Manchester City Council
Report for Information

Report to: Manchester Health and Wellbeing Board – 14th November 2012

Subject: Community Budgets Update on Progress and Outcomes

Report of: Geoff Little, Deputy Chief Executive, Manchester City Council
Liz Bruce, Strategic Director, Adults Health and Wellbeing

Summary

This report updates the Health and Wellbeing Board on progress and outcomes of the GM Whole Place Community Budget Pilot at three levels; a) the overall pilot; b) the Health and Social Care theme; and c) Manchester's reforms and links to the McKinsey study.

Recommendations

1. To note the contents of this report.
2. To receive an update report from the Executive Health and Wellbeing Group on how the Manchester reforms should be re-shaped in light of this Board's consideration of the McKinsey study.

Board Priority(s) Addressed:
Primary HWB Strategic Priority 1-8

Contact Officers:

Name: Geoff Little
Position: Deputy Chief Executive, Manchester City Council
Telephone: 0161 234 3280
Email: g.little@manchester.gov.uk

Name: Liz Bruce
Position: Strategic Director, Adults Health and Wellbeing, Manchester City Council
Telephone: 0161 234 3280
Email: liz.bruce@manchester.gov,.uk

Background documents (available for public inspection):

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

Greater Manchester Whole Place Community Budget: The Health and Social Care 'Theme Narrative'.

1.0 Introduction

1.1 This report provides an update on the progress of the Greater Manchester Whole Place Community Budget pilot. It highlights progress at an overall programme level within Greater Manchester and progress within the health and social care theme within Manchester.

1.2 The Health and Social Care 'Theme Narrative' is available as a background document. This articulates the challenges facing the health and social care system at a GM level, the case for change, what a new system should look like and implications in terms of money flows and barriers to change.

2.0 Background to Community Budgets

2.1 Greater Manchester is driving a programme of public service reform over the next three to five years. This programme is firmly embedded in a refresh of the GM Strategy and is designed to make a significant contribution to the GM priorities of:

- Reducing high levels of dependency and demand for a range of public services in the context of declining public spending
- Ambitious growth plans and helping people to connect to opportunities, reduce worklessness, improve skills and workforce productivity.

2.2 Within this long-term programme The Whole Place Community Budget (CB) pilot was a key short-term opportunity to work closely with Government departments and local partners to rapidly increase the pace and scale of change, and unblock barriers to more effective, integrated public services across GM.

2.3 The purpose of the initial pilot phase, operating from March to October 2012, was to prove key concepts of new delivery models and new investment models to national and local stakeholders. In particular, forensic cost benefit analysis; robust evaluation principles; designing and testing new delivery models; and determining where and how investment agreements can unlock some of the barriers to the movement of money flows across the public service systems in GM.

2.4 Health and Social Care is a key strand of the pilot, alongside work and skills, reducing re-offending, early years and troubled families. The priorities for the Health and Social Care theme in particular have been to articulate the case for change at a GM level to secure buy in from public service leaders that doing nothing is not an option; influence the system at a GM level, in particular the Healthier Together programme, recognising that acute sector reconfiguration cannot operate in isolation; supporting the development of exemplars which exemplify the community budget approach; and identifying projects that can be scaled from a local to GM level.

2.5 Across each theme, an underpinning principle of the work is that the upfront investment should be paid back through savings across the public sector, some of which can be captured locally through investment agreements. However, beyond a certain scale, this requires savings captured by the exchequer and national commissioners to be reinvested in local public

services within GM. At present, national systems and structures of financing, commissioning, delivery and accountability create barriers to Community Budgets operating at scale.

3.0 Progress and Outcomes at the Community Budget Programme Level

3.1 The pilot has been an opportunity for GM to co-design these propositions both on a cross organisational basis within GM and between GM and Whitehall. The strategy within the pilot has been to focus on those propositions that best evidence the above to achieve partner and Whitehall buy-in to a co-design/GM deal over the 3-5 years of GM's public service reform programme.

3.2 This approach has been reasonably successful and much excellent work has gone into developing new delivery models with detailed business cases. Government seems to be "in-principle" convinced about the need to move resources across organisations. Investment agreements have proved challenging but there are examples of very good progress being made including in Health and Social Care and troubled families (both progressing well in Manchester).

3.3 At an overall programme level, progress includes:

- New delivery models developed in each thematic area, focused on taking demand out of the system
- Understanding the ways in which resources can flow across organisational boundaries to support new delivery models
- Investment models in development across a thematic areas.
- Robust Cost Benefit Analysis tested by the Technical Advisory Group (a group of financial analysts from HM Treasury and from across Whitehall)
- Local and national 'asks' developed across the thematic areas identifying what needs to be changed to enable delivery
- Senior support for developing collaborative proposals across the whole public sector
- Whole system deep dive work identifying radical options for future public sector
- Input to a national toolkit to support wider roll out of the Community Budget approach

3.4 The implications of the Community Budget initial pilot phase includes:

- Adoption of core principles, organisation and implementation of new delivery models
- Single and common outcomes and performance frameworks built around needs and effective early intervention
- Common assessment frameworks
- Commonly applied referral pathways to consistent evidence based interventions (on basis of need)
- Decommissioning non-evidenced based interventions

- Joint, strategic commissioning and procurement of interventions at most appropriate spatial levels
- Joint integrated workforce
- Investment in early intervention and prevention
- Quality assured Cost-Benefit Analysis via Technical Advisory Group meetings with Treasury and other departments

3.5 Key next steps are set out in each of the thematic narratives and business cases, but at a high level include:

- November 2012 to end March 2013 – continued development of investment agreements with key partners, further developing new delivery models;
- March 2013 onwards – implementation at scale and pace over the next three to five years, embedding into organisational budgets and strategies such that Community Budgets become business as usual.

3.6 The aim now is for GM and Government to continue co-design of public service reform, based on the principles of the Community Budgets work. The features of this relationship could include a 'place based settlement for GM' that aligns funding and financial incentives currently driven through separate Government departments and agencies for both public services and economic growth; greater devolution of system controls that maximise the benefit of these financial incentives; and a rebalancing of local and national accountability.

4.0 Progress and Outcomes within the Health and Social Care Theme

4.1 Within the Health and Social Care theme, significant progress has been made towards the reform required to address the fundamental challenges of improving health outcomes; tightening budgets; increased demand pressures; and a fragmented and disconnected patient experience. The key messages from the GM Health and Social Care business case are attached at Appendix A.

4.2 The Health and Social Care theme has made the following progress:

1) Articulated the financial flows at a GM level and the relationship to wider public service reform ambition, in particular the unaffordable cost of doing nothing and the implications on costs and outcomes of people with multiple long term conditions
2) Supported 5 business cases to understand for each: the case for change, the money flow, the new delivery model and the asks of government, including:

    - Manchester Integrated Care
    - Dementia (Psychiatric Liaison, Memory Services, Primary Care)
    - Fit for Work
    - Falls and Fire and Rescue Service
    - End of Life Care

3) Achieved progress towards Investment Agreements between partners, including for example a Service Level Agreement between Manchester City Council and Central Manchester CCG to fund the proof of concept phase of the new delivery model

4) Particular focus has been on influencing the leadership debate within GM, in particular, the interconnected nature of the GM acute system and locally derived models of integrated care.

5) Asks of Government have been informally and formally channelled into Whitehall, with positive engagement and understanding of opportunities such as a three year budgeting cycle for selected CCGs as apposed to annual.

4.3 The theme team working on the health and social care theme has engaged intensively with leaders across the health and social care system to secure a shared vision for reform. See Appendix B for the vision.

4.4 Delivery of this vision at the necessary pace and scale requires significant changes in the way the health and social care system operates in GM currently. The team proposes a number of recommendations to achieve a substantial reduction in unplanned admissions to hospital and care homes for the over 65 population in both the short and long term. See Appendix C for the recommendations.

5.0 Progress and Outcomes of Manchester's H&SC Reforms

5.1 The theme narrative highlights the interconnected nature of the Greater Manchester health and social care system, in particular the acute sector and locally derived models of integrated care in each GM District (the "1 &10" solution). This is reflected within Manchester, with a need to secure the financial sustainability of the acute sector, move care closer to home and as a result improve quality and outcomes and reduce costs. To achieve this, two key strands of work were established:

a) Development and co-design of three new delivery models using a Community Budget approach for integrated care, implementing three proof of concepts in North, Central and South Manchester; and

b) Co-investment into a Health Study by McKinsey to review the performance, quality and financial sustainability of the health and social care system in Manchester, resulting in recommendations for the future shape of the Manchester system.

Taking each in turn, in March 2012, Manchester City Council and NHS Leaders across the Manchester health economy agreed the development of a proof of concept to inform a new investment framework for integrated Health and Social Care using a Community Budget approach. The original purpose of this work was 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. The Manchester Integrated Care Business Case which describes at a summary level the

models, rationale and costs and benefits of the new delivery models within Manchester is attached at Appendix D.

5.2 Since then, joint teams from the CCGs, Acute Trusts and City Council have co-designed new delivery models in North, Central and South Manchester. Detailed work has been undertaken to understand the at risk cohorts; the costs and benefits; patient flows; clinical pathways; and data sharing implications of new delivery models in the community and closer to home.

5.3 Each area is now moving towards the implementation phase, as follows:

- Central Manchester – Practice Integrated Teams started work in Central Manchester from the end of October 2012. Wave 1 includes 13 GP Practices working with district nurses, active case managers and social workers to support and case manage Very High and High Risk patients. Wave 2 will commence in January 2013.
- North Manchester – Integrated Neighbourhood Care teams will start work in January 2013, focusing on GP practices in one patch initially, with rollout through the remainder of 2013. The North project team are also developing a model for increasing health literacy and self care for patients with moderate needs and risks
- South Manchester – are launching 3 specialist integrated care pilots in November 2012, focusing on patients in the following groups – Respiratory Care; Diabetes and Stroke. Redesign of the community health and social care services is in a consultation phase, with implementation to start in April 2013.

5.4 In designing and developing the new delivery models, key achievements include:

- Three co-located hospital teams established at NMGH, MRI and Wythenshawe
- Two hospitals with single management posts (NMGH & Wythenshawe, MRI to follow)
- Implemented NHS Number as a Key Identifier in Adult Social Care, enabling secure information sharing with health partners
- City Wide Information Governance working group established Agreed Protocols and Information Governance Agreement Template to expediate information sharing under a framework agreement.
- Sharing of financial data across partners to inform estimated costs and benefits from New Delivery Models
- The Local Medical Committee for Manchester GPs has approved data sharing for Integrated Teams
- The Graphnet Gateway is being developed on behalf of the three CCGs in Manchester. It will hold GP, hospital and social care information in a shared Care Record, which will enable for the first time a single source of information on patient needs (and risks). This will go live in November 2012.

Please refer to the attached Business Case which provides further detail on the Manchester integrated Care proposals.

5.5 The summary findings of the Health Study, undertaken with McKinsey will be presented to this meeting of the Board. Taken together, the Community Budget and Health Study work highlight:

- The unsustainable nature of the health and social care system in Manchester as a result of demand pressures and budget cuts;
- The need to adopt new models of care across primary, secondary, community and social care that deliver better outcomes at lower cost;
- The competing pressures of scaling up quickly to respond to the financial and quality challenge at the same time as developing the evidence base to inform that scaling up;
- A single place based solution for Manchester as being essential, agreeing a shared vision and co-designing new delivery models across the City Council, the three CCGs and Acute Trusts;
- The need for the Health and Wellbeing Board to provide a leadership role in supporting the development of new funding and delivery models for health and social care, bringing together the programmes for acute sector reconfiguration and integrated care;
- The interconnected nature of the Greater Manchester Healthier Together programme and the Manchester system, and the need for continued leadership from the Board in terms of the future shape of services within the City.

In summary, both the development of new models of integrated care using a Community Budget approach and the findings of the Health Study illustrate the scale of the challenge facing the health and social care system in Manchester but also practical options for the way forward that respond to the fundamental question of how can we deliver better quality care for less money.

APPENDIX A

Health and Social Care Key Messages

As is

- Health and Social Care System in GM is £6bn. 42% is in hospitals, 18% in adult social care.
- Older people account for 62% of total bed days, 68% of emergency bed days, and 75% of council funded registered nursing and residential care home funding.
- Of the 6,790 beds in GM, 2,037 are occupied by people with multiple long term conditions, equating to 743,505 bed days annually at a cost of £800m - £1.2bn annually.
- Of those bed days, the average number of admissions per person with long term conditions is two, with a length of stay of 20.7 days. 75% are likely to be unplanned or emergency admissions.
- North West Ambulance service estimate that in GM 24% of emergency ambulance journeys are accounted for by those who have fallen, most of whom are older people.
- Current spend is locked in to reactive and unplanned admissions, mostly for older people, for want of alternative community based provision. Such spend is unaffordable, and not delivering best outcomes.

To be

- Whole system commitment to new or scaled delivery models to deliver substantial reduction in unplanned admissions to hospital and residential/nursing homes. **Avoidable admission to be recognised as system failure.**
- High quality specialised hospital services to be concentrated around clinical 'critical mass'
- In primary care the need to reduce unwarranted variation, increased primary care access and capability potentially through agreements between practices, a focus on empowerment of patients towards self care, and a broader population health perspective.
- Reformed primary and community health services, and social care ready to sustain a fundamental shift in activity from hospital to the community
- Creation of locally derived integrated models of health and social care delivery, building on new partnerships with Clinical Commissioning Groups (CCGs), Local Authorities and others.
- Systematic and large scale deployment at a local level across GM of interventions that can reduce future demand for services.
- Diverse market, including engagement of current providers of hospital services in design of future model.

Reform

- NHS GM proposals for reconfiguration of acute trusts in GM to public consultation April 2013

- Stocktake of all locally derived models of integrated care identified in report in Nov. 2012
- Scaled implementation at pace of agreed GM wide interventions
- Evidence base for integration to be developed and shared as we proceed with current and future local plans
- Exemplars and Business Cases and CBAs for 4 elements of local integrated plans, with scope for wider adoption across GM
    - Integrated Care in Manchester
    - Dementia Care
    - Falls Risk Assessment
    - Fuel Poverty in Oldham
- As a result of demographic change we do not believe we can extract cost savings across the system as a whole beyond immediate efficiency savings required in NHS and LAs.

Agreement and next steps

- Agreements in place/under development across GM – e.g. Manchester, Salford, Oldham, Stockport
- Implementation plan for wider narrative report in development
- Core ask of government is direct DH and Monitor support to GM for exploiting tariff flexibilities and competition/integration guidance, and commitment to 3 year CCG budgets.
- Across GM we cannot afford to leave this to chance. We need at least to secure alignment of vision and implementation via shadow GM Health and Well Being board or another cross GM forum backed by the Combined Authority and the joint work of the Council of GM CCGs

Health and Social Care Theme Contents

- Narrative Report
- 4 Exemplar Business Cases
- Supplementary Papers

APPENDIX B

Community Budgets Health and Social Care Vision

Overall Vision

There needs to be a substantial reduction in the number of unplanned care admissions in all parts of GM.

This will deliver better outcomes for patients and clients in a more financially sustainable system

The trigger for doing this is the reform of the interdependent acute hospital system in GM – “Healthier Together”

Successful implementation of Healthier Together requires increased capacity and capability of primary care, social care and community services and the necessary shift of resource to sustain it

To deliver this at scale there will be a new, consistent and agreed relationship between the operation of locally derived integrated care models across each of the 10 local authority areas and services requiring a GM wide planning and delivery perspective

Strategic housing planning for older people locally and across GM where appropriate will further focus on the promotion of independence, community resilience and carer support

This vision will be achieved based on a whole system leadership commitment to the case for change and the objectives of the reform, by the establishment of a system of governance to ensure alignment of cross system working, and by a joint commitment to a system rather than organisational specific outcomes framework.

The reform will be co-designed with public and patients, focused on increasing personalisation and supporting increased carer and community resilience

GM will develop and collectively own a population wide and targeted health and wellbeing interventions that tackle the “on flow” of future demand for older peoples services, as well as addressing health inequality, and promoting independence

APPENDIX C

Report Recommendations of the Health and Social Care Theme

The recommendations are to:

1. Secure agreement across the leadership of the health and social care system in GM on the case for change, on the scale of reform required, the priority of reducing unplanned and avoidable admission, and an agreed system wide joint outcomes framework across GM.
2. Develop the necessary governance arrangements to deliver this scale of reform. This could be achieved through a recasting of existing arrangements (e.g. through a Public Sector Reform Executive and the GM Health and Well Being Board), or a wider governance framework including national partners as part of a City Deal with Whitehall.
3. Implement a joint NHS/LA senior leadership and middle management development programme to create the trust and cultural change required to deliver this scale of reform.
4. To support and strengthen the work of the Healthier Together Programme and ensure whole system leadership commitment to the principles of acute services reconfiguration as a trigger for necessary wider system reform
5. Create a programme of work to support the implementation of the 10 integrated plans (covering each of the local authority / CCG footprints), and support local Health and Well Being Boards in ensuring that such plans have an interface with GM wide reform and share a consistency of access points.
6. Identify those strands of delivery that are best developed at a GM wide level and ensure co-ordinated and consistent implementation at scale across the City Region.
7. Develop a programme to support innovation in funding and contracting of acute services, to include the exploration of new organisational forms and delivery vehicles.
8. Clarify, support and challenge the primary care reform programme in Greater Manchester to be led by the CCGs, GM CCG Council, Healthier Together, and the GM Locality NHS Commissioning Board.
9. Challenge and support the GM Directors of Adult Services (and GM Directors of Children's Services) to construct robust and integrated programmes of work that exploit economies of scale in GM where possible.
10. Assess and reconfigure as required the necessary information management capacity to secure the development and implementation of system wide information/ joint outcomes information.
11. Clarify as part of a follow up work to the Community Budgets Programme that DH, NHS Commissioning Board, and Monitor establish GM as a national "Accelerator" or "Enterprise Zone" site for health and social care integrated working, with a particular focus on exploiting flexibilities in the

tariff, developing new models of contracting, and securing 3 year CCG budgets.

12. Secure the necessary capacity from within GM and with Whitehall to drive this work forward at pace and scale in context of the wider reform reinvestment proposals to ensure the delivery of these recommendations.
13. Establish a formalised joint programme of work between NHS Commissioning Board, GM Directors of Adult Services, and the GM Housing Officers group to scale interventions to promote independence of older people.
14. Adopt a whole conurbation population health and well being improvement programme, seeking to reduce future demand for services by systematically and at scale addressing determinants of poor population health.

APPENDIX D

Health and Social Care: Integrated Care in Manchester

Executive Summary

Current service models within health and social care are not fit for the coming financial and quality challenge. Manchester needs to achieve a transformational reduction in demand, not just for individual service providers, but across the whole health and social care system. More people will live longer with multiple long term conditions and yet a further tightening of the fiscal environment, with both NHS and Local Authority budgets reducing in real terms, will mean continuing with the 'as is' model is unsustainable financially, or able to deliver the quality of care expected by local residents.

Partners in the health and social care system are continuing to improve value for money and efficiency. But individual organisational efficiency isn't enough. To deliver the scale of reform required, new investment and delivery models are necessary to overcome the split incentive where one partner invests but others benefit.

Manchester's work on integrated care is set within the context of reform to the Greater Manchester health and social care system – a £5.8bn inter-connected system with patient flows and providers operating across local authority boundaries. As well as the development of three integrated care models in North, Central and South Manchester, models are being developed in each of the other nine local authority areas, and at a GM level, Healthier Together is the overarching acute sector reconfiguration programme.

The New Delivery Models in each locality and the associated Cost Benefit Analysis, have been co-designed between Manchester's key health and social care stakeholders, the CCGs, Acute Trusts and Local Authority. The over-riding principle of the Models is to reduce unplanned admissions through coordinated, targeted interventions in the community. However, the three models are different, reflecting the differing health needs and priorities of the local population, with differing implementation timetables and emphasis on particular diseases and cohorts.

It is important to state a health warning regarding the lack of a robust evidence base to support the assumptions, particularly around estimated costs and benefits. Whilst there are examples of integrated care both nationally and internationally, the evidence is not compelling in terms of impact, savings or cashability. That is why Manchester is adopting a Proof of Concept approach, to rigorously test, evaluate and refine the assumptions in each Model to inform both any scaling up activity and the national evidence base.

But ultimately, Manchester has no option but to move away from expensive, reactive services towards proactive interventions – on an industrial scale – that will develop self-reliance, improve quality of care, reduce demand and take cost out of the system. Taken together – a continued focus on organisational efficiency, new delivery and investment models, local integrated care planning and GM wide acute reconfiguration – we have the opportunity to deliver real savings that

will enable us to respond to the future demand pressures within today's fiscal constraints and deliver a better quality of service for our shared customers and patients.

1 Aims and objectives

The Big Idea

More patients are living longer, with more long term conditions. As a result, demand for services is increasing, and is forecast to continue to increase. This is set against the context of reduced budgets in real terms on both health and social care commissioners. Integrated care has been identified as a key route to more effectively addressing the demand challenges posed by people with multiple long term conditions.

Integrated Care makes sense for the patient. It means a better customer experience, better patient outcomes, less confusion and complexity for patient (and carer), and, because it is mostly focused on care closer to home and the community, it presents a real cost saving opportunity to the heath and social care system.

And yet. Integrated care is often talked about and rarely delivered. The complexity of the supply side; divergent priorities; disincentives to invest in new activity or reduce existing activity; cultural and historical differences all conspire to limit the impact of integrated care activity.

The New Delivery Models in North, Central and South Manchester offers an opportunity to test different ways of working to achieve shared goals of reducing unplanned care admissions and reducing the cost of people with long term conditions to the system.

Aims and Objectives

The New Delivery Models in Manchester have been designed with the following long term aims:

- Demand shift across the health and social care system in Manchester, to enable real and cashable savings to be made and re-invested in evidence based early interventions.
- Better health and social care outcomes, including improved management of long term conditions.
- Improved experience for patients / services users and carers – a more coordinated, coherent customer journey; better social connectivity; improved self reported well being; and improved social independence.
- Reduced health and social care costs – particularly acute care costs (e. g. reduced admissions and bed days attributed to people with multiple long term conditions) but also greater efficiencies and de-duplication of services in the community.

Fit with Greater Manchester Strategy and Government Policy

GM cannot afford the continued rise in spending on ill-health. The GM population needs to be fitter and healthier, not only to reduce the cost to the state, but to increase the proportion of working age adults that are in work and actively

contributing to society.

Some aspects of the Community Budgets programme are specifically targeted at helping more people stay in work (such as the Fit for Work programme, or Early Years). However, a significant proportion of the Integrated Care New Delivery Models in Manchester target cohort is the older population, those most likely to have multiple long term conditions and be at risk of hospital admission. So whilst it may not directly increase economic productivity, the key contribution to the GMS lies in reducing the high levels of reactive public sector spend on people with long term conditions – health and social care spend accounts for one third of total public sector expenditure in GM. The New Delivery Models are designed to test whether and how we can reduce demand and invest in more cost effective, evidence based interventions.

The New Delivery Models are also interlinked and interconnected with the 'Healthier Together' programme, GM's acute sector reconfiguration programme. It means that for the first time both Health and Social Care partners are taking a whole system approach to reform.

Nationally, Integrated Care lies at the heart of current NHS priorities. It has been a consistent theme of successive white papers, strategies and priorities over the last ten years. It is also central to the Government's proposed social care reforms. The New Delivery Models draws on recommendations from the King's Fund, Nuffield Trust, NHS Confederation and Monitor.

2 Case for change

The Cohort

The development of the New Delivery Models for integrated care has been developed by the Partners to respond to the demand and cost pressures arising from people with multiple long-term conditions. Each locality is adopting a different approach to its target cohort to reflect the different health needs of the population. For example, In South Manchester, the New Delivery Model is piloting community based provision targeting people with Respiratory, Diabetes and Stroke care needs through a step down model from Hospital. In Central Manchester, a risk stratification approach (using the PARR++ tool) has identified Very High and High Risk patients at risk of re-admission. To give a sense of scale, at a Manchester level, this equates to 6,119 patients.

People with multiple long term conditions in Manchester represent one of the main drivers of cost and activity in the health and social care system. Prevalent conditions include Asthma; Atrial Fibrilation; Cancer; Chronic kidney disease; COPD; Dementia; Diabetes; Epilepsy; Falls including syncope or collapse; Heart Failure & Coronary Heart disease; and Stroke. People with these conditions experience the highest frequency of ambulance activity; unplanned hospital admissions; the highest cost in terms of activity; and prevalence within the local population.

To illustrate the common characteristics of this cohort, 'Mrs Smith', a 75-yr old resident living in Collyhurst (North Manchester), will:

- live on average 10 years of her life with a limiting illness or disability (2004).

- Have a 70% chance of having a longstanding illness and a 50% chance of it limiting her ability to carry out daily activities (2006).
- Have a 23% chance of having 2+ long-term conditions and a 17% chance of having 3+ LTCs (HSE 1997).
- Have a 25% chance of having a mental health problem (Age Concern, Health Survey 2005 data for 65+).
- Have a 20% chance of developing dementia (Dementia UK, 2007).
- Have a 32-42% of falling this year (National Clinical Audit of Falls and Bone Health in Older people, Royal College of Physicians).

Mrs Smith may interact with Primary care – including regular GP visits and district nursing, including out of hours services; Informal care – from family members and neighbours to advice and information from voluntary and community sector providers; Emergency hospital admissions – for example, ambulance services; A&E attendance for falls; Intermediate care – including reablement activity; Social Worker assessment – determining future levels of support; and a Social Care provider – from domiciliary to residential care.

The Rationale for Change

Funding streams for the cohort are split between different commissioners and providers, creating a fragmented patchwork of delivery. Patients and their carers experience a confusing, disjointed service, interacting with multiple professionals, from different service providers, commissioned by different organisations. This results in duplication; reactive and unplanned episodic care; increased hospital admissions; and confusion for the service user. They also experience poorer health outcomes in comparison to other localities in the North West and nationally.

The case for change is built on four key drivers:

I. **Rising demand –** There are currently 50,400 people aged 65 and over living in Manchester. Whilst the number of over 65s will remain relatively static (as a result of movement to other LA areas in GM), the number of over 85s is forecast to rise by 28.3% in the next 20 years[1]. Similarly, the number of people living longer with multiple LTCs is predicted to increase. To illustrate the scale of the challenge, if current delivery and funding models continue as is, the significant majority of the local authority budget by 2024 will be spent on Adult and Children's Services.[2]

II. **High costs –** DoH[3] estimates that people with long term conditions account for 70% of overall health and care spend. They are disproportionately higher users of health services, representing 50% of GP appointments, 60% of outpatients and A&E attendances and 70% of

[1] ONS Data 2011

[2] See LGA analysis 'Funding Outlook for Councils 2010/11 – 2019/20

[3] See various DoH reports and public statements, including Sir John Oldham, National Clinical Lead, QIPP, Long term conditions and Urgent Care, Department of Health (27 June 2011)

inpatient days. Older people with long term conditions account for a significant proportion of all healthcare activity delivered in either an acute or community setting accounting for substantial commissioner expenditure.

III. **Poor health outcomes –** older people in Manchester with long term conditions experience high rates of emergency admissions to hospital (ranked 23/23 in the NW for non-elective admissions aged 65+ per 1000 pop 65+); high rates of non-elective bed days (23/23); and high re-admission rates in the over 65 population group (19/23), in the lowest quartile in the North West region[4].

IV. **Reduced commissioner budgets –** Whilst NHS resources will have grown in real terms by 1.3% between 2011/12 and 2014/15, costs are expected to increase further resulting in the need to save £20bn by 2014/15. Similarly, the Local Authority has made cuts of £160m with £39.5m coming from Adults, Health and Wellbeing. To further compound the case for change, the next spending period is forecast to be even tighter, with further deeper cuts expected across all commissioners.[5]

Incentives and Funding Flows

The implications and challenges of current commissioning activity, funding flows and incentives in the health and social care system are well stated. To summarise, the current incentive and funding model results in:

- A lack of coherence for service users, with individuals interacting with different services commissioned by different organisations.
- Different funding, payment and threshold criteria for different services across the health and social care spectrum.
- Disincentives to deliver new delivery models as a result of existing payment models. For example, the tariff based system within Acute Trusts results in activity based payments – with little incentive to reduce that activity. Similarly service reductions in areas such as public health or housing may increase attendances within the acute sector.
- If one part of the system (be it acute, primary, community or social care) reduce access to their services, there is very often an impact on cost and resources in another part of the system. The system co-exists and is far more interdependent than current funding flows suggest.
- Patients may fall through the gaps in the system if on referral to social care services they are not eligible under FACs. This may result in the identification of significant levels of unmet need as more targeted early intervention services are delivered.
- Measures to reduce demand create additional up front costs for some parts of the system. For example, investment in reablement services to reduce emergency re-admissions results in additional costs for the Local Authority, with the benefits realised within the Acute Trusts.

[4] ADASS / AQuA scorecard, data from SUS October 2010 to September 2011.
[5] GM Community Budget Team Analysis
[6] GM Community Budget Team Analysis

The Cost of Today's Delivery Models

At a GM level, the cost of people with multiple long term conditions is estimated to be in the region of 2,000 beds occupied equating to c750,000 bed days annually, or equivalent spend of £800m to £1.2bn a year[6]. Social care expenditure is over £1bn, with almost £200m on residential care – a particular issue in relation to the high number of patients discharged directly to residential care.

In the development of the Cost Benefit Analysis, local research and analysis by the Partners has been undertaken to attempt to develop a more robust understanding of the existing costs. As an example, the table below illustrates some of the high level costs identified across health and social care in Central Manchester for the 'Very High' target cohort:

Commissioner	Category	Average Cost per Episode
CCG	A&E Attendance	£103
Local Authority	Residential Care	£16,812
CCG	Hospital Admission (Short Stay)	£616
CCG	Hospital Admission (Long Stay)	£2,337
CCG	Excess Bed Days (over Trim Point)	£228

(please see CBA for more details)

3 New service propositions / new delivery models (NDMs)

Overview of the New Delivery Models

Each of the three New Delivery Models for integrated care are being developed locally, with local variations and differences in priorities and delivery strategies in North, Central and South Manchester to best reflect the local health economies, with an overarching Integrated Care Reference Group joining up the three Models at a Manchester level.

At a high level, the New Delivery Models have the following principles:

1) Improved quality of service and patient outcomes lie at the heart of each New Delivery Model, and the impact of each Model will be measured.
2) Patient safety will be prioritised at all times.
3) The integrated delivery models are based on proactive joint health and social care planning and delivery, at a strategic commissioning level down to individual care plans.
4) The New Delivery Model focuses on prevention and early intervention both at hospital and in the community, alongside longer term measures designed to reduce demand. It includes a range of evidence based interventions appropriate for the service user, and includes both risk stratified and disease/condition specific interventions.
5) Clinical Leadership will be central to each New Delivery Model.
6) The New Delivery Model requires changes to services, pathways and

resources across all sectors and departments around the needs of patients / customers.

More specific details of each of the New Delivery Models are available on request.

Please note that for modelling and CBA purposes in later sections of this business case, Central Manchester has been used (as apposed to submitting three lots of CBAs, business cases etc at this stage).

Governance and Accountability Arrangements

An Integrated Care Reference Group has been established to support the development of the New Delivery Models for integrated care across Manchester. The Group has representatives from Manchester City Council; Mental Health; 3 x Manchester CCGs; 3 x Acute Hospital Trusts; together with representatives from the Greater Manchester Community Budgets team. A sub team composed of key Financial representatives from across all organisations has been established to shape the Cost Benefit Analysis.

Governance arrangements for the New Delivery Models vary based on locality. In Central Manchester for example, the Central Manchester Integrated Care Board will oversee the work, with Executive level representatives from all Partner organisations.

4 Changes required

Proposed Differences between New Delivery Models and Business as Usual

The implementation of the New Delivery Models will require changes to clinical pathways and business processes. In addition, more intangible changes are required particularly in terms of culture and non-silo'd working between previously disparate parts of the health and social care system. The differences between the New Delivery Models and Business as Usual differs in each locality, but includes for example:

- Integrated teams at key points within the clinical pathways, at GP practices and in the community, to better meet the needs of patients.
- A single care plan, rather than multiple assessments and separate professional contact, to provide a more joined up and coherent response to the patients' care needs.
- Disease/condition specific interventions in the community nearer the patients' home.
- Strategically planned Joint working between social care and primary care, where traditionally there has been only low level contact and engagement.
- Trialling of a new shared technology platform to enable each part of the health and social care system to access patient data in a secure way.

National Changes Required to Make Scaled Up Activity a Reality

Much of the changes needed to make integrated care a reality are in the hands of local commissioners and providers. In terms of any scaling up activity, the key areas

of support for central government are centred on the following.

- The New Delivery Models have been co-designed by local stakeholders in Manchester. However, collaboration may present a challenge in relation to the choice and competition requirements of the Health and Social Care Act. Monitor is consulting upon the way in which integrated care can be managed in this context.
- At present, apart from the LTC Year of Care Pilots and the work of the King's Fund there appears to be few mechanisms to support innovation in the area of funding and contracting mechanisms. Two related developments are Monitor's role in licensing – which again could be constructed to support integration and the role of the NTDA.
- Data sharing – we need to quickly address the real and perceived barriers to data sharing across the constituent parts of the local health and social care system. Local evidence of what works to feed into a national case for change needs to be developed, and patient privacy representative groups engaged. GM is supporting a framework agreement for information sharing to all partners to use as a template for the development of local agreements.
- On the finance side, with no central funding available to finance large-scale transformation, annual budgeting in the NHS could be a significant barrier to change/transformation. Similarly CCGs will need to collaborate and work on more than an annual budget – these are matters for the NHS Commissioning Board.

Potential for Reducing or De-Commissioning Services

The underlying premise of the New Delivery Models is that savings can be made by reducing hospital admissions for patients with multiple long term conditions and treating patients in the community and closer to home. This will in turn result in freed up bed space / capacity, either enabling savings that can be re-allocated into the New Delivery Models, or a shift in commissioned activity within the acute sector towards specialist and tertiary services. This assumption lacks a robust national evidence base and will be tested during the Proof of Concept phases of the New Delivery Models.

5 Delivery plan for implementation

Project Teams have been established in North, Central and South Manchester, supported by dedicated Project Managers, to lead on the implementation of the New Delivery Models. Both Central and South Manchester begin testing the New Delivery Models in October 2012.

Individual programme plans are available on request.

Key Risks and Mitigating Actions

The table below provides a high level overview of the key risks and mitigating actions to the three different New Delivery Models.

Risk	Action
Implementation – the speed and scale of implementation is slow in comparison to the financial challenges facing the system.	Stakeholders are attempting to balance the need for change vs. the lack of an evidence base and a lack of certainty on the impact of financial flows. A continued collaborative approach is necessary balancing aspirations with the need for change on the ground to happen.
Model Risk – there are significant risks attached to the financial model – the lack of a robust evidence base, the lack of a granular understanding of cohort specific costs, and that the New Delivery Models may not deliver anywhere near the forecast costs & benefits.	The Proof of Concept phases of the New Delivery Models are designed to test the assumptions, rather than firmly committing partners to any particular numbers or targets.
Capacity – At an operational level there are capacity pressures in terms of allocating (and / or recruiting) staff to the New Delivery Models which may slow down NDM implementation.	Partners are resourcing planning now to determine any particular gaps or staffing issues. The smaller scale of the Proof of Concept phase should enable NDM delivery.
Identifying unmet need - By risk stratifying the patients, it is likely that unmet need will be identified within local GP practices, creating a short term spike in demand.	Demand will be tracked as part of the evaluation process and will be factored into the financial monitoring process. Transitional funding is being used to support potential pressures for partners across health and social care.
Evidence for Cost and Benefit drivers – Whilst national evidence (where it exists) and local management insight have been used to determine initial cost and benefit assumptions, they remain estimates. Similarly, a number of gaps remain, including prescribing costs.	Ongoing tracking of costs and benefits will result in replacing estimates with actuals to determine the actual CBA over the lifetime of the proof of concept phase.
Cashability of Savings – both the nature of the costs (predominantly semi-variable and fixed costs) and the ability to reduce future demand need to be tested within the NDM. E.g. If	The cashability of savings needs to be taken in the round alongside the Healthier Together programme within the Proof of Concept phase. Current assumptions at a GM level assume no net benefits, because savings are re-invested to

activity reduces providers will incur retained costs, at least for a period of time or until substitution with other services and income occur.	respond to rising future demand.
Provider Plans – the model does not include or take account of whether and how providers (i.e. acute trusts) will take costs out, particularly fixed costs, or whether costs may increase as a result of a move to higher value tertiary/specialist services.	Joint work with Trusts during the implementation of the New Delivery Models to develop a better understanding of any bed reduction / re-allocation plans as a result of New Delivery Model impact.

6 Cost-Benefit Analysis

The Costs of the New Delivery Models

The costs of each New Delivery Model in Manchester are different, reflecting the different Models.

For the purpose of this business case, we have focused on Central Manchester's New Delivery Model. Further details of the costs of the models in South and North Manchester will be available going forward.

The costs below reflect a theoretical 'scaled up' model of the Central Manchester New Delivery Model across Manchester over five years for the full target cohort.

Funder	Cost Category	Cost (5yrs)
Manchester City Council	Homecare	£4,332,981
	Reablement	£157,959
	Social workers	£799,705
	Community Alarms	£7,804
CCGs	Prescriptions	£-*
	Active Case Managers	£1,483,392
	GP Contribution	£1,988,675
	Community Nurses	£4,287,520
Set Up Costs	Upfront costs	£540,000
	ICT	£150,000

** forecast to have +- 10% impact but zero rated in current CBA, this is likely to change in the next iteration of the CBA*

The Estimated Benefits of the Central Manchester New Delivery Model

Again using Central Manchester as an example, Partners have developed a set of estimated benefits of the New Delivery Model, using worst case and best case scenarios to stress test the viability of the Model. The estimated benefits draw on what evidence there is of similar integrated care programmes (particularly Torbay and North West London); secondary research from the King's Fund and Monitor; and local management insight based on their understanding of the local health economy in Manchester.

At a high level, the estimated benefits over five years are:

- 10% - 30% reduction in bed days.
- 20% - 40% reduction in emergency admissions.
- 10% reduction in readmissions.
- 9% - 20% reduction in care home admissions.

Modelled on a theoretical scaled up basis across Manchester, this is predicted to realize £13.8m of cost avoidance and potential reinvestment, 94% of which accrue to the Clinical Commissioning Groups over five years. However, there is at present limited evidence to support these estimated benefits and will be tested during the Proof of Concept phase.

In addition to these estimated tangible benefits, other benefits have been identified by the Partners of the New Delivery Model:

- The user and carer experience – e.g. improved social independence; improved satisfaction with services received; and improved social connectivity.
- Clinical and social outcomes – e.g. improved identification and recording of diabetes; extension of NHS health checks; increased flu vaccinations.
- Organisational and staff benefits – e.g. improved ITMA score within integrated teams; increased system coordination; reduced overhead costs.

Benefits Cost Ratio and Payback Period

The estimated BCR and Payback Period of the scaled up central Manchester model are detailed in the table below.

Overall Fiscal benefit - cost ratio	0.93
Payback period	N/A

This shows that the NDM scaled up does not quite meet the threshold of being economically justified (a BCR of 1). However, the level of uncertainty on the current estimates means that this is indicative only and estimates must be replaced by actuals during the Proof of Concept phase to determine a more accurate BCR and Payback Period.

Assumptions and Caveats to the Central Manchester Model

The following assumptions and caveats apply to the CBA for the Central Manchester scaled up model.

Benefits

- Benefits last for circa 36 weeks for residential & nursing.
- Optimism bias for benefits, 10%.
- It is assumed that 80% of the cohort will engage with the process and therefore be potentially able to improve – this assumptions needs to be tested.
- Deadweight for admissions is 10%. This is an estimate based on indicative data.
- Deadweight for admissions to residential and nursing is nil as this seems to be increasing so any reduction could potentially be all attributed to the pilot.
- Deadweight for excess bed days is 5%. This is an estimate.
- Acute Trusts are assumed to save 13% of costs associated with the tariff for each non-admittance.

Costs

- District nursing and social worker costs for the cohort will increase by 20% - the mid-point of the range of assumptions.
- Active Case Managers costs for the cohort will increase by 20% - the mid-point of the range of assumptions.
- A GP practice of £65 per patient has been assumed – the mid-point of the range.
- We anticipate that pharmacy costs will be affected, with the next iteration of the CBA including estimated impact. It is zero rated within the current model.
- Within social services, homecare, Community alarms, reablement and equipment are also assumed to increase by 20%.
- All the costs excluding GPs have an optimism bias of 20%. This means that they have been inflated by 20% to reflect the fact that they are estimates.
- Locality co-ordinators are assumed to work for two full years to set up the system.
- Set up costs have been excluded from any particular organisation and are shown separately.

General

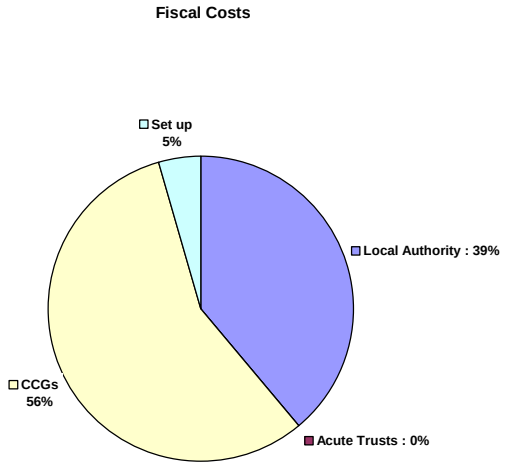
- It is assumed that no benefits will accrue for the first year. This is actually probably over cautious as there are likely to be some (as yet unidentified) quick wins.
- Very high risk patients are assumed to have benefits for two years after the initial period above.
- High risk patients are assumed to have benefits for a full two years and then

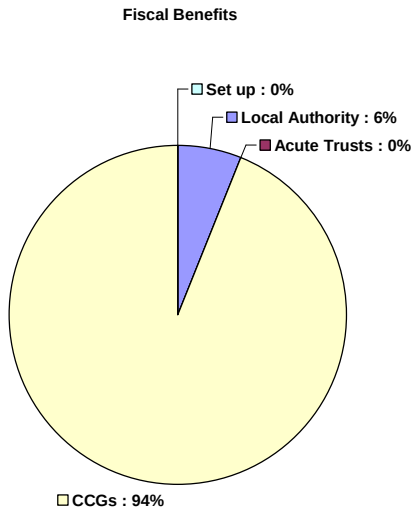
75% in year 3 and 65% in year 4 as the impact of the work tails off.

7 Financial plan

Investment and Savings between Partners

The graphs below illustrate the proposed costs and savings forecast to be realised from the Manchester-wide scaled up New Delivery Model. However as per the BCR and Payback Period note earlier, this is very much subject to testing and change during the Proof of Concept Phase.





Sources of Investment

The initial Proof of Concept phase will be funded by the CCGs, Acute trusts and Local Authority in each locality, including additional funds secured from the SHA to support implementation particularly the IT platform.