NHS
North Manchester
Clinical Commissioning Group

North Manchester Clinical Commissioning Group

Dr Martin Whiting
Chief Clinical Officer

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North Manchester – Intro

- 36 member practices (April 2013)
- Registered population – 189,447 (Sept 12)
- Growth – 3.5% in 18 months
- 75% live in North Manchester / 84% live in Manchester
- Two thirds of our patients go to Pennine Acute
- *Live local = Stay local*

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Our Issues

- Second highest level of deprivation in the country
- Alcohol specific admission rates higher than other Manchester CCGs
- Higher than average rates of cancer mortality
- High proportion of elderly referred for mental health services
- Low outcomes in many areas such as mental health, respiratory disease
- The economy

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Drivers for Strategic Change across GM (Healthier Together)

Increasing expectation that care will be delivered outside the hospital
Pattern of disease – increasing proportion of patients with long term conditions and multiple co-morbidities
Public sector financial austerity
Increasing public expectation on the NHS and intolerance of dissatisfaction
Increasing competition driven by policy and patient choice
Integrated care – care organised around the patient, not around services
Demographic change
Outdated models of care
Incremental improvements no longer sufficient to address challenges
Advancements in information and communication technologies
Breakthroughs in treatment technologies

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The Manchester View

- Green light for scaling up Integrated Care – target 20% of population
- Ambitious roll-out of integrated care plans across the city plus achievement of upper levels of performance – assumption: reduce acute beds by 27-33% (i.e. up to 800)
- Achievement of integrated care goals may require a reduction in the number of GP practices and increased federation to provide a quality wider service offer
- Timeliness of Healthier Together changes given local financial circumstances (health and social care)

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Joint Health and Wellbeing Strategy - Links to our Local Strategy

1. Best Start in Life

Complex Families
Improving quality of primary care
Health Visitor redesign

2. Self Care

Self care support for long term conditions
Telehealth
Health Literacy

3. Shift to Community

North Manchester Integrated Neighbourhood Care (NMINC)
Urology Pathways (including catheter management)
Diabetes management in the community

4. Right treatment, place, time

Focus on prevention and management
Cardio-vascular disease in primary care
Referral gateway
Ambulatory care development
Reducing variation in primary care

5. Troubled Families

Work with local agencies
Complex families

6. Mental Health

Physical health needs of people with serious mental health
Emotional resilience
Integrated care for people with mental health needs

7. Employment

Support GP practices to support fit for work
Self care and patient education e.g. Diabetes
Emotional resilience and mental health

8. Older People

Falls prevention
Integrated health and social care
Stroke improvement
Diabetes Management
Nursing homes review

Quality Care

Clinically Led

for healthier communities in Central Manchester

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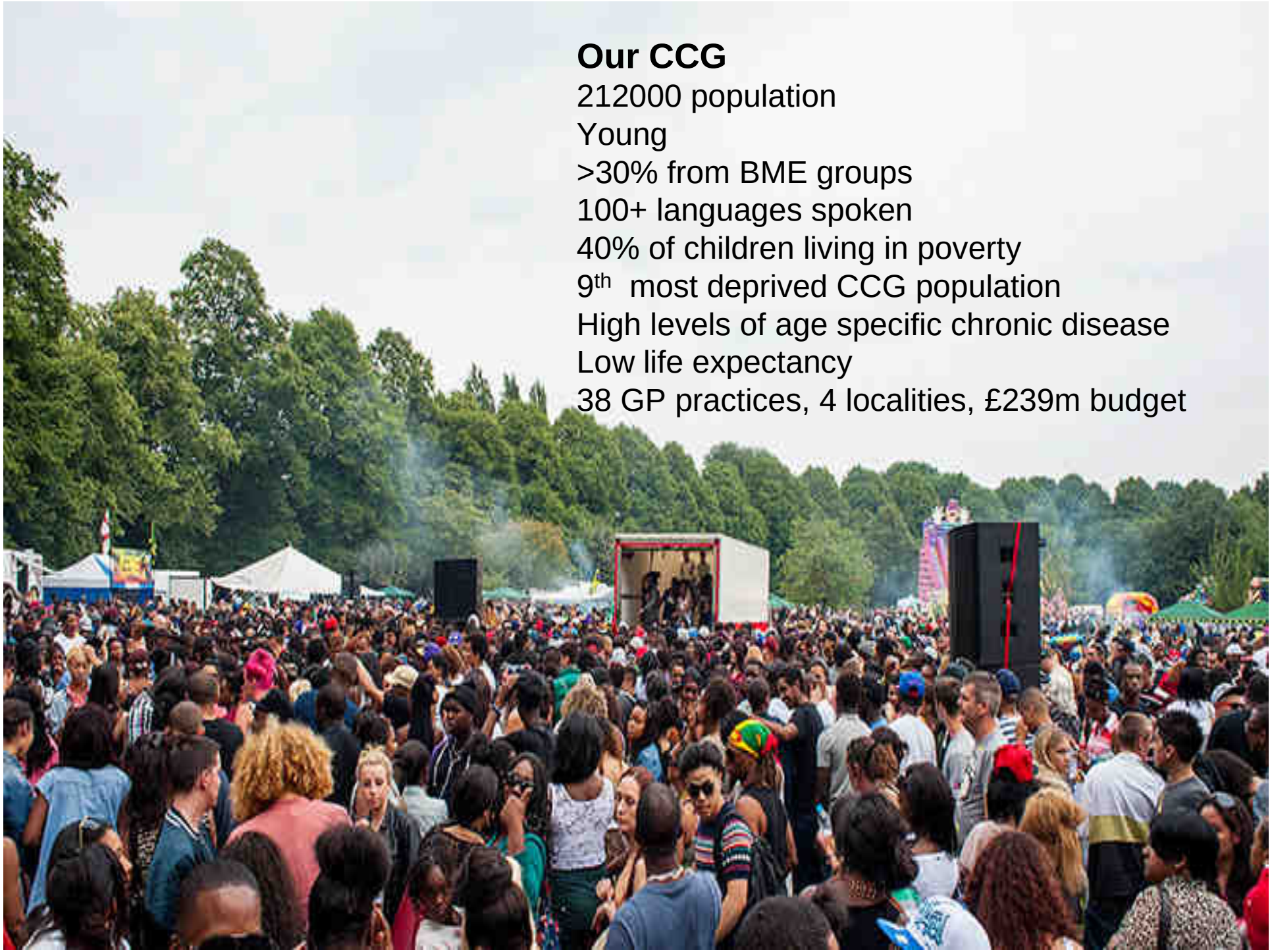
Mike Eeckelaers – Chair

Ian Williamson – Chief Officer



Our CCG

212000 population
Young
>30% from BME groups
100+ languages spoken
40% of children living in poverty
9th most deprived CCG population
High levels of age specific chronic disease
Low life expectancy
38 GP practices, 4 localities, £239m budget

By 2015, we will….

Improve life expectancy by one year by 2015	Achieve expected long term condition prevalence	Reduce avoidable readmissions by 1/3
Improve: Access to primary care End of life care	Reduce avoidable harm	Deliver a balanced budget and shift resource from hospital to community

Delivering the Joint Health and Well Being Strategy

Best start in life

Redesign paediatric care pathways
Review paediatric community nursing
Health visitor redesign

Self care

Choose Well
Self management of chronic disease
Telehealth

Shift to community

Integrated Care Teams
End of life care
Planned and urgent care pathway redesign

Right treatment, place, time

Better identification, management and care of people with long term conditions in primary care
Healthier together
Primary Care development

Troubled families

Enable better access to mental health, drug and alcohol services
Contribute to multi-agency work

Mental health

Review and improve mental health services
Improve quality of current care
Improved access to psychological therapies

Employment

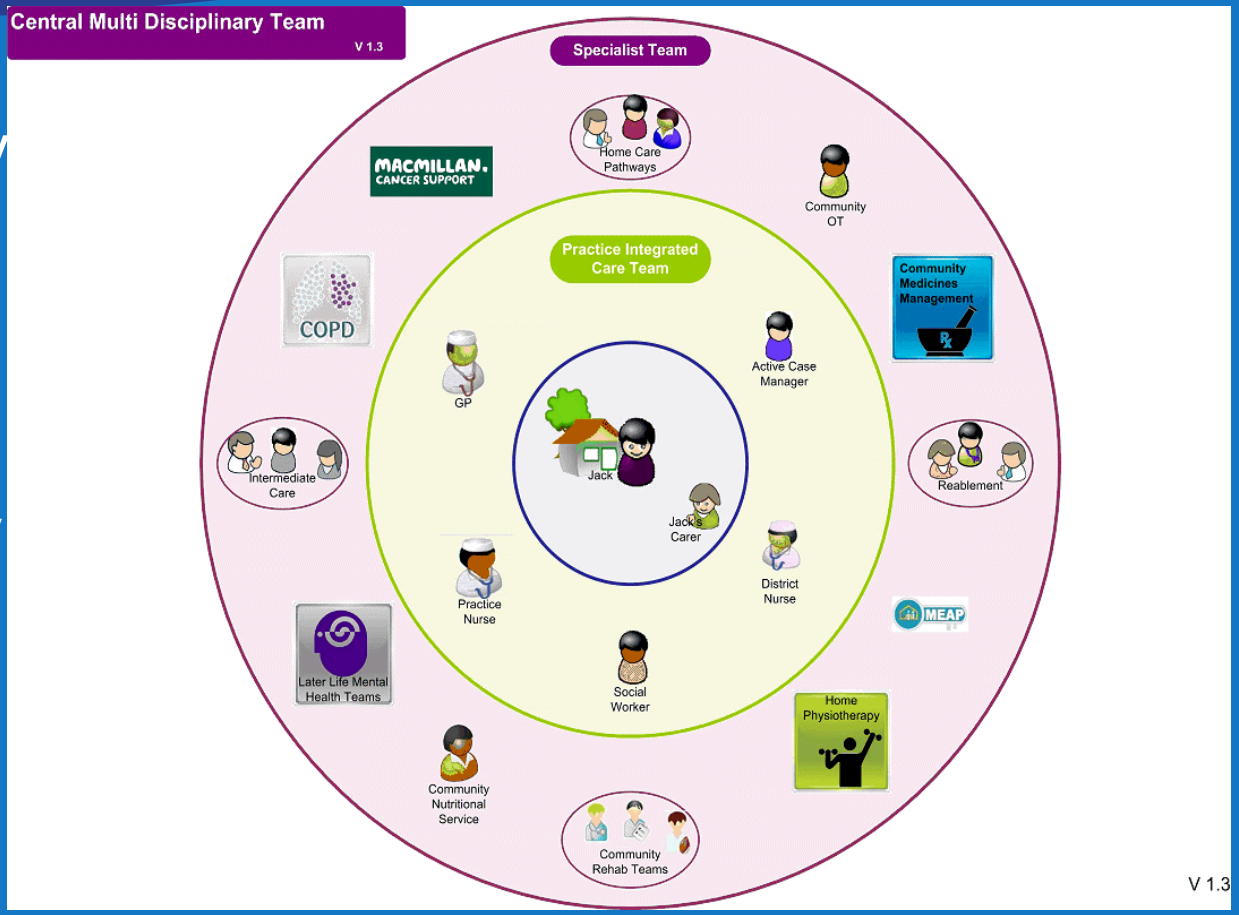
Support GP practices to deliver their role in Fit for Work programme
Mental health service improvement to support people to get, and remain in, work

Older people

Deliver improvements in:
Stroke care
End of Life Care
Dementia

Integration

- Integrated strategy
- Integrated planning
- Integrated delivery
- Community Budgets



In summary

Quality Care

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Established membership organisation	Strong collaboration with our communities and partners	Record of delivery: clinical and financial

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South Manchester CCG's Strategic Priorities 2013-16

Dr Mark Whitaker
GP Clinical Lead

Clinically led for better health
With you, for you

Hilda

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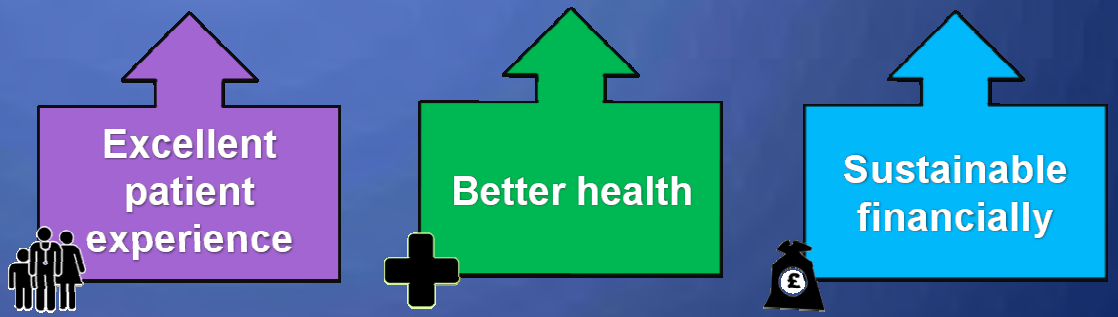
Vision

"We will improve radically how health and social care is delivered and experienced in South Manchester.

We will use evidence based medicine and develop new relationships to provide high quality care.

We will enhance outcomes within the resources available"



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Strategic Priorities

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1. Prevention

PRIORITY 1: To provide a healthy start and improve outcomes for children

PRIORITY 2: To increase life expectancy and narrow the gap between Manchester and England. To reduce health inequalities, in terms of life expectancy, between the best and worst areas of (south) Manchester

Strategic Priorities

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2. People with Long Term & Complex Conditions

PRIORITY 3: Early detection, secondary prevention and management of people with long term conditions (LTCs).

PRIORITY 4: Improved outcomes for people with mental health problems, including dementia.

PRIORITY 5: To improve outcomes for learning disabled people and / or people with Autistic Spectrum Conditions (ASC).

Strategic Priorities

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3. Integration

PRIORITY 6: Improve and Reform the Quality of Primary Care.

PRIORITY 7: Reform Urgent Care.

PRIORITY 8: Integrated Health and Social Care Services

Delivering the Joint Health & Wellbeing Strategy

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Best start in life

- Increase uptake of immunisations and vaccinations
- Health visiting redesign

Educating, informing and involving the community

- Choose well
- Increase the number of health checks
- Increase the take-up of healthy lifestyle programmes and services

Troubled families

- General Practice contributing to the multi agency work – Benchill Practice
- Strengthen the protection of vulnerable children

Mental health and wellbeing

- Improve early diagnosis/ management of patients with dementia and access to support for carers.
- Increase access to Psychological Therapies

Providing care in the community

- Reforming urgent care
- Improving the identification & management of patients with LTCs
- Reforming primary care
- Improving respiratory and diabetes services models in a community setting

Treatment at the right place and right time

- Reforming urgent care
- Reforming primary care
- Healthier Together

Employment

- Improve access to mental health and acohol services
- Working with GP pratices to fullfil their roles in enabling people to be fit for work

Older People

- Implementation of Integrated Neighbourhood teams
- End of life
- Dementia care

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Delivering our Strategy With Partners

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- University Hospital of South Manchester
- Manchester City Council
- Manchester Mental Health & Social Care Trust
- The third / voluntary sector
- Patients and the public

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Integration

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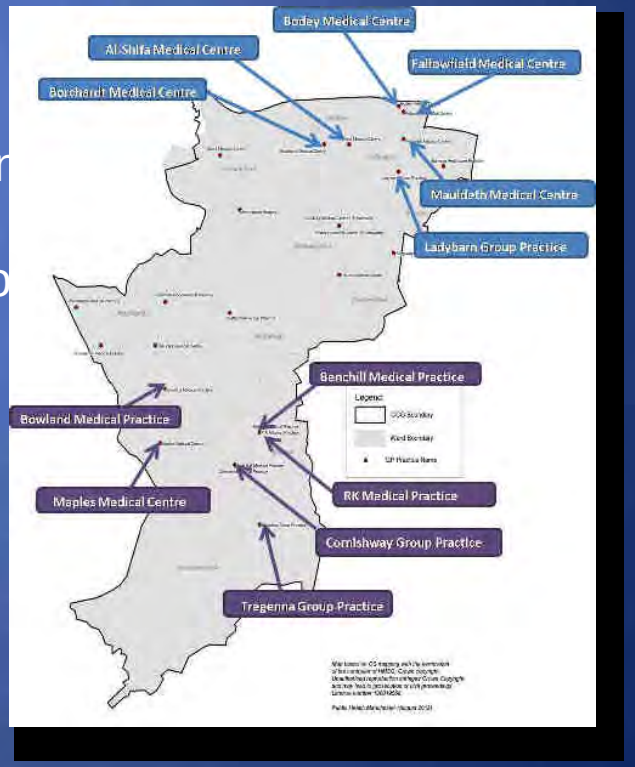
- The South Manchester Integrated Care Delivery Board approved proposals to accelerate the implementation of two neighbourhood teams by April 2013.

- Will pilot in two of our patches; a south facing patch (Wythenshawe population), and a north facing patch (Withington and Fallowfield population).

- Neighbourhood Team Design Workshop was run in December (with the second taking place tomorrow) -pulled together health and social care colleagues to discuss and agree the configuration of the teams.

- Considerations included how a multidisciplinary approach can support patients who have been categorised as moderate to very high risk (c.6% of our registered population)



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Pilots

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Aspire Diabetes Stroke

Aspire aims to prevent admissions to hospital and get people with respiratory conditions home sooner.

One patient, if not for the Aspire team, would have had to spend 4 months in hospital (120 days and nights in an acute hospital bed) in order to receive a daily infusion.

As an inpatient he would have been unable to provide childcare for his children, meaning that that his wife would have had to take leave from her job whilst her husband was in hospital.

Instead the patient attends the ward each day, is connected to his infusion for an hour and then returns home.