. The core drivers of the case for change include:

- **The consequences of budget deficit** in which Local Authorities are making 25% + reductions in budgets and over time the requirement to fund social care will create fundamental choices about service provision. The NHS on flat cash is facing a financial challenge of massive proportions. The 4% Nicholson challenge on efficiency is in a context of inexorable growth and will need to continue to fund the growth deficit which will amount to continual efficiency on a grand scale. All the indications are that this is our reality for a very long time and that it will get worse before it gets better.
- **The growth in demand** and cost arising from population and expectations. This is impacting on the level of activity anticipated by health and care services and is an immediate pressure. Underlying the immediate service pressure is the long term challenge of population health.
- **The poor quality of people's experience** in relation to both fragmented care and (in some instances) institutional care. Whilst individual services are often welcomed the lack of co-ordination around people generates risk and dissatisfaction. We know that there has been a clear rise in people's expectations which needs to be taken seriously, and people also want more choice and control in how they access and use public services.
- **Unsustainable models of care** on both the health and social care sides of the system**:**
    - **Health -** "Our current organisation of services was designed to meet the needs of the last century and not this one. It was designed to respond to episodic moments of health crisis and not on-going care. The management of multiple long term conditions is now the NHS' core business and the balance between hospital and community care needs to shift" (Safe and Sustainable)
    - **Social Care -** The unsustainable model of "care and support" services is based on too many admissions to residential care. The emergence of "reablement" and the presumption that people can get better and be independent from service again has had clear strategic influence. Similarly the presumption for direct payments and carer support is about avoiding

assessing for “a service” toward a focus on need, self-directed solutions and independence. Local Authorities have a key wider role in building stronger communities and in supported housing.

The following graphs illustrate the scale and nature of the challenge. The first illustrates the proportion of Local Authority funding allocated to adult social care as a proportion of total budget assuming delivery models stay as is. Secondly, forecast rises in population within GM and the consequent impact on health and social care services.

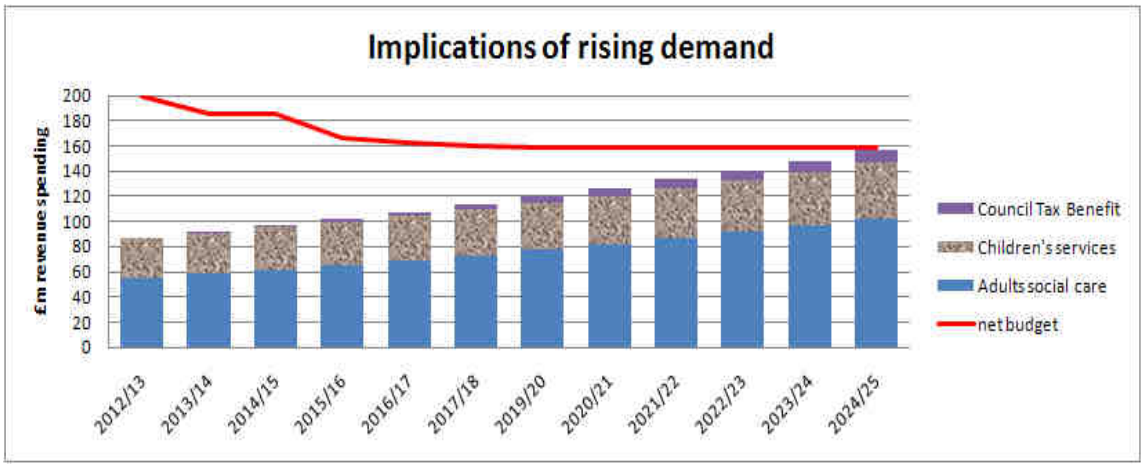


Chart1 : Implications of Rising Demand in Tameside MBC

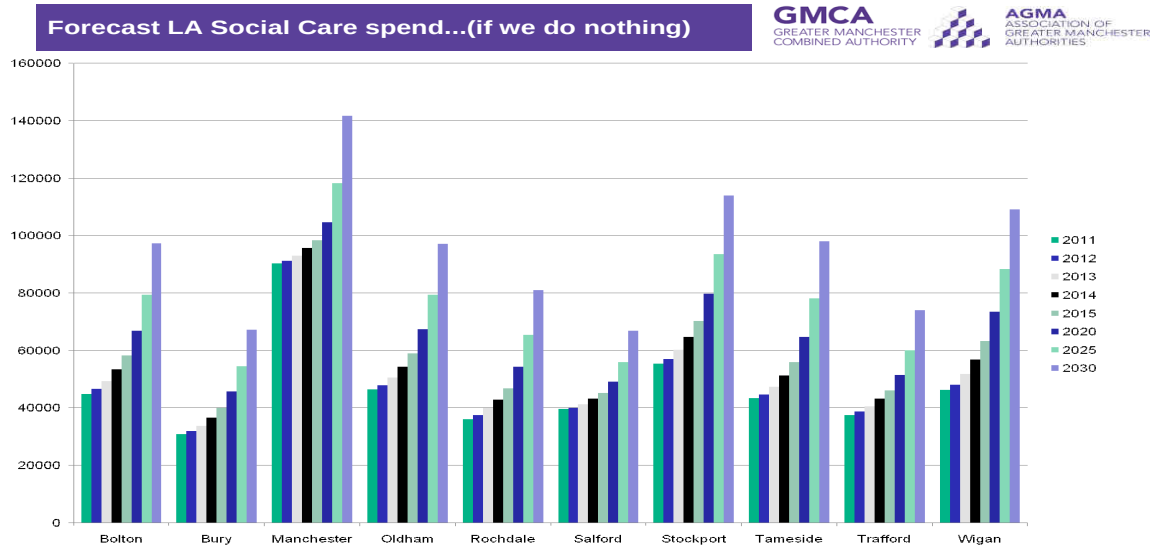


Chart 2: Forecast LA Adult Care Spend in GM

In social care the funding gap is driven by increased projected demand and in a context in which the underlying model of funding for social care remains in a state that needs reform. The funding gap may, at least in part, be addressed by a solution such as has been proposed by the Dilnot Commission. Even if this, or a version of the proposal, is picked up and progressed soon, there is a long period in which the funding gap is getting worse.

A stark reality is that a failure in social care funding will play back into serious consequences for the NHS. The Kings Fund was quick to point to the risk to the NHS. An early response to the challenge has been to put in place the requirement for the NHS to transfer funding to Local Government to ensure continuity and development of services that will support the demand on Hospital Beds. This transfer of budget has created a further opportunity to design services that integrate or align services to secure better care and efficient systems.

What it underlines is the high level of inter-dependency that the system faces in relation to timely capacity in hospital and the securing of care and support outside of hospital. This goes beyond pooled budgets and fines towards a new paradigm of managing the system. The Community Budget exemplars, e.g. the Integrated Care model in Central Manchester, are early working examples of the virtuous circle of investment needed to deliver sustainable care – in the hospital and the home.

Within the narrative, it is also clear that we need also to move away from a deficit model of care and ageing towards seeing the massive contribution that is and can be made by people, their families and communities. We need (a) more of our population to be healthy and productive and (b) the whole population to be productive for longer. This requires a different approach, for example,

a) promoting through the education system a clear understanding of life expectancy, and the positive impact on work on good health;

b) promoting public understanding both that people will normally be living into their 80's[1], and that the ageing process can be managed - it doesn't have to be a continuous series of losses ending in death;

c) communities should be helped to visualise what an ageing community would look like in their area, and to identify local leaders to lead that activity and the community response (helping people avoid isolation and be supported to live interdependently);

d) better deployment of technologies can also mitigate against isolation.

e) recognising that the aging community may change the way our communities look (for example how our town centre spaces are used)

Work is underway to ensure a positive perspective on the changing demographic of our society infuses the work of this programme and related programmes such as the refresh of the Greater Manchester Strategy

[1] This may of course not be the case if the impact of obesity, unhealthy lifestyles and multiple long term conditions continue – there may be a reduction, particularly in localities experiencing multiple deprivation.

3. Building Blocks for Radical Reform

3.1 Safe and Sustainable Programme & Local Integrated Care Planning

> *"Our current organisation of services was designed to meet the needs of the last century and not this one. It was designed to respond to episodic moments of health crisis and not on-going care. The management of multiple long term conditions is now the NHS' core business* [with 30% of patients, who are in the main older people with Long Term Conditions, require 70% of spend, 70% of all inpatient bed days and 50% of GP appointments] *and the balance between hospital and community care needs to shift. This shift will generate step changes in relation to the integration of services, personalised care and choice for individuals and the quality and consistency of care across hospitals, general practice, social care and community services"*
>
> NHS GM report 2011

The community budget programme in GM sits as part of a much wider programme of reform within the health and social care system. One key element of this is the NHS Greater Manchester led Safe and Sustainable programme, tasked with the reconfiguration of acute care which has two key goals:

1. To deliver care closer to home – ensuring that people are only in hospital when they need to be
2. To deliver better specialist care in our hospitals, ensuring that hospital services are organised to meet clear quality standards

The number of hospitals across the city region and the numbers of surgical rotas and emergency departments in the city are widely seen as unsustainable in their current form. Even if this were only focused on acute specialisms, there is a very substantial partnership agenda which will need to "well managed" politically and in terms of community engagement (recognising the previously slow pace of change and the significant local pressure to not 'close hospitals).

The community budget proposition revolves around the question of how the model of care is changed to deliver care closer to home, and how this can be funded. This ambition of "care closer to home", of "transformed community services", has been a part of the intended direction for the NHS for some time and it has been remarkably difficult to deliver. It is clear is that a community based vision of health care for people with long term conditions cannot be achieved in silos. From clarity for all parties of the urgent response to care management to support related housing options and community support it needs a joined up strategy at the right spatial level.

The challenge can perhaps be best articulated as a crude challenge: "of the 6263 acute and medical beds in Greater Manchester, how many actually require hospital based services, and shouldn't this revised number form at least in part the basis of the planning assumption for hospital reconfiguration?"

This means that in addition to an effective and strategic city region programme tasked with hospital reconfiguration, there needs to be at least 10 effective primary and community locality plans, developed "bottom up" by the CCGs, Local Authorities and Health and Wellbeing Boards in GM. It will require a shift of capacity and resource from acute to community settings. Community Budgets are a key mechanism to enhance the accessibility and quality of primary care and "care and support" services, by being clear in agreements what all parts of the system, including acute trusts, have to gain.

Work is also underway particularly to align the primary care development workstream of safe and sustainable with that required from the emerging NHS Commissioning Board, and the

understanding of the reform of primary care necessary to link to locally integrated health and social care services.

The working assumption of the theme is that the Community Budget methodology will enable the local primary and community plans to become a reality, through realigning funding flows between the acute and community sectors. The table below illustrates the different considerations at a local and GM level.

Greater Manchester	Local Health Economies
• Acute Trust reconfiguration of clinical services • Delayed discharge activity should cross local government boundaries • It may be that a 24/7 Joint Urgent response is required at GM and local level • Elements of telecare / tele health • Public health programmes	• Horizontal and vertical integration including more co-ordinated primary and community services • Integrated care management • Primary Care Access • Self-Care • Case finding

3.2 Public Health Transition

The demographic driver of demand has been made in the context of current and short term demand for services. The reality is that the long term challenge facing the public sector lies in the way in which population health and well being is supported. A focus solely on interventions will miss the important part of a whole population approach – shifting the whole curve of poor health in GM rather than simply tackling only those at the most demanding end of the distribution. Work is underway with the GM Directors of Public Health group to understand the drivers for a fundamental shift in the health of the population in GM, and where possible to link this to the work of refreshing the Greater Manchester Strategy.

In part this work will be informed by a degree of social marketing insight work on public aspirations and ambitions and appreciation of dependence and independence. It will also require an appreciation of different interventions in the life course – there is evidence for example that the needs of the current elderly population may be different to those in the future. This has implications for how to intervene at an earlier stage (for example delivering health checks at an earlier stage than currently). Work is underway to scale learning from work in Salford in this area.

Also important in this context is the issue of resilience of local communities and the critical role they play in supporting and maintaining independence of individuals. Work has been commissioned from the Greater Manchester Centre for Voluntary Organisation to understand this in more detail and the levers and opportunities to support such an approach, and to place such a perspective alongside new models of working already in GM.

3.3 Deal for Cities

The opportunity to extend the principles that sit behind the GM Deal for Cities for Transport, Housing and Skills into the health and social care system are significant. Identifying what, how and why a GM specific deal for particular aspects of health (and social care) will deliver better outcomes at lower cost.

Work is now underway to explore what a health component of the second phase of a Deal for Cities in GM would look like, with a primary focus on organisational form, potential tariff adjustments, and proposals around future funding arrangements. Where GM investment

achieves better financial and population outcomes, we will develop an earn back proposition of the financial benefit which would otherwise accrue only to DoH or other Whitehall departments.

3.4 Scaling Up Best Practice & Maximising Efficiency and Economies of Scale

Within GM, there is significant opportunity to scale up good practice and existing efficiency programmes, alongside the wider reform agenda. Two examples suffice:

1) Work on Cross Boundary Hospital Discharge Liaison – developed through Manchester and including partnerships with Salford, Stockport and Trafford to date.
2) Implementation of the GM Good Work Good Health Charter – indicative of a pride in Good Work that Greater Manchester should prioritise, ensuring all workplaces promote health and well being in a way that supports profit, reduces cost, and promotes better employee health.

The DAS group are co-ordinating a programme of work to secure maximum efficiency from current arrangements. These are mostly going to require a step change in the extent to which local authorities collaborate in procurement. A small example is the procurement of client facing social care provider information and review systems – there are a number of these in operation in GM. Work is underway to refresh this programme of work and it may be that senior leadership will be challenged on the commitment to achieve such economies of scale.

One of the key aspects of improved efficiency and productivity is the use of assistive technology. Despite areas of good practice, GM is not collectively and systematically exploiting assistive technology. Work is underway to understand current models of working and the potential for scale. This maybe something for example that could be commissioned at a GM level (to deliver economies of scale through bulk purchase) and administered locally.

3.5 GM Whole System Leadership

Alongside the detailed work on new investment models, changes in delivery models, and planning the reconfiguration of services, the Theme is supporting a whole system approach to leadership within health and social care in GM. Through a series of stakeholder events comprising senior leadership from commissioners and providers from across the health and social care spectrum, the Theme is helping the system develop:

- A common understanding of the case for change and the implications of doing nothing
- A common narrative on the way forward, and how collectively we can get there at a macro and meso level
- The respective roles and contributions of different parts of the system in delivering the new model of health and social care in GM, under the safe and sustainable programme and local primary and community care plans.

4. Community Budget Exemplars & New Ways of Working

"The evidence shows that it is the cumulative impact of multiple strategies for care integration that are more likely to be successful in meeting the demands and improving the experience of patients, service users and carers" Powell-Davies et al 2008 *"Integrated care must be delivered at scale and pace. This requires work across large populations at a city, and county- wide level." King's Fund and Nuffield Report to the DoH - 2012*

4.1 Community Budgets Exemplars Overview

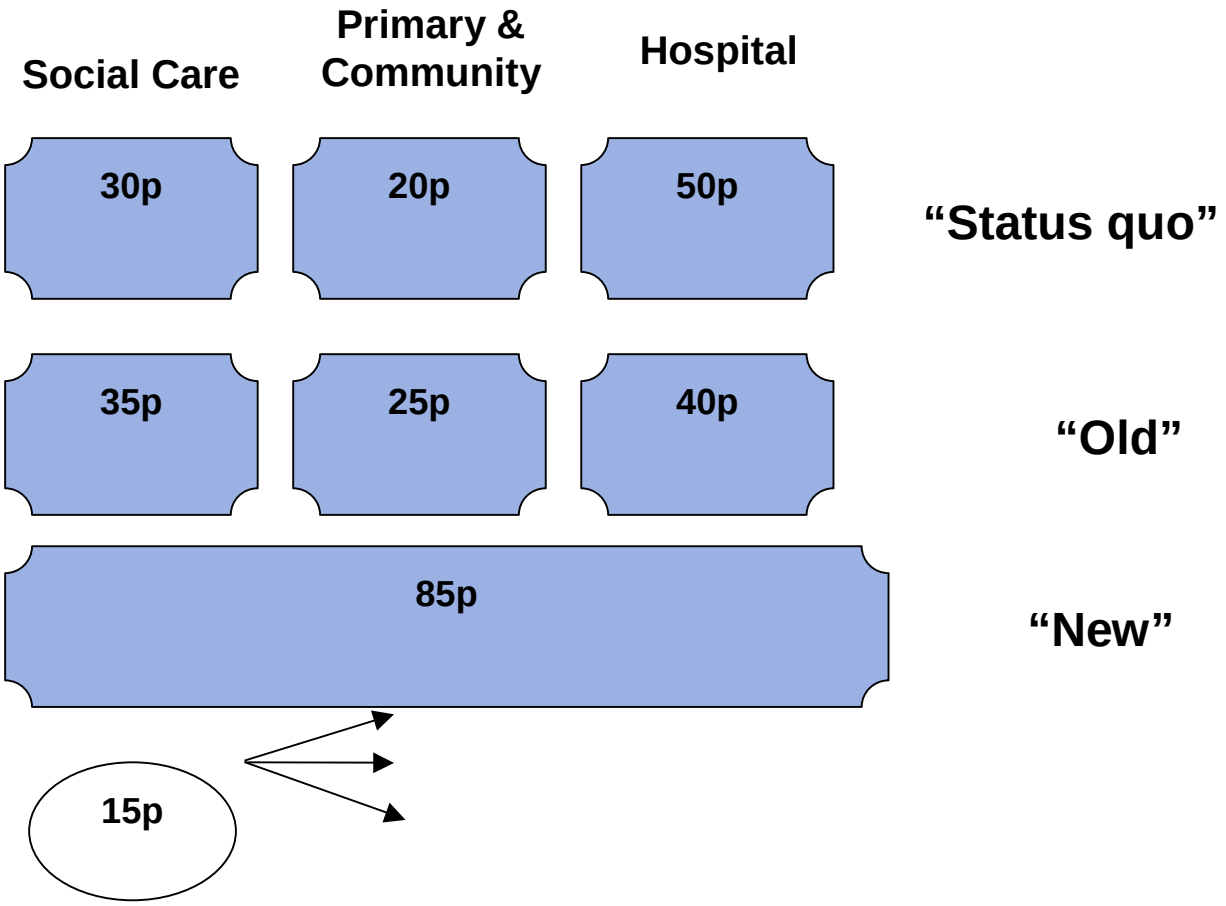
Over the first three months of the Community Budget programme, the Theme has identified a range of potential exemplars that are at different stages of development, reflecting the particular characteristics of the local health economy and the engagement of local commissioners & providers. As the community budget programme has developed, the nature and scope of these exemplars has evolved, as commissioners develop a greater understanding of the opportunities and challenges, and the interconnectedness of different programmes of activity.

The following exemplar projects are in play and for each there is a target milestone by October 2012. More detailed outline business cases have been developed for three representative exemplars: firstly, the work on over 65s co-morbidity in the Manchester health economy; secondly, the dementia exemplar; and finally the Fit for Work programme.

Level of Activity	Project / Exemplar	Project/Exemplar Description	Target Milestone for CB Exemplar Oct-12
Local Horizontally integrated / aligned exemplars, to be considered in context of Safe and sustainable[2]	Manchester North	Over 65s Co-morbidity - alternative community based models	6. Track outcomes and financial benefits of NDM VS BAU
	Manchester Central	Over 65s Co-morbidity - alternative community based models	6. Track outcomes and financial benefits of NDM VS BAU
	Manchester South	Over 65s Co-morbidity - alternative community based models	6. Track outcomes and financial benefits of NDM VS BAU
	Salford	Over 65s Co-morbidity - alternative community based models	3. New Delivery Model Designed
	Stockport	Over 65s Co-morbidity - alternative community based models - scaling of existing prototype	6. Track outcomes and financial benefits of NDM VS BAU
	Tameside	Over 65s Co-morbidity - alternative community based models	3. New Delivery Model Designed
Dementia Care	Dementia Care Psychiatric Liaison	Test models in the dementia care pilot sites across the pathway	8. Implement Scaled Up Working Example
Fit for Work	Keep people in work	Create sustainable funding based on good evaluation	8. Implement Scaled Up Working Example
Falls Prevention - Fire and Rescue	Testing new model of working in Wigan. Bury and Trafford	Incorporate Falls Risk Assessment and subsequent action or signposting	8. Implement Scaled Up Working Example
End of Life Care	End of Life Care	Explore new delivery models for end of life care	6. Track outcomes and financial benefits of NDM VS BAU

[2] Other localities from across GM in development

4.2 Delivering the return on investment



The fundamental community budget challenge is to create a virtuous circle of investment and "payback", within a new model of care delivery, that recognises the different business development and risks to different organisations in the H&SC system in GM. For example:

a) integrated care at or near people's home based on integrated care teams built on primary care practices;

b) FTs providing the basic district general hospital services; and

c) FTs providing specialist tertiary services.

In this model the case for a pooled public sector budget is based on each partner doing what they do well and generating efficiency internally – whilst creating an integrated model of care and support that results in the possibility of realigning the investment in acute services towards a more sustainable model – closer to home.

The evidence for the success of this suite of interventions is often described in terms of admissions and beds days saved. The reality of that is not only the question of where else might the cost appear but that in fact the theoretical reduction in admissions and bed days is not realised in cashable savings because the beds are not taken out – they are filled with other patients.

This returns the debate to how to secure transformation in community services in such a way as to actually recast the business plan of Foundation Trusts in a way that does not

compromise the viability of provider organisations where substantial elements of their core business will still be needed.

Work is underway to understand the incentives and opportunities for engaging with Acute Trusts, building on existing learning and good practice (for example where deals to extract cash out of hospitals have recognised the stepped fixed costs of hospitals such that cash was released only at the pace of costs being reduced).

In this context work is also underway to explore the value of new organisational forms to effect the scale of change required at a local level (for example the potential value of accountable care organisations – where a group of healthcare organisation potentially invest at shared risk and potential shared benefit). This potential of this is best demonstrated by this diagram

5. Emerging Themes

5.1 Developing a Joint Outcomes Framework

Any successful alignment of activity across the health / care and support divide will need to be precise about what it is intended to achieve. In discussing the way forward on integration the Health Select Committee recommended that "The Government should develop a financial, performance and outcome framework rather than prescribe the model". The Future Forum also made observations about the three emergent outcome frameworks and the case for measures that reflect the partnership agenda. In the context of localism and the presumption of local accountability, the development of a joint outcome framework should be addressed rapidly in order to demonstrate such accountability but also as a core platform for local progress.

Any cost based analysis of the redesign of services across the public sector is therefore predicated upon clearly agreed joint outcomes. For the purpose of taking the debate forward the following "outcomes" are intended to stand for greater independence and other higher order outcomes which might be the underlying requisites of success and system redesign. The evidence of other work on integration has been that without clarity in this regard different elements of the system are accentuated, creating cost for partners. Joint outcomes seem to be a critical start point.

A starter option (with associated metrics being developed) for joint outcomes might be:

- Improve the quality of the citizen experience
- Reduce demand at the front door of community based services
- Reduce admissions to residential care and nursing home
- Reduce admissions (and re-admissions) to hospital

Work is underway, building on the existing AQUA locality benchmarking report, to produce a more comprehensive representation of a joint outcomes framework. We propose to develop the outcomes framework by Oct-12, including the financial implications of the outcomes. It is intended that this framework will be of use nationally.

5.2 Other Emerging Themes

In addition to driving the pace of the Community Budget Exemplars and the building blocks of reform, other emerging themes are coming out of the work by the Community Budget team. These themes are being picked up by the team and the Public Service Reform Executive (PSRE). Briefly, they include:

- Incentives and disincentives – a workstream has been established, involving colleagues from DH, Acute Providers, NHS GM and local authorities, to explore where and how specific financial payment models within the system act as an incentive/disincentive to deliver better patient outcomes at lower cost.
- Market making and commissioning – GM wide commissioning of people services (as apposed to infrastructure/transport) is in its infancy, and GM lacks sufficient market making capability in the health and social care system. This applies at both a simplistic and tactical level (such as the consistent use of a web portal across 10 local authority areas) to the large and transformational, such as jointly commissioned community/primary care services. At the same time, neighbourhood and family based commissioning activity can be significantly improved. A piece of work is underway to be led by the PSRE to review where and how better market making and commissioning could deliver better outcomes at lower cost.
- Personalisation – the take up and usage of direct payments remains low in GM. The Theme group is working with the DAS group and other stakeholders to promote the increase in direct payments and better personalised care, alongside the case for

change outlined above. Early learning from the Right to Control pilot will be tested against the community budget methodology not only to demonstrate uni-sector efficiency and improved client experience, but potential total place savings.

- Data Sharing – data sharing, particularly between health commissioners and local authority commissioners, is particularly challenging but a necessary prerequisite of integrated work. Work is underway in a number of Exemplars to implement shared data systems to better track customer outcomes across the health and social care system. (e.g. Manchester where the city council will track social care via the NHS number, and in relation to sharing live birth data with local authorities)
- Workforce Flexibility – alongside more creative mechanisms for funding flows, there is also a need for much greater flexibility in the development and deployment of the public service workforce across the boundaries of the NHS and local government, and their supply chains. We need such flexibility if we are to move capacity at the speed and scale required by the crisis in front of us. It is key to cashablity.

Appendix 2: Examples from the Central Locality

Example One- Investment Funding

1.0 Introduction

The Central Integrated Commissioning Board (CICB) has committed to working together as a health and social care system to create integrated services which offer care in the community where possible. This partnership has created a turning point in how the Central Manchester system works together to improve the care for the population.

Since the CICB started there has been design and implementation of separate projects which have given confidence to managers and clinicians alike that the CICB programmes can make an impact. This confidence has driven a desire to scale up our efforts and make more significant change.

This paper has two aspects to it.

- How investment funding can be used on a year on year basis giving a permanent source of investment for development of out of hospital care programmes.

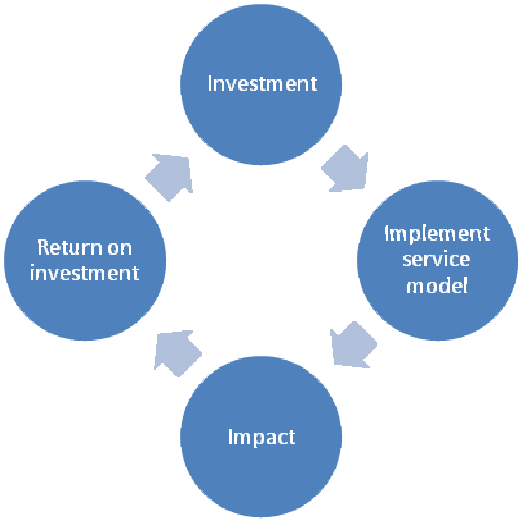
- Investment decisions relating to specific proposals for Intermediate Care and Integrated Care teams.

2.0 Creating a virtuous circle of investment

In the period 2011/12 urgent care activity reduced within Central Manchester. This meant that the block contract between Central Manchester CCG and Central Manchester Foundation Trust could reduce from £64m to £61m. As part of this agreement, an investment fund of £1m is created to support implementation of work programmes held under the CICB. This is the first time such a fund has been identified.

Historically demand for hospital services has risen year on year and this has restricted investment in out of hospital settings thus failing to mitigate against further rises in acute demand. This vicious circle has hampered efforts to create a more balanced health and social care economy.

The opportunity created through the CICB investment fund should be used to turn the tables by creating a virtuous circle, shifting care and resource into community settings, reducing demand upon secondary care services and thus, in turn, creating a further funding stream for future year's investments. The £1m created in the CCG/CMFT contract agreement for 2012/13, is the ‘kick start’ to this virtuous circle.



CICB - annual investment cycle

Whilst this investment fund is a precious resource, it is imperative that it is utilised promptly in order to demonstrate the tangible impacts which will generate the next year's investment fund. Typically investments will need to be fully operational by the beginning of October, in order for returns to be seen in budgets, contracts and further re-investment in the following financial year. This will require some degree of courage and acceptance of shared risk.

The Transactional Redesign Board will be responsible for establishing means for assessing, tracking and mitigating risks relating to CICB investments and will assess each investment on a case by case basis. This will put safeguards into the system to protect the investment fund and to ensure that service models achieve their predicted impacts. This will include developing an assessment of the targeted level of reduction in the urgent care CCG/CMFT contract annually, resulting from the CICB approved investments, and to plan from that the scope of investments for the following year. This will allow development of a stronger evidence base in proposals and a more strategic approach to investment.

This re-investment model also connects with a wider picture of Public Sector Reform (PSR) and local developments relating to community budgets, for which the CICB programme to develop Practice Integrated Care Teams is being used as a case study for Greater Manchester. The PSR reports back to Whitehall in October and this is a good opportunity for the CICB to highlight policy enablers/barriers.

3.0 Intermediate care scale up

The Intermediate Care scale up paper (see example 2) reports upon four pilots developed under the Transforming Community Services Board.

- Continuing healthcare - improving patient experience at the MRI
- Integrated community care pathway for COPD
- End of life care in residential care homes
- Intermediate care assessment team for falls

The detailed proposals relating to these are described in the attached paper and will be presented alongside this. This section brings out the key considerations relating to investment funding so that these are considered as a whole. Whilst this section does not appraise the value of these projects the benefits in terms of patient experience and clinical outcomes are very important context for an investment decision.

The table below shows the net cost/benefit for the scale up of these service models. Net cost is represented by figures in brackets and net savings without.

Service model	FY 12/13 £k	FY 13/14 £k	FY 14/15 £k
Continuing healthcare	(61) *	466	466
COPD	(106) *	277	277
End of life care	(63) *	12	12
Falls	(103)*	0	0
Total	**(333)***	**755**	**755**

Net financial impacts from Intermediate care scale up.

* all investments in 12/13 represent 7 months investment in the current year., 13/14 onwards assumes full year costs and return on investment. The table shows the net impact.

The Intermediate Care paper has been discussed by the Transactional Redesign Board and internally within partner organisations. A number of risks have been raised and means of managing these risks discussed. The table below shows these in summary form.

Risk of investment	Means of managing risk
The business case has small sample sizes from which it makes its projections.	Whilst the scale up happens a clear reporting arrangement will be put in place to continue to measure impacts and a report will be submitted to CICB in September. This may include revised planning assumptions. There is a need to take a degree of risk in this in order to make the impacts in time for investments in the following year.
Programme duplication with Manchester CHC developments.	Further work is taking place to establish how these CHC proposals best fit with existing initiatives.
How to monitor impact	The aforementioned monitoring system will be perform this function on an on-going basis.
How to ensure savings are pulled through into an investment fund	The Transactional Redesign Board will be tasked with devising this mechanism. Ultimately the scale of a re-investment fund will be impacted by the macro position i.e. the outturn against the urgent care contract as a whole, as well as the specific results achieved from

	projects that have been undertaken during the course of the year.
Freed up hospital capacity is used for other activity at a cost to the commissioner	Hospital plans include alternative income sources for re-utilising this capacity over the medium-term. Capacity freed up will not be used to drive elective waiting times down from the levels modelled into contract plans, unless by prior agreement. Where there is a timing gap between reduced non elective bed usage and any new activity/income sources, beds will be closed in the interim period.
Does investment in this model reduce the opportunity for investment in other project areas.	The original proposal showed the full year cost of the projects. However, the scale up will be for seven months of the year. The investment is, therefore, £333k rather than £570k leaving more scope for other investments.
Details of the service model	The TCS Board will manage the remaining points of clarity relating to the service models

Risk assessment - Intermediate care scale up

4.0 Development of Integrated Care Teams

The attached paper (see example 3) explains the detailed progress with development of the Integrated Care Teams (ICTs). This section, again, focuses upon the teams in the context of the investment fund. ICTs are at an earlier stage of development than the intermediate care projects and so the call upon the investment fund is with consideration to initial set up rather than scaling up. A proposal to mainstream funding will be made in December 2012.

The initial proposal for use of the CICB Investment fund in the current year is as follows:-

Description	**Non recurrent funding 12/13**
Project management	£70k**
IT development	£100k*
Clinical backfill	£50k
Team facilitators	£40k
Evaluation	£30k **
Patient engagement	£10k **
Funding to be determined	£100k
Total	**£400k**

Proposed set up costs for ICTs

* There is a good chance this funding can be accessed through Greater Manchester IM&T funding. The project will need to commit this funding at risk from its fund in case the GM funding bid is unsuccessful and in order to start development now whilst the bid process takes place.

** There may be a requirement for non recurrent costs in 2013/14

Recommendations

CICB investment funding

- That the CICB supports the approach of developing a virtuous circle of investment
- That a target figure is agreed by the Transactional Redesign Board to build and sustain an investment fund year on year
- That it is noted that the entire fund has not been committed and options should be explored in this regard.

Intermediate care scale up

- That the scale up of the intermediate care pilot is supported from the investment fund. Approval will be finalised by the CCG Acting Accountable Officer once outstanding issues e.g. continuing healthcare are worked through.
- That the joint risks are noted and the means by which they are mitigated are approved.

Integrated Care Teams

- That approval is given to use the investment fund to cover the costs outlined in section four.

Ed Dyson
Sara Radcliffe
CICB Board - May 2012

Example 2:

Integrated Care – Scaling Up the Intermediate Care Pilots for Sustainable Change

May 2012

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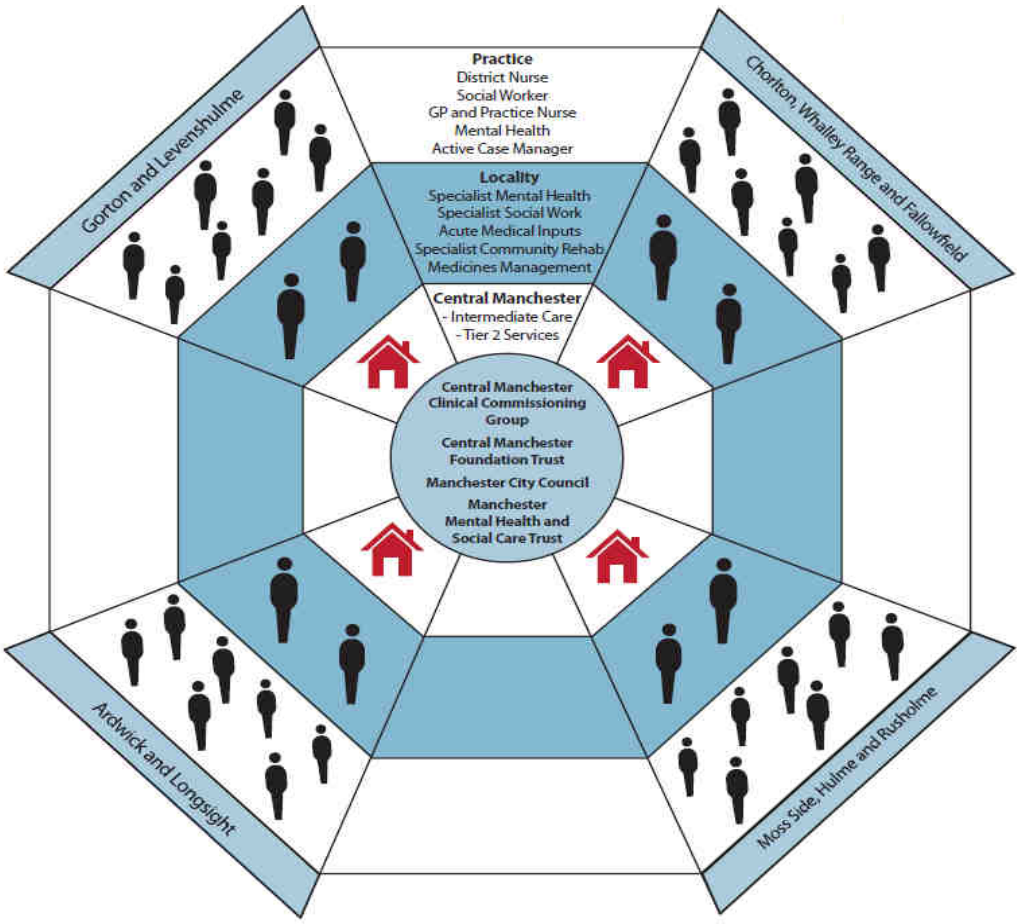
Strategic Direction Context

1.1 Central Manchester health and social care economy has agreed an ambitious programme of work to implement a sustainable integrated model of care across 40 practices, for people aged 65 with long term conditions. The diagram below summarises the model. The scaling up of the four intermediate care pilots, EoL, COPD, CHC and falls, under the guidance of the intermediate care task force is part of this work, and has many interdependences across different agencies, not only in terms of provision but also in terms of savings and sustainability.

1.2 It is apparent that no part of the system can develop in isolation and we are aware scaling up these projects will also have an impact in terms of delivery and sustainability with other parts of the system. Therefore, before the paper is presented to the CICB the transactional board will assess the impact upon other parts of the system - predominantly primary and social care of scaling up these projects if agreed. The outcome of this work will be incorporated into the final paper that will go to the TCS board on 27th May and the CICB on 30th May.

Phase one of a five year project to implement integration



1.3 Since July 2011, colleagues from across health and social care have been working together to transform integrated care for patients living in Central Manchester. Providing care by the right people, at the right place and the right time will improve outcomes for patients, increase multi-agency working, reduce hospital admissions, lengths of stay and readmissions and provide better value for money for health and social care services.

1.4 As a system we are committed to increasing care in the community with the integrated teams being a building block. We believe that the up scaling of these projects to make them sustainable should be seen as a proposed five year plan to strategically move the system to care closer home, and reinvest the savings that we make as a system into integrated care. We will work with our partners on this proposed plan to ensure it is agreed, owned and an effective tool for integrating the system further.

1.5 The four pilots we have identified for scaling up we believe are integral to the development of the practice integrated care model. We believe the success of these scaled up pilots will produce a shift of resource into integrated care through redistribution of savings. This will mean that the effective use of urgent care services to keep people in the community rather than admission, intermediate care to enable people to live in the community, effective discharge so people move to their place of choice for EoL, rather than a prolonged stay in a hospital bed, the self management of long term conditions and the ability to manage complex conditions in the community, these will all enable the PICTs to work more effectively.

1.6 The governance of this scale up will be through the intermediate care task force and TCS board to the CICB. However we will ensure that it is also part of the project plan for the PICTs so it is a supporting and enabling work stream for the development of the integrated care model.

1.7 We believe that the involvement of the third sector over the next five years will be invaluable to the achievement of this model. We acknowledge that at present we are looking predominantly at the statutory public sector, however we are conscious that there is a wealth of voluntary services that we believe could integrate and support this programme of work to make it more effective. We are also conscious that the largest workforce for the people who are most at risk is probably the informal carer be that family, friend or neighbour. Carer breakdown is a major reason for people being admitted into hospital with an unplanned urgent admission, and we will need to work more with carer groups in the city to ensure that we are involving and learning from this source of care.

1.8 We belief patients are our partners in their care. Therefore we need to communicate, inform and promote our services effectively over the 5 years of this plan. We want to work with the customer experience team, the communications team and the Intermediate Care Service User Reference Group to establish best practice.

1.9 As part of the work with the Kings Fund and AQuA we are planning three specific areas of input before the proposed scaling up and implementation of the integrated model in October. These are evaluation, clinical leadership and critique of the model we will ensure that any learning from these events is fed into the scaling up work.

1.10 The purpose of this paper is to show case what has been achieved by the pilot projects so far, outline the resources needed to up scale and the assumed outcomes. The diagram below shows how we would plan to move and increase care in the community over the next five years. We would do so by up scaling the pilots we currently use in a way that gives them enough impact to achieve effective outcomes and use resources differently.

Strategic Projection 2012 to 2017

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	5 year vision
	Development of Practice Integrated Care Teams						**Patients who do not require inpatient care will be cared for out of hospital. Integrated teams will deliver pathways of care for chronic disease management, an urgent community response to health and social care need 24 hours a day and offer a range of high quality end of life care supporting individual choice. Inpatients will leave hospital fully informed with ongoing care plans when acute care is complete.**
	Pathways piloted using existing resource	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	
Development of Integrated Care for Central Manchester at practice, locality and specialist level	CHC Pilot	Upscale Pilot*	Upscale to cover CHC fast track assessments	Upscale to cover all discharges. Patients will be fully aware of their condition with self care options	All patients will have ongoing plan of care shared with integrated teams prior to discharge	All patients will be ready for discharge when acute care is complete and arrangements in place to accept their ongoing care.	
	COPD Pilot	Upscale Pilot*	Roll out COPD pilot to all CM & pilot next chronic disease pathway ie heart failure	Upscale 'heart failure' pilot to all CM & pilot integrated pathway for 3rd chronic disease ie diabetes.	Upscale diabetes pilot to all CM localities & pilot integrated pathway for frail elderly.	All patients with for example COPD, heart failure, diabetes and the frail elderly will be managed by integrated teams at home	
	EoL Pilot	Upscale Pilot*	Design a multidisciplinary robust hospice at home model.	Implement and deliver a multidisciplinary robust hospice at home model	Commission end of life beds outside hospital co located with intermediate care	All patients on end of life pathways have a choice of location for receiving high quality end of life care outside hospital & preferred place of death is met.	
	Falls Pilot	Upscale Pilot*	Include new pathways ie diabetic hypos, frail elderly, urinary catheters	Upscale to two hour response in partnership with city council.	Expand service to cover 24 hours response	An urgent 2 hour health and social care response for all appropriate conditions including NWAS self care pathways.	
Quality Patient safety Efficiency	**Workforce development, Education, Skill mix, Care pathways, Shared care, Redesigned teams**						

Intermediate Care Pilot 1
Continuing Health Care (CHC) - Improving patient experience at the MRI

2.1 The pilot tested an alternative system for the co-ordination of CHC assessments within MRI. The model tested was in line with best practice guidance from the Department of Health (2010). It was based on evidence from a similar model at Stockport PCT, which when evaluated, showed that it both improved patient and family experience and reduced the length of assessment process from an average of 56 bed days prior to the pilot to 15 bed days.

- The pilot adopted an end to end ownership model which used dedicated CHC co-ordinators to improve patient experience and reduce length of stay by:
- ensuring all assessments were collected in a timely manner and in parallel to the treatment and discharge process,
- helping the patient and family to understand the assessment and eligibility process,
- and clearly communicating with the multi-disciplinary team, commissioners, the patient and the family.

Staff Perspective

The staff involved noted that their relationships with ward staff improved representing the opportunity for further improvements in the timescales. They felt that patient and family expectations were managed better and that it was easier to co-ordinate communication with the patient and family and to check they understand the process. They also reported feeling frustrated about not being able to start the process earlier as this would have led to a further reduction in timescales and further improvements to the patient experience.

2.2 Baseline - At the MRI there are people waiting for assessment following their admission and treatment. An average of 10 new patients per month start the full consideration process for CHC: roughly 70% are Central Manchester's patients, 15% from North and 15% from South. An audit in 2010 showed that the average length of time from the start of the assessment process to discharge was **38 days**. Projected over the year this equates to **4560 bed days** or over 12 beds.

Performance

2.3 During the pilot two patients underwent CHC assessment; one was found eligible for CHC funding and the other was found ineligible but received local authority funding with a nursing care contribution from the NHS. Both patients suffered set backs, one due to ill health and the other due to the bereavement of a partner but analysis of the timeline showed that 1 patient was taken through the process and ready for discharge after 19 days and the other in 20 days. This represents a saving of 19 and 18 days over the average time expected.

2.4 If the assessment and discharge process is reduced to 19 days this would represent a reduction of 2280 days per year or a saving of **£570,000p.a**. £400,000 of this saving would be to Central Manchester as there are approximately 70% of patients from Central Manchester. *Based on the cost of a basic bed day for elderly care 2010/11 (£250)*. If the assessment and discharge process is reduced to 15 days, as in Stockport, this would represent a reduction of 2760 days equating to a saving of **£690,000p.a**.

Scaling Up for Sustainability

2.5 In order to achieve a 19 day process we would need to form a dedicated integrated care coordination service for all Manchester patients requiring 'full consideration' for NHS Continuing Health Care at the MRI. In addition to carrying out assessment and facilitating discharges these staff will also provide training and act as a specialist resource for other health and social care staff. The development of this team would be at a cost of £104,000, with a potential savings based on commissioned bed days of 570,000 per annum – this would make the team cost neutral with a potential reinvestment of at least 466,000 to the integrated system.

Associated Costs

2.6 A senior practitioner grade social worker has been costed into the project as part of the dedicated coordination service for MRI, along with administration and support costs etc. However, social care have identified that we would need to monitor that the increased pace of change does not lead to pressure on social worker capacity.

Intermediate Care Pilot 2
Integrated community care pathway for COPD

3.1 An integrated community care pathway has been developed and piloted to provide care for patients exacerbating from COPD. The pathway is led by Central Manchester Active Case Management service in collaboration with the COPD team and West Gorton Medical Centre.

3.2 Baseline - In the pilot practice, 282 patients are registered with COPD; a prevalence of 4.7% of the practice list. In 2010/11 there were 52 admissions with an average length of stay of 8 days. The cost of these admissions was **£128,915**. In the month before the project was launched, 3 of the patients who had been identified as at high risk of admission died. All of the deaths were in hospital and the average length of stay was 18 days.

Performance

3.3 As part of the pilot the patients most at risk of exacerbation were identified, joint management and assessment documentation was used to create individualised multi-disciplinary care plans and an integrated end to end pathway for managing exacerbations in the community was agreed. Tele-health units have also been installed for 6 patients and work is continuing to evaluate their use as a self management and early warning tool.

A Patient Perspective

After numerous admissions to hospital for chest related problems, Patient A was referred to the COPD and Active Case Management teams. At the beginning of the COPD pilot the patient was identified as high risk and was placed on the integrated care pathway. The patient was jointly assessed by the ACM and COPD teams and an management plan was developed.

Before referral the patient reported that they felt alone when managing their COPD and often felt out of control.

The patient now reports that they understand their condition, exacerbations and early warning signs better. They feel less worried about being admitted to hospital and know who to contact in the community if they need support. Their condition has improved to the extent that they have now started to go out with their family again.

3.4 Since launching the pilot 12 patients have been assessed as high risk and have been given an individualised management plan, 5 exacerbations have been managed in the community without triggering a hospital admission and there has been 1 hospital admission which was deemed appropriate by the multi-disciplinary team. The length of stay was 4 days.

3.5 The average cost of a hospital admission for COPD in 2010/11 was **£2665**. Assuming that the 5 patients who had exacerbations managed in the community would have otherwise been treated in hospital, this represents a total cost saving of **£13,325** since the beginning of the pilot.

3.6 Scaling up of this pilot would mean rolling it out to all other GPs in the **Gorton and Levenshulme** locality. In Central Manchester 40% of patients registered with COPD live in the Gorton and Levenshulme locality, and the area has the highest urgent care costs for COPD admissions; there were 218 admissions for COPD from this locality in 2010/11 costing **£575,456**.

Scaling Up for Sustainability

3.7 In order to expand this team over the locality we would need to increase capacity in the COPD team and Active Case Management service using a phased approach. It would also be used to provide weekend cover for the active case management service; a major risk which was identified during the pilot. The cost of developing the team would be 183,000. Based on the pilot figures 80% of admissions could be prevented, with an assumed potential saving of commissioned bed days of 460,364, this would mean the development of the team would be cost neutral with a potential reinvestment to the integrated system of 277,364.

Associated Costs

3.8 We do not envisage at this stage there will be extra demands on social services re ablement team. However, this is a risk that social care have identified and we will need to monitor to ensure that we do not put extra pressure on this part of the system without extra resource for capacity.

3.9 The Tele Health units were included in the pilot because they had already been purchased by another part of the Manchester system but were not being used. The pilot has no plans to procure further units until the evaluation and benefits of Tele Health within the local community has been assessed. Therefore, at this stage we would not include the cost of extra Tele Health units. If we were to consider them in the future, there would be additional costs of the units, their monitoring by the MCC contact centre and the software licence costs – all of which have been identified by social care.

Intermediate Care Pilot 3
End of life Care in residential Homes

4.1 This pilot builds on the success of the highly acclaimed Central Manchester Shine project which was funded by the Health Foundation. The Shine project was a collaborative care home improvement programme which worked with a residential home in the second phase. After involvement in the project, data shows that there

was a 58% increase in the number of residents dying within the home rather than being admitted to hospital.

4.2 The aims of the project are to increase knowledge of end of life care amongst residential home staff, increase the number of residents with end of life care plans and increase the number of residents who die in their preferred place of care. Each residential home has now been nominated with a designated district nursing team and this has further improved the good working relationships and communication between the district nurses and the homes. 14 district nurses have attended facilitator training and have developed two training sessions on end of life care and communications.

4.3 Baseline - Over the last 7 years 358 residents living in residential homes have died; 163 (45%) died in the home, 151 (42%) died at the MRI and 41 (11%) died in other hospitals. This data does not include residents who are admitted to hospital and then discharged to a nursing home for end of life care. The average length of stay for patients over 65 who die in hospital is 22 days. NICE estimate that the average cost of an inpatient admission in the last year of life that ends in death is £2506. This equates to an average cost of £68,736pa for residential patients receiving end of life care in hospital. If 50% of these admissions could be avoided, it would represent a cost saving of £34,368.

Performance

4.4 The training has now been delivered in 3 homes, end of life champions in the homes have been identified and a resource pack has been provided. The care home staff have been provided with 'My Life' Books and information about end of life preferences will be shared with District Nurses, the GP and Out of Hours.

4.5 In the next phase of the project the team plan to roll out the training package to all eleven residential homes in Central Manchester and provide on-going support. They would also aim to provide training to the home care providers who make regular visits to 469 patients in the community. The complex discharge team will also be engaged to raise awareness that the end of life supportive care pathway is available for people living in residential care.

Scaling Up for Sustainability

4.6 There is a need for a district nurse to cover the caseload whilst the district nurses provide training and support to residential home and home care staff. This post will ensure that there is no loss of capacity or quality to practices as they establish the practice integrated care model.

A care home staff Perspective

The District Nurses came to St Georges Residential home and delivered 2 training sessions on end of life. In the past we have worked alongside these nurses to provide end of life care and we looked forward to learning more.

We enjoyed both sessions but we particularly benefited from the advice about how to start difficult conversations, completing the "my life" booklet and the different documents used at the end of life.

Since having the training we have began to complete the "my life" booklets with residents and are looking into completing NVQ training in end of life care.

4.7 The current district nursing service is not provided over a 24 hour period as there is a gap in service between 04.00 and 08.30. It is essential to increase the service

to cover these hours and increase the cover for end of life care. Data shows that in 2011/12 there were 68 admissions for people over 65 who then died in hospital between the hours of 4.00 and 8.30am. If even 50% of these admissions could be avoided it would equate to a cost saving of £85,204. There have also been incidents reported where patient care has been adversely affected during these hours. This will not only benefit this project but will also increase the provision of end of life care in the community and provide continuity of the district nursing service to prevent hospital admissions.

4.8 The cost of developing the team would be £107,658 with a potential saving of £85,204 for admissions prevented between the hours of 04.00 and 8.30 and £34,368 for admissions prevented by caring for residential home patients in their own home. This would mean the development of the team would be cost neutral with a potential reinvestment to the integrated system of at least 11,914 per year.

Associated Costs

4.9 We do not envisage that scaling up this pilot will mean an increase in the staff needed in residential homes, as the carers are already providing 24 hour care for the residents, and the aim of the project is to provide better quality care. The extra support for patients at their last stage of life will be provided by District Nurses with a potential for CHC funding. However, social care have highlighted that we need to monitor this closely and evaluate if we are seeing an increased pressure on residential homes by people remaining in their place of choice, rather than being moved to a hospital or nursing home bed. Extra equipment such as profiling beds for end of life patients would be provided by District Nurses, as it would if they were in their own home. If, however, we see more people dying in their place of choice this may be a pressure.

Intermediate Care Pilot 4
Intermediate Care Assessment Team for falls

5.1 An Intermediate Care Assessment Team (ICAT) has been developed which provides assessments for patients who fall in the community within 24 hours of receiving a referral. The majority of referrals are currently received via the North West Ambulance Services (NWAS) but the community alarms service, district nurses and active case managers also have access to this service. In addition, a pathway has been developed to accept referrals from A&E and the rapid response team to avoid hospital admissions where appropriate.

Performance

5.2 Since the beginning of the pilot in January 2012, the ICAT team have assessed 44 patients in their own homes; 14 of which have been admitted onto the intermediate care home pathway for ongoing treatment and interventions. The home pathway is a multi disciplinary service for people in their own homes provided by heath and social care.

5.3 It is difficult to assess the actual cost saving from avoiding transporting patients to hospital which would have been the pathway prior to this project. Many patients who arrive in A&E are elderly with chronic diseases and polypharmacy issues that are effectively managed in the community, but whose complexity once they reach hospital may result in over assessment and short stay admissions. This has a

significant cost to the organisation and increased risk to patients from hospital acquired infections, disorientation from their usual environment and complications of immobility. On this basis an average potential saving of **£1000** per deflected admission is assumed.

44 assessments in 13 weeks x £1000 = **£44,000**

x4 for anticipated annual savings = **£176,000**

5.4 At present the team have not been actively publicising this service in order to manage demand. As more time is invested into the promotion of the service with NWAS, and other health and social care partners, it is anticipated that the level of referrals will increase. New referral pathways have been developed but have not yet been advertised due to the risk of not being able to meet demand.

Scaling up for Sustainability

5.5 We would need to provide clinical staffing to enable both the assessment of patients and the provision of care / therapies for 15 extra places on the homecare pathway. All administration and management costs will be absorbed by the existing intermediate care service.

5.6 As the same staff will be providing both the ICAT assessments and the extra capacity on the home care pathway, when the extra 15 home care pathway places are filled there will only be enough capacity to assess a maximum of 8 new patients per week. For this reason demand and flow will be monitored closely over the year.

5.7 The cost of increasing the team would be £176,000 with an assumed potential saving of £176,000, which would mean the development of the team would be cost neutral with a reinvestment to the integrated system of 000.

A Patient Perspective

Patient A had multiple falls at home and made frequent 999 calls to NWAS.

Following assessment by the ICAT team the patient had a number of interventions over a 6 week period including; decluttering of the home environment, a review of medication in close liaison with the GP, physiotherapy to improve strength and balance, practical instruction on self lifting techniques, and outside walking practice with a walking aid so that the patient can now do his own shopping.

Since discharge, the patient has made no further calls to 999 and describes how the ICAT service has increased his independence and confidence and prevented unnecessary trips to A&E.

Associated costs

5.8 At present we do not believe that the scaling up of the falls project will have an impact on Community Alarms, apart from the monitoring of fallers and the potential to be able to alert ICAT of any patients that the team feel will benefit from an assessment. There is also the potential for Community alarms to alert ICAT concerning any identified repeat fallers, so that ICAT may be able to assess and help with any obvious needs. Social care have highlighted that any pressure on capacity in other parts of the system will need to be assessed as the pilot is scaled up.

5.9 There is a separate project between NWAS and MCC in respect of developing "falls lifting service" from low category / C fallers. This piece of work is separate from this pilot and any dependencies would need to be assessed as the pilot is

rolled out, but it is our assumption that the lower category of risk patients that are currently referred to ICAT from NWAS may then be referred from Community Alarms.

Evaluation and transactional redesign

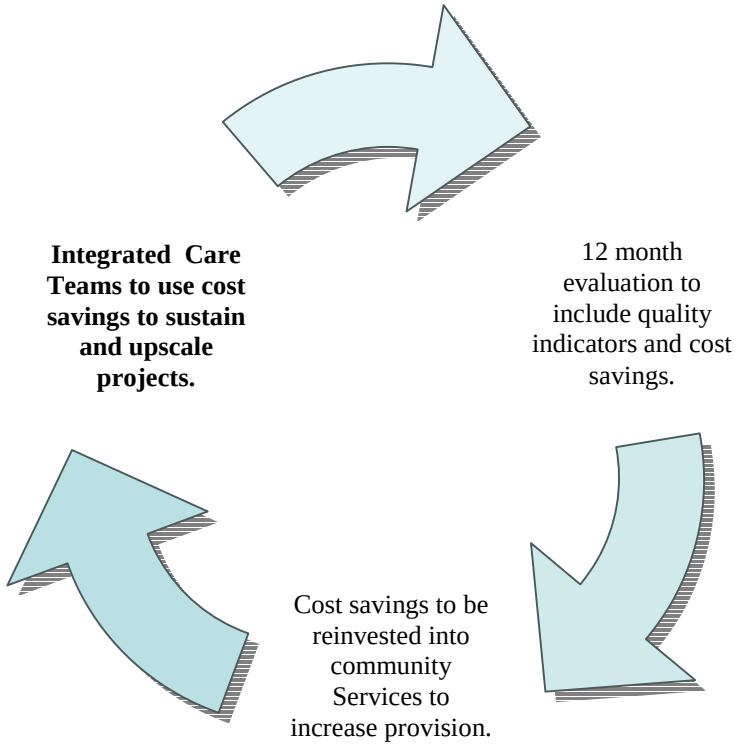
6.1 Each pilot has produced data, however if the proposal is approved further work will be put in place to continue to develop clear metrics and patient engagement processes, giving quantitative and qualitative information. Community Services will work closely with informatics to build a robust evaluation framework to monitor the activity and impact of these projects over time, and make projections for cost savings over the year. This data will be shared with the Intermediate Care Task Force, Transforming Community Service Board, Transactional Redesign Board and the Clinical Integrated Care Board, to review the impact on the urgent care contract and the wider integrated care system.

6.2 We also acknowledge that there is a city wide CHC pilot being undertaken which will be evaluated in the near future. However, even though this intermediate care pilot provides care for the same category of patients it does not duplicate the city wide pilot; i.e. an individual patient would only experience one of the pathways. The intermediate care pilot provides the assessment and screening process for patients whilst they are in an acute bed, rather than the city wide pilot which transfers patients from an acute bed to a nursing home bed to await the assessment and screening process.

6.3 It must be stated that the traditional financial model is to create savings by closing beds/wards. In such a framework the assessment of the overall impact on CMFT beds through the implementation of the 4 pilots would be a reduction of 15 beds. This would produce a savings of £388 based upon savings calculated on pay costs, with non-pay costs being apportioned. This would then leave a calculated short fall of £183k.

6.4 It is our assumption in this paper that closing beds does not save the system the resources it needs to build community services. We need to more fully understand the wider capacity and business model of the FT. We need to appreciate admission and lengths of stay for these patients may be reduced, and services moved into the community. However, capacity may remain open for CMFT to use and generate income from other commissioners in areas such as specialist and tertiary services.

Diagram to show cycle of development and reinvestment



Summary

7.1 The Intermediate Task Force have demonstrated how complex patients can be successfully managed in the community using specialist services and integrated teams. The Care pilots models designed will have a positive impact on ambulance call outs, admissions to hospital, length of stay and end of life care in the community.

7.2 Small data sets are prone to random variation, and therefore success is harder to measure. However, the evidence collected so far suggests that it is possible to provide quality care in the community providing that processes are in place for regular monitoring, evaluation and transactional redesign.

7.3 So far, the intermediate care pilots have been carried out within existing resources and therefore it has only been possible to release a finite amount of clinical time and pilot the new service models on a small scale.

7.4 The progression from these fairly small pilots has been described, and the proposed five year vision, building incrementally on each work stream will deliver a system fit for purpose. It will enable care closer to home for many more people, reducing dependency on inpatient services whilst continuing to deliver safe and effective quality care.

7.5 The risks for up scaling these pilots and achieving the projected savings can be summarised in three main points

- Recruitment, retention and training of a permanent rather than agency workforce.
- The system not enabling funding to be released to provide sustainable community services.
- The success of the integrated teams to support wider intermediate care models.

7.6 There is also a risk of doing nothing, and not learning from the pilots, which will be disempower staff who have been involved in this work over the last twelve months.

This could adversely affect the enthusiasm required to work within the integrated model making the implementation more difficult.

7.7 To reduce the risk to the workforce it is recommended that the extra posts are funded on a permanent basis, with the agreement that if the outcomes are not achieved natural wastage from the teams will take place over a period of time to reduce the workforce back to its funded establishment. This would be made explicit to team managers prior to recruitment. A committed workforce is essential and this cannot be achieved through temporary or expensive agency staff.

7.8 Although these projects have not yet been formally advertised, knowledge of the pilots has spread and the number of referrals has increased. If future funding is not agreed, these pilots will no longer be able to continue and a strategy for withdrawal will need to be developed.

Transactional redesign

	Impact	Resource required	Projected savings	Other benefits	Issues / Risks	Possible Consequences
CHC	Reduction of average LOS for assessment from 38 days to 19.5 days for 2 patients. = 37 bed days = **£9250***	**£104,000**pa for an integrated care coordination Staffing at mid-point: 1x B7 Nurse 1x B7 Social Worker 1x B3 Support Officer	*Based on 10 new assessments per month* If the assessment and discharge process is reduced from an average of 38 days to 19 days for all assessments this would save 2280 bed days saving **£570,000** pa* If reduced to 15 days, as in Stockport this would represent a reduction of 2760 days saving **£690,000** pa.	• Provision of training & specialist advice to other health and social care staff. • Improved patient experience • Meets DoH guidance • Less complications for frail elderly due to extended LOS	The complex nature of frail elderly can result in deterioration and change of circumstances with little notice. There is currently a city wide CHC pilot which provides care for the same category of patients	Impact on social care if throughput increased beyond the pilot expectations
COPD	4 out of 5 admissions avoided in 8 weeks x £2665 = **£13,325**	**£183,000**pa to build extra capacity inc weekends Staffing at mid-point **ACM** 1x B8a ANP (inc OOH) 1x B7 (inc OOH) 1x B5 **COPD team** 1x B6 (inc OOH)	= 80% of admissions saved in pilot would suggest that **460,364**pa could be saved at current level of admissions	• Provision of ACM cover 7 days a week. • GP QOF data • Locality CCG priorities	Impact on OOH Impact on Primary Care Relies on integrated team Disease incidence can be unpredictable and vary from year to year	Less Call outs for NWAS Less call outs for OOH Impact on social care if Tele Health was rolled out in terms of kit and the MCC contact centre
EoL	Due to the small nature of the pilot impact has not been realised yet as no deaths have occurred for the duration of the pilot in the three homes involved.	**£107,658**pa for a relief nurse and DN OOH cover Staffing at mid –point: 1x B6 relief nurse 1x B6 DN (inc OOH) 0.8x B5 DN (inc OOH)	Saving 50% of hospital admissions between 4 and 8.30 from the whole of Central Manchester and 50% of admissions for eol from residential patients = £119,572 based on NICE estimate that the average cost of an inpatient admission in the last year of life that ends in death is £2506.	• Provision of DN cover 24 hours a day. • National End of Life Care Strategy	Engagement of care homes Impact on Primary care	Less Call outs for NWAS Less call outs for OOH Less patients stepping up to nursing care Impact on carer and equipment capacity in homes
Falls	44 admissions avoided in 13 weeks x assumed admission cost of £1000 = **£44,000**	**£176,000**pa for clinical staffing to provide assessments & 15 extra places on the home care pathway. 1 x B7 2 x B6 1 x B5 1 x B3	*Minimum saving - Based on current level of referrals* **44,000 x 4 = £176,000**pa	• Citywide JSNA expected June • Improved mobility and independence for frail elderly • Pathways and integration with other organisations across health and social care	NWAS engagement Data clarity due to coding of falls in A & E Out of area NWAS crews affecting uptake of referrals	Less Call outs for NWAS Less call outs for OOH Impact of the NWAS and Community Alarm pilot
		Total £570,658	**Total £1,325,936**			

* Based on the cost of a basic bed day for elderly care 2010/11 **Average cost of a hospital admission for COPD 2010/11

Recommendations

8.1 The CICB is asked to consider this paper and the following recommendations:

- To agree the additional funding to upscale the four pilots, depending on implementation this will incur part year costs and related potential savings.
- To agree the staff can be appointed on permanent contracts.
- To commit to any potential savings being reinvested in the integrated system.
- To agree that the process for performance and transactional redesign will be over seen by the transactional board.

Kate Tattersall
Sara Radcliffe
Chris Lamb
May 2012

Example 3- Integrated Care Teams

1.0 Introduction

The CICB received a proposal to develop integrated care teams at its meeting in March. The CICB approved the project proposal and also a first call on the CICB investment fund of £200k.

The CICB requested that a leadership team from Central Manchester CCG (CMCCG), Central Manchester Foundation Trust (CMFT) and Manchester City Council – Adult Social Care (MCC).

The CICB requested a report at its May meeting to provide an update of progress towards establishing teams phased from October 2012.

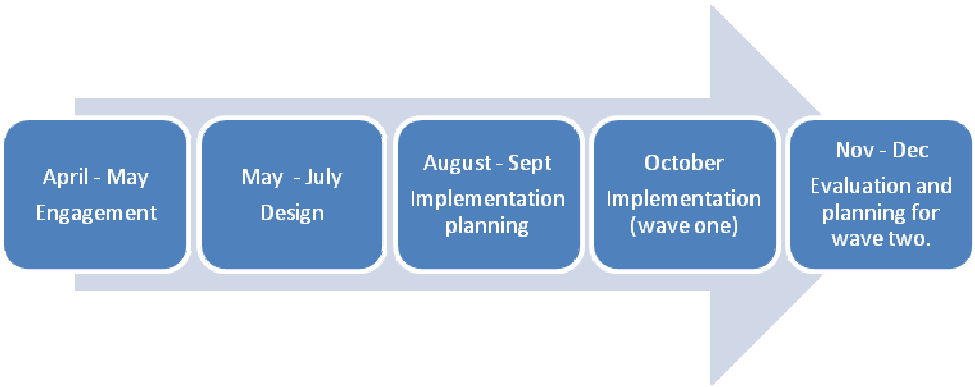
This report updates the CICB on development of the Integrated Care Teams.

2.0 Outline project plan

2.1 Milestones

The milestone plan for the teams is shown in appendix one.

A summary of this is shown in the figure below.



2.2 Proposed use of resources

The proposal agreed by the CICB allowed an initial fund of £200k to be made available to the leadership team to put in place the initial steps in place to progress the project. The schedule below shows the expected costs of development of the project. This schedule is not in addition to the initial call of £200k.

It is important to note that this factors in no investment in front line staffing other than each team having a 'facilitator role'. The first waves of the programme will include assessment of the impact upon services to deliver this model of care sustainably.

Description	Cost
Project manager	£70k
Information technology This will fund developer time to produce an online care record to support the team's management of patients. It is hoped that this funding can be recouped by a bid to NHS GM's IM&T Funding	£100k
Clinical backfill Funding to support clinical time where necessary.	£50k
Integrated care team – facilitators Each team will need an individual to ensure that the overall work of the team is coordinated well and the groundwork for developing case conferences etc. is in place	£40k 4 x 0.5 WTE for six months Likely to be a recurrent cost.
Evaluation The leadership team is keen that the project is evaluated effectively and independently. This cost may span more than one financial year.	£30k
Patient engagement At the March CICB this funding was approved to develop patient engagement in this work.	£10k
Funding yet to be determined The project is still in an early stage of development. The leadership team would like to build some funding into the plan to use at their discretion.	£100k
Total	**£400k**

3.0 Progress since the March CICB

Leadership
The leadership group has met on a number of occasions and the Taskforce has now been established. A project manager is yet to be appointed.

Development of teams
Fifteen GP practices have put themselves forward to be Wave One practices, representing over half of Central Manchester's registered population. This is a greater number than planned. In order to maintain enthusiasm we will work with all fifteen practices but will implement the teams gradually from October. A list of the practices, with patient numbers, is shown in appendix two.

The team have met with various practices and services to brief them on these proposals. The proposals have been met with enthusiasm.

The Quality and Productivity element of GP QOF has been designed around development of teams. All 40 GP practices will do a practice level review of a sample of their high and very high risk patients. They will produce a report based upon their practice profile. They will then peer review these reports on a locality basis. The team will then have four locality level profiles to build the design towards. The teams will need to have a certain commonality in their design but may have a different emphasis based upon local needs.

Enabling workstreams

A summary of progress in the enabling workstreams is as follows:-

Information Management and Technology

Risk stratification

NHS Manchester already has the infrastructure in place to extract data for this purpose and has the basis for online reporting. The risk stratification tool is in place and patients lists can be produced manually. The online functionality for this is expected to be in place for July.

Online healthcare record

This is the bulk of the investment in IMT outlined below and will give an online record for the patient that teams can access.

Shared Care plan

Ideally the teams would have access to an online careplan. This is not considered feasible in the first phase of the service development.

Evaluation

Evaluation of success will be built into the programme and will be able to measure results at a patient, practice, locality and Central Manchester level.

Finance

This workstream is in the process of forming and is linked into the citywide work on community budgets. The Greater Manchester team are supporting development of a cost benefit analysis which will be used to measure the overall financial implications of the service model.

Specialist inputs

This workstream is in the process of forming and work is underway to look at how specialist clinical inputs may be accessed via teams. The GP audits will add more detail to the nature of inputs required.

Evaluation

The leadership team are keen that the service model is thoroughly and independently evaluated. Manchester University and MAHSC have been approached in this regard.

We are seeking to use one of the King's fund faculty days to support the development of an evaluation framework.

Patient Engagement

A CICB patient engagement forum has been established which includes engagement leads from partner organisations. This group will start to pull together existing engagement information to support development of the teams. Patient diaries are being developed to issue to potential patients for the service. These will give the team a picture of the experience of care planning from the patient perspective and will influence how the teams operate. It will also act as a baseline for evaluation.

Organisational development

This is being held at the Taskforce as it is a key requirement for implementation. However, workforce planning has been identified as a gap in our planning. This is being followed up.

Citywide working

A Citywide Integrated Care Reference Group has been started which ensures that infrastructure is developed together in order to ensure compatibility and increase cost effectiveness. This Citywide reference group will focus upon IM&T, finance and performance monitoring. The group includes the CCG and Trust from North, Central with the City Council. The invitation has been extended to the Mental Health Trust and NWAS.

The King's fund

As part of the King's fund discovery community there aer a number of days of King's Fund faculty time to be accessed. These are planned to be used on developing an evaluation framework for the model, supporting development of clinical leadership in and around the teams and giving an objective critique of the model we have developed.

4.0 Key risks and issues

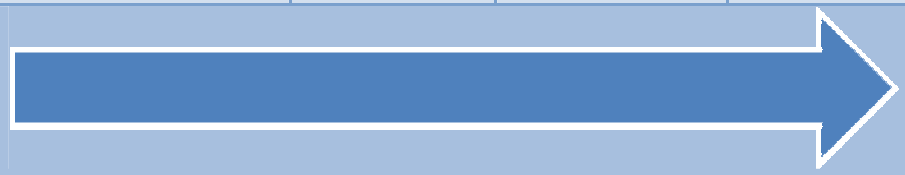
Key risks are as follows:-

- Delivery timescales will remain a risk throughout the programme.
- Information governance arrangements are not yet clear
- Identification of a project manager to manage the day to day running of the project.

5.0 Action for the CICB

- The CICB are asked to note this report.

Milestone plan

Work programme	April	May	June	July	August	September	October
Leadership	• Identify leadership	• Establish taskforce • Identify project management • Identify enabling workstream leads	• Maintain overall leadership, tracking and strategic direction				
Team development	• Identify wave one practices • Briefing of practices and teams	• Design GP patient audit	• Practice audit report complete	• Locality level audit complete • Patient diaries issued • Define core team	• Patient diary results • Core team identified	• Core team in place	
Specialist input		• Identify workstream lead	• Workstream scope completed	• Define specialist inputs		• Mechanisms designed for specialist advice for teams	• Specialist inputs in place for teams to access.
Finance		• Identify workstream lead	• Workstream scope completed	• Cost benefit model defined	• Baseline information completed	• Outline business case for scale up developed	• Tracking of impacts starts
Informatics		• Identify workstream lead	• Workstream scope completed	• Online risk stratification tool complete	• Baseline information complete	• Online performance monitoring tool in place	• Online health record phased implementation starts
Evaluation		• Identify workstream lead	• Workstream scope completed	• Evaluation criteria complete			

HR and OD		• Identify workstream lead	• Workstream scope completed				
Patient and public engagement		• Identify workstream lead	• Workstream scope completed • Patient diaries designed	• Desktop reviews complete			

Wave one practices

Practice – First wave	List Size	High and very high risk patients
Chorlton, Whalley Range and Fallowfield		
Princess Road	4,158	49
Chorlton (Ratcliffe and Chew-Graham)	3,434	37
Alexandra	5,904	69
Ashville	7,061	72
Chorlton (Chen, Davies and Chavdarov)	3,254	30
Gorton and Levenshulme		
West Gorton	5,899	77
Gorton Medical Centre	8,849	132
West Point Medical Centre	7,329	90

Ardwick and Longsight		
Ailsa Craig	8,843	77
Dr Cunningham	7,039	77
Longsight medical practice	4,691	35
Moss Side, Hulme and Rusholme		
Moss Side family practice	2,531	13
Cornbrook	9,958	60
Wilmslow Road	4,081	33
The Arch Medical Practice	9,985	65
Total	**116,827**	**1,173**