Manchester City Council
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 20 March 2013

Subject: Living Longer and Living Better: An Integrated Care Blueprint for Manchester

Report of: Liz Bruce, Strategic Director, Adults, Health and Wellbeing

Summary

The attached report proposes the city wide blueprint to take forward integrated care in Manchester and has been written by identified senior colleagues from each of the organisations listed below, on behalf of the Executive Health and Wellbeing Group and Health and Wellbeing Board:

- North Manchester Clinical Commissioning Group
- Central Manchester Clinical Commissioning Group
- South Manchester Clinical Commissioning Group
- Manchester City Council
- Manchester Mental Health and Social Care Trust
- University Hospitals South Manchester Foundation Trust
- Pennine Acute NHS Trust
- Central Manchester University Hospitals Foundation Trust

This blueprint and the development of the strategic outline case are integral to the delivery of the Joint Health and Well Being Strategy and the programme has relevance to all of the eight priorities of the Health and Wellbeing Board. However, it will form the cornerstone of work on priorities two, three, four six and eight in particular:

- Educating, informing and involving the community in improving their own health and well being
- Moving more health provision into the community
- Providing the best treatment we can to people in the right place at the right Time
- Improving people's mental health and wellbeing
- Enabling older people to keep well and live independently in their community

Recommendations

The Board is asked to:

1. Approve the document and support the progression to a strategic outline case by June 2013, which would include
    - Wider engagement with key partners
    - Detailed immediate plans (local and citywide) 1-3 years
    - Scoped medium term plans (local and citywide) 3-5 years
    - Scoped long term plans (local and citywide) 5-10 years

2. Identify a leader to take forward this programme of work
3. Identify a team from within the organisations to be released to undertake this work
4. Support the identification of expertise to be brought into the team as needed
5. Support the governance of this programme through the Health and Wellbeing Board, its Executive Health and Wellbeing Group (EHWG) and the local structures in North, Central and South Manchester.
6. Request that the EHWG take forward the implementation of recommendations 2, 3 and 4 above if agreed.

Board Priority(s) Addressed:

All

Contact Officers:

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Background documents (available for public inspection):

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

Footnote

NB: Although the blueprint has been written by the identified senior colleagues from each of the organisations specified time constraints mean that it has not been to individual organisations' governing structures. However, following the meeting of the Health and Wellbeing Board it will be taken through the appropriate reporting structures in each organisation.

Living Longer and Living Better

An Integrated Care Blueprint for Manchester

People **Pride** **Place**

This document has been compiled for the Health and Wellbeing Board (HWB) by the following people on behalf of their respective organisations.

Manchester City Council

Liz Bruce	Strategic Director of Adults, Health and Wellbeing (HWB sponsor)
David Regan	Public Health Manchester
Andy Bowie	Public Sector Reform
Diane Eaton	Directorate for Adults, Health and Wellbeing
Emma Gilbey	Directorate for Adults Health and Wellbeing – Report Writing Team

Clinical Commissioning Groups

Helen Speed	North Manchester CCG
Ed Dyson	Central Manchester CCG – Report Writing Team
Claudette Elliot	South Manchester CCG
John Scampion	All Manchester CCGs

Trusts

Deborah Lyon	Pennine Acute NHS Trust
Sara Radcliffe	Central Manchester Foundation Trust - Report Writing Team
John Harrop	Manchester Mental Health and Social Care Trust
Joanne Royle	University Hospitals South Manchester Foundation Trust
Annabel Hammond	University Hospitals South Manchester Foundation Trust

Many others from within these organisations have contributed to the production of this document (appendix 1).

Special thanks to David Fillingham, Chief Executive and Elizabeth Bradbury, Director of AQuA for facilitating the first workshop and Neil Bendel Head of Health Intelligence Public Health Manchester.

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Section One

Introduction and Executive Summary

Introduction and Executive Summary

Background

i) The January Health and Well Being Board (HWB) asked for a high level city wide framework for integration, a blueprint to be brought to the March meeting. The blueprint would describe how we could build our out of hospital services to support our population and shift care from our hospitals. Each of the 8 public sector organisations in the city, that are members of the HWB, put forward their senior leader for integration to form a "blueprint group" to undertake this work.

ii) A presentation was given to the HWB Executive, and three workshops were held, in February and March to build on the work that has taken place in the three systems over the last two years including:

iii) Community services transferred to the acute hospitals in 2011. This has enabled a far more comprehensive exploration of how we can co-ordinate care across the traditional artificial boundaries of hospital and community that existed. It has allowed the acute organisations to see developing community care as one of their own priorities, in order to enable the health and social care system to operate efficiently and effectively.

iv) Integrated care has been led by the three health and social care systems in North, Central and South Manchester with joint programmes of work that have crossed the CCGs, acute and community sector, primary care, mental health, social care and other agencies. Each of the areas has developed integrated services under their own local governance structures (Appendix 2). The three systems have also started to explore what benefits working together would bring, in terms of particular areas of integration, through the City Wide Integrated Care Reference Group that was established. The systems have also been supported by national programmes of work such as the AQuA and Kings Fund Integrated Care Discovery Communities and the Leadership for Integration programmes.

v) There are National and Greater Manchester strategies that can support and accelerate the scale and pace of integration programmes of work. In particular the Public Sector Reform work which is concentrating on Whole Place Community Budget Pilots is providing opportunities to look at how care is delivered and funded differently in the future. Also the Healthier Together Greater Manchester programme of work is a platform by which we should look at how care is delivered across sectors and how the community can be developed in order to help sustain a different health and social care system in the future.

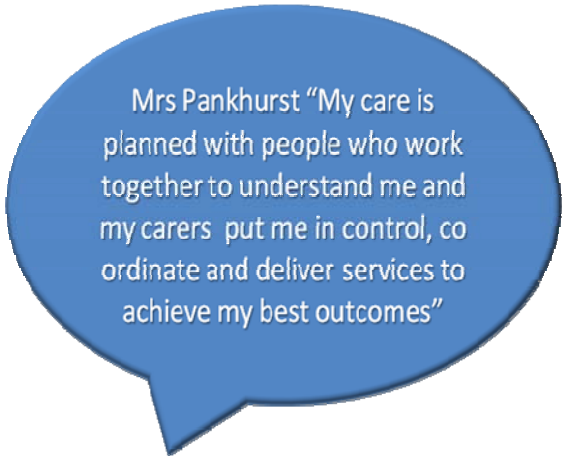
vi) A Study into Health and Social Care in Manchester was commissioned from McKinsey and Company in 2012. The key messages from the report were that the health and social care system in Manchester required considerable change. The health outcomes of our population are poor, the quality and access to services

variable and the use of the acute sector for the delivery of services is high, relative to the national average. Their proposal was for a far more ambitious programme for integration to be developed which would target up to 20% of the Manchester population with the most need.

The Blueprint Future Direction

vii) We believe our goal in Manchester is to help our population to live longer and live better - we want our focus as a health and social care economy to be on people, pride and place.

viii) Integration is a means by which we want our care to be centred around the individual. We must always ask ourselves whether what we do will benefit Mrs Pankhurst. We have chosen Mrs Pankhurst as a symbol of our change. It is a nod to our reforming past as a city and a signal to our future, which aims for our population to have personal power and independence.



National Voices Definition of Integration

ix) The work we have undertaken over the last 2 months has detailed more specifically what we need to do in the areas of our population, service model, overall system, workforce, infrastructure, resources and engaging people in change. If this paper is accepted we believe our next step is to write a strategic outline case which will further develop the main themes covered in this report.

Population

x) We now know who in our city are in our top 20% of GP patients needing care. They are people who are likely to be living with limiting long term conditions, growing older with a burden of disease and likely to be living with high levels of deprivation. We have mapped where people live who are in the target 20% of the population with the most need, and we know how many days these people will spend in hospital and the cost of this care to the health system.

Blueprint statement: We will identify those people most at risk of hospital admissions, who would benefit from a co-ordinated community response to enable them to live longer and live better.

Model of Care

xi) We recognise how important it is that people continue to receive excellent care when they need to go into hospital. However, we believe that by providing a properly co-ordinated and better resourced range of services, in their homes and close to where they live, we can improve their quality of life and reduce their need for hospital nursing and residential care. We have produced a shared model of need for our population most likely to need care, which describes what the outcomes should be for these people and what care we should offer.

Blueprint statement: We will develop a model of care which co–ordinates out of hospital services across the city based on a consistent offer to achieve outcomes which will enable people to live longer and live better.

Different Health and Social Care System

xii) If we are to provide a different model of care which enables people to have co-ordinated care as near to their homes as possible, and reduce their risk of being admitted to hospital, we will need to change our health and social care system. If people are not needing to go into hospital as much, as they are living longer and better at home, then the function of our hospital and community system will need to change. All community services need to wrap around our hospitals and they need to be seen as an integral part of a changing system of care.

Blueprint statement: We will develop a health and social care system which commissions and provides more co-ordinated care in the community to enable people to live longer and live better.

Our Workforce

xiii) Our population is living with increased levels of illness and we know that we have a complexity of care that we haven't seen before in the community. If we achieve our goal of people living longer and better then the workforce has to change to support this. We need exceptional practitioners across our system who view the care of people in the community as a prestigious speciality in its own right, e.g. doctors, nurses, therapists, social care professionals and support staff. We believe that these people are only part of the workforce which should include carers, friends and neighbours. We need to put carers and patients themselves at the centre of how we build and co ordinate teams around Mrs Pankhurst.

Blueprint statement: A workforce which is skilled to deliver co-ordinated care in the community to enable people to live longer and live better.

Buildings

xiv) Knowing our needs, changing our service models will not be enough to enable change to be embedded. We need to shape the infrastructure so it works for Mrs Pankhurst and not against her. We need to have facilities in our community, be they on existing hospital sites, or in buildings around the city that are redesigned to co-ordinate care in one place. Mrs Pankhurst's time is as important as anyone else's and she should be able to have coordinated, efficient and effective care as near to her home as possible. She should not have an army of people, and appointments on different days across the city, which could be co-ordinated better around her and near to her.

Blueprint Statement: To have quality buildings providing multi agency co-ordinated care to support people to live longer and liver better.

Information

xv) We need to have mobile solutions supporting information needs with information systems that are shaped across the different agencies, so that Mrs Pankhurst can be assured that she is having the most effective and co-ordinated care, based on her needs. Information is up to date and can be shared with her, and between the practitioners that care for her, as she wishes.

Blueprint statement: To connect systems and people with up to date information and support co-ordinated care for people to enable them to live longer and live better.

Money

xvi) Our resources need to follow Mrs Pankhurst. If she doesn't need hospital but community care then we should be able to shift the resources to where she needs them. We need to have a resource cycle that is long enough to be able to assess that the services we put in place are embedded and having an impact. We need to be able to collaborate together across the organisations to ensure that we work together to provide the best services for Mrs. Pankhurst, not compete against each other causing fragmentation.

Blueprint statement: For resources to be aligned to the person and their needs to support co-ordinated care for people to live longer and live better.

Engagement for Social Change

xvii) We believe that to change the perception of what care is in our city and to enable people to live longer and live better, this is the biggest change programme we will have entered into as a health and social care economy. To do this we need an

engagement programme that is not just about informing but involving. We need to move from traditional ways in which we have communicated separately, to a programme of engagement which is a single story of our city and how we have a movement for social change.

Blueprint statement: To create a movement for social change to provide a new paradigm for how people view their health, and this programme of change, to live longer and live better.

Governance: Leadership and Team

xviii) We will govern, redesign and deliver our health and social care system through city wide governance of the Health and Wellbeing Board and the three Integrated Care governance arrangements in North, Central and South Manchester. We will create a team of people who have the skills and expertise as well as the local knowledge and influence to enable the delivery of a different health and social care integrated programme for Manchester.

In Summary

We will develop a strategic outline case which offers a health and social care system where;

- We will keep learning about your needs, the services and the community where you live to ensure we base decisions on up to date knowledge and evidence.
- We will co ordinate care and design services around you and as close to your community as possible.
- We will organise our health and social care system so it is right for you, your community and Manchester.
- We will create a workforce which is centred on promoting your well being and whose goal is to help you to live longer and better.
- We will ensure that resources are spent wisely, targeted where they are needed and where they can make a difference, working together to change the way resources are shared.
- We will have up to date information that we can share with you and can be accessed at the right time and right place between the right people.
- We will aim to co ordinate care around you and bring it together in facilities in your community when appropriate.
- We will listen to you, talk to you and together positively change care in Manchester together.

Section Two

The Blueprint

The Blueprint

Chapter One - Our People

Blueprint statement: We will identify those people most at risk of hospital admissions, who would benefit from a co-ordinated community response to enable them to live longer and live better.

Introduction and Background

1.1 Manchester is a vibrant, dynamic city with a growing population. However, the city has the second worst life expectancy for men and the worst for women in England. We have a higher than average prevalence of long term conditions such as diabetes, chronic obstructive pulmonary disease and heart disease, leading to an increased burden of disease and people dying younger.

1.2 Our deaths from circulatory disease are almost double the England average and yet our GP practices report lower than average numbers of patients with circulatory diseases. This could be because patients do not present to general practice in the early stages of their disease, and therefore only become known to the system when they experience a medical emergency, or that GP practices may not accurately diagnose, record or optimally manage conditions.

1.3 Across the city, there is variation in levels of disease and the way individuals receive their care. Our approach has therefore, been to gain an understanding of the city's population to develop a model of integrated care that identifies the Manchester offer to its citizens. Three Clinical Commissioning Groups have developed in Manchester taking on much of the commissioning responsibilities from Manchester Primary Care Trust. CCGs are clinically led membership organisations, their membership being made up from the GP practices in their area. This has created a sea change in how commissioning is undertaken. There is greater clinical dialogue within the system and greater input into decision making by grass root GPs.

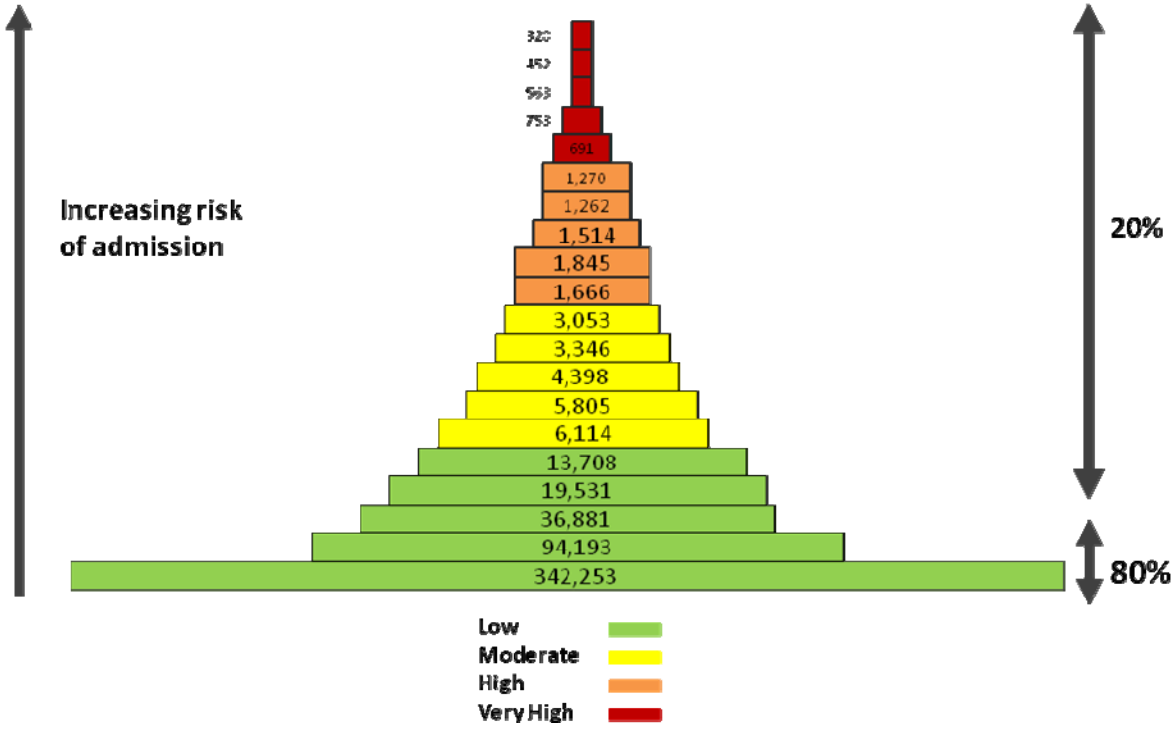
1.4 This blueprint has been informed by the information about the health needs of the population in North, Central and South Manchester that is contained in the latest edition of the Manchester Joint Strategic Needs Assessment (JSNA). This can be accessed via the Manchester City Council website at www.manchester.gov.uk/jsna. In additional to statistical information providing a profile of the three localities in Manchester, the JSNA contains a more in-depth look at a number of specific health issues, three of which (circulatory diseases, mental health and wellbeing, and falls in the elderly) have particular relevance to local work in respect of integrated care.

What Risk Stratification Shows:

1.5 We have used a risk stratification tool to identify the level of risk of hospital admission for all patients registered with Manchester GP practices. The tool uses acute hospital data and GP practice disease registers to derive an individual score from 0-100 that

shows the patient's risk of admission to hospital. It shows patients registered with Manchester GPs who do not live in Manchester but does not show patients resident in Manchester with no GP or a GP outside the city.

1.6 However, for the purposes of starting to identify the needs of our population, who those people are, where they live and how many are currently at risk of having to be admitted into hospital, it is a good start.



Risk Group	Number of people (registered)	A&E Attendances 2012	Admissions 2012	Emergency Bed Days 2012	Average admissions per person 2012	Average Length of stay 2012	Total Cost £k 2012
Low	506,566	298,165	80,282	13,220	0.16	0.16	37,633
Medium	22,716	31,546	13,497	46,683	0.59	3.46	26,033
High	7,557	17,687	9,591	96,846	1.27	10.10	21,582
Very High	2,787	14,934	9,358	217,081	3.36	23.20	19,972
Total	**539,626**	**362,334**	**112,728**	**373,831**	**0.21**	**3.32**	**105,220**

1.7 The diagram and table above show the risk stratification picture for the whole GP population and sub divides them by their score into 4 cohorts by their risk of hospital admission; very high (red), high (orange), moderate (yellow) and low (green). The steps in each cohort further divide the cohort by risk score and so highlight those on the boundaries between risk groups. Patients at the highest risk of admission tend to have multiple long term conditions and will have had previous hospital admissions.

Although mental health trust activity is not reflected in patients' risk scores, it is known that patients with multiple long term conditions often have a long term mental health condition such as depression or dementia. The risk stratification data includes children and adults. Most, but not all, of those in the high and very high risk groups are adults. There is an association between age and deprivation and level of risk.

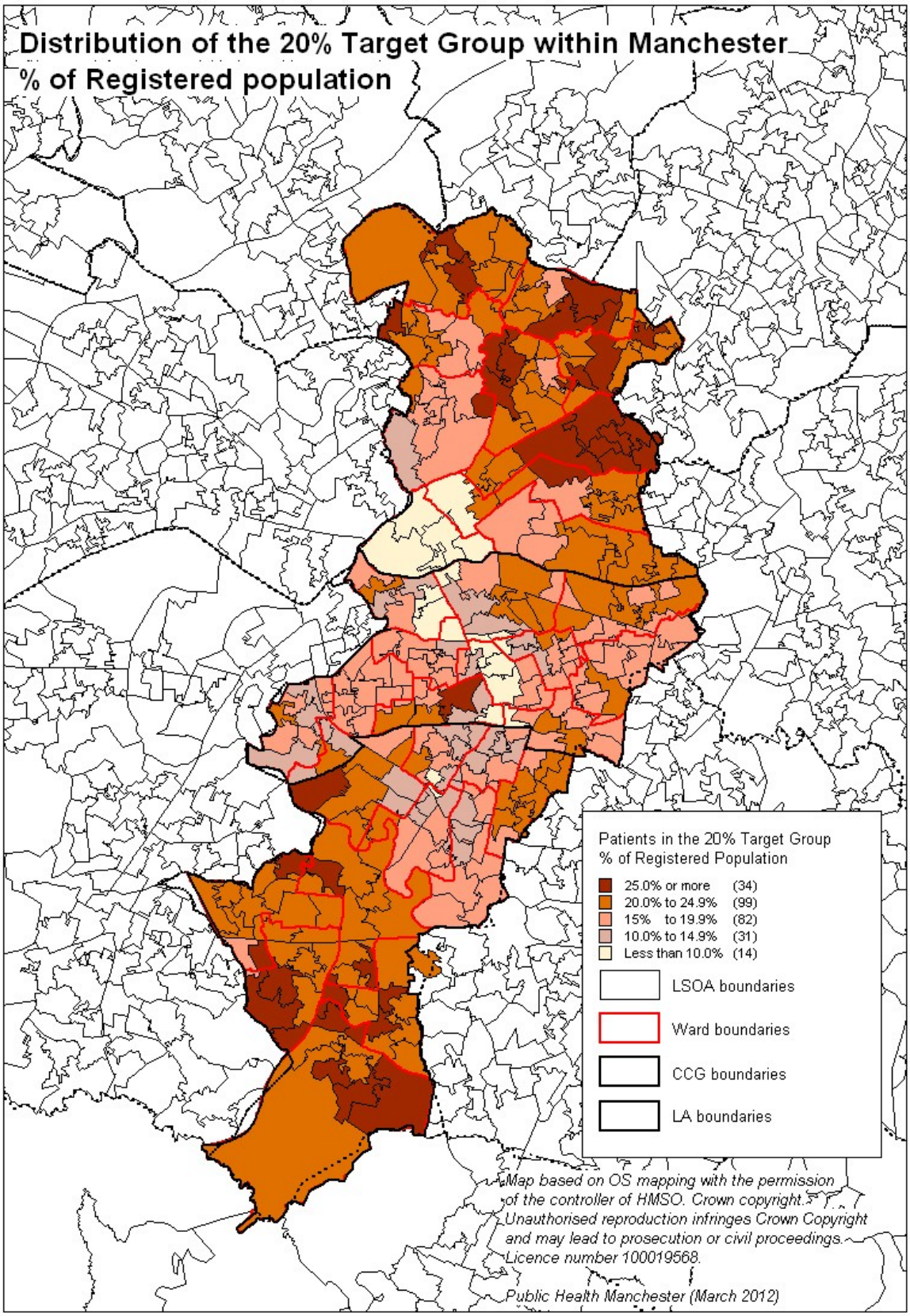
1.8 In summary, at this point in time, across the city, the breakdown of very high, high, moderate and low risk patients is as follows:

	North	%	Central	%	South	%	Total	%
Very high	1085	0.60	837	0.42	865	0.54	2787	0.52
High	2823	1.55	2142	1.08	2592	1.63	7557	1.40
Moderate	8717	4.80	6908	3.48	7091	4.45	22716	4.21
Low	168990	93.00	188827	95.02	148749	93.38	506566	93.87
Total	181615	100	198714	100	159297	100	539626	100

Future Direction

1.9 For Manchester we believe our goal is for people to live longer and better, and when they are at the end of their life to die with dignity in the place of their choice. Integrated care is a means by which we can co ordinate care around the individual in our community living with complex and complicated long term conditions, to enable our goal to be realised.

1.10 We believe we must consistently base our service redesign and development of out of hospital care on the public health evidence we have about what our populations needs are, and where they live. By doing this we would want the map below to move from being red and towards being white – for people in Manchester to be living longer and better without so much of the burden of disease they do at present.


Distribution of the 20% Target Group within Manchester
% of Registered population
Patients in the 20% Target Group
% of Registered Population
25.0% or more (34)
20.0% to 24.9% (99)
15% to 19.9% (82)
10.0% to 14.9% (31)
Less than 10.0% (14)
LSOA boundaries
Ward boundaries
CCG boundaries
LA boundaries
Map based on OS mapping with the permission of the controller of HMSO. Crown copyright. Unauthorised reproduction infringes Crown Copyright and may lead to prosecution or civil proceedings. Licence number 100019568.
Public Health Manchester (March 2012)

How will it be different? Where Should We Focus our Understanding of The Population Pyramid?

1.11 By basing our service redesign on the risk stratification of the population's needs, the person and their community, we can start to plan and co-ordinate care more effectively. We believe by doing this we can target, test and evaluate interventions at different groups. We can work to overcome the inverse care law where those with the highest needs may not have the best access to services. We can support and identify the type of intervention that will have the biggest impact for the people in the different risk areas e.g. medical, lifestyle change, emotional wellbeing. Social interventions such as good housing and employment can have a bigger impact on the risk level than a medical intervention, therefore our solutions need to be broad and inclusive of other agencies.

1.12 To date, the three localities have made most progress in developing models for those at the highest risk of hospital admission through integrated health and social care teams to provide co-ordinated proactive care.

1.13 The integrated care "offer" will need to be different for the other risk cohorts, for example for those at the lowest risk levels this will be predominantly around lifestyle choices. This will include activities outside the scope of formal health and social care such as access to employment and good quality housing as well as effective primary care diagnosis and management of long term conditions and services such as smoking cessation.

Recommended Next Steps for Strategic Outline Case

- Secure public health personnel attached to the city and locality teams.
- Overlay Social care data to the pyramid – we have a total caseload of 20,000 customers which is approximately 5% of the population with targeted interventions at 6,000 customers or just below 1% of the city's population.
- Overlay mental health data to the pyramid - the data from the MHSCT of their 12000 patients - and to understand the dementia and depression prevalence across the different risk groups.
- We need to understand the shape of the pyramid over time – whether the number of people in each group has changed and whether there has been significant movement between groups.
- Overlay the number of people who are not registered with a GP and where they would score on the pyramid.
- Use of tools such as MOSAIC (which groups populations with common characteristics) to identify "how" we would work with different groups to understand the "what".
- This data analysis will require the sharing of information across organisations. Appropriate information governance actions, including data sharing agreements, will need to be in place quickly to allow the analysis to take place.

The Blueprint

Chapter Two – Our Service Model

Blueprint statement: We will develop a model of care which co–ordinates out of hospital services across the city based on a consistent offer to achieve outcomes which will enable people to live longer and live better.

Introduction and Background

2.1 With an ageing population, who currently live longer but in poorer health, the current health and care service model is no longer fit for purpose. Hospital clinicians are becoming more specialised and community health provision has become more generalist. Hospitals often provide the only appropriate service available for people with long term conditions who require an increase in their care. This is not necessarily the best option for the person, as it can be reactive in addressing their urgent care needs, and it can create too much dependence on institutional care (hospitals and care homes).

2.2 Care provision is often fragmented, uncoordinated and inconsistent across the city. Our service model needs to re-shape around a strong evidence based offer, with prevention / early intervention and planned care at its heart.

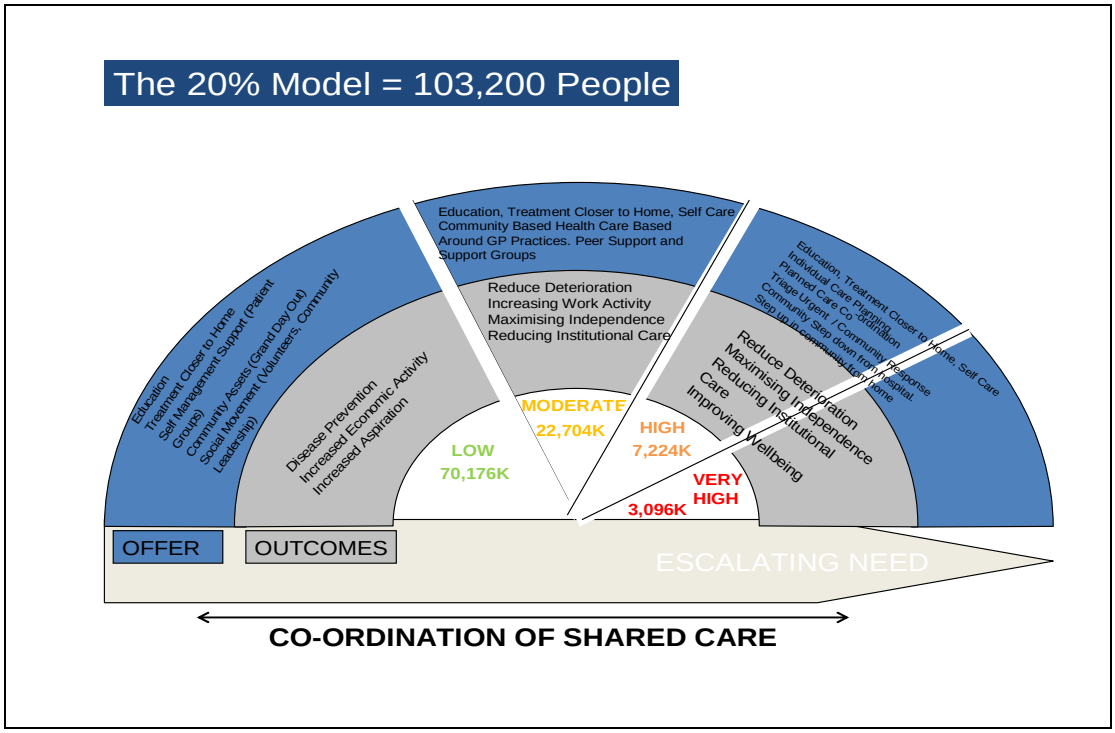
2.3 The future model for integrated care will have a number of core characteristics:

- Identification of each individual patient's level of risk of hospital admission.
- Early identification and early intervention for at risk patients.
- Provision of one care offer for the city.
- Recognition and support of the person, not just the condition.
- Shared approach to risk across the whole provider system.
- Supported self care.

Future Direction

2.4 Our future model needs to have an evidence based offer mapped against the continuum of risk. People currently at low risk will have different targeted outcomes from those at the highest risk that are likely to have multiple long term conditions and already be quite unwell. Targeted offers need to maximise independence, choice and wellbeing, with personalised care and support dependent on individual circumstances. Intervention and care will be provided closer to home, dependent on patient need. When crisis or exacerbations occur, which may in some cases require hospital treatment, then early discharge planning whilst they are in hospital will enable people to receive the less acute phase of care nearer to home, thus supporting people to recover quickly back to their optimum state of health and wellbeing.

2.5 The future direction needs to be about creating a care model with a principal focus on prevention and early intervention with people in Manchester supported to self care, and having better choices and control over their own lives.



The Combined Predictive Model is a proven evidence based case finding tool (Ref: Wennberg D and others (2006) Combined Predictive Model: Final report and technical documentation. London: The King's Fund). It uses hospital data and GP Practice disease registers to identify Patients at risk of hospital admission. The top 20% (in terms of admission risk) of Manchester's registered population equates to approximately 100,000 people. Analysis of this cohort demonstrates a strong correlation of Risk with number of long term conditions, with age, with deprivation and cost of acute hospital based care services.

How Will It Be Different?

2.6 **Low Risk Patient**. A low risk patient may be someone in middle age recently diagnosed with a long term condition, for example, high blood pressure. The health and care offer would be focussed on supporting healthy lifestyles (e.g. fit for life, smoking cessation), education (e.g. managing your weight) and self care (e.g. regular checkups in primary care). We also encourage a wider social movement, engaging community leaders and community support beyond the scope of traditional health and social care services in local health and wellbeing initiatives.

2.7 **Medium Risk Patient**. The health and care offer for this patient would be focused on supporting the person to remain an active member of the community, and to continue to lead a fulfilling life. Planned care needs (e.g. regular check-ups or blood tests) will be met in a community setting (GP practice led) with continuing focus on health promotion, education and self care. They may also require some input from specialist community services, which will provide support to the patient in self managing their long term condition.

2.8 **High or Very High Risk Patient**. For high or very high risk patients, outcomes will focus on maximising independence and wellbeing. Using high quality neighbourhood based health and care services, equipment and assistive technologies to support people to remain at home and in their communities for as long as possible. From the patient's perspective, health and care support will be co-ordinated by one team, which includes their GP, and they will be regularly monitored and assessed. The integrated team will ensure that the patient is receiving the right care in the right place at the right time, and that the care is personalised and undertaken with full patient and carer involvement.

Recommended Next Steps for Strategic Outline Case

- Further analysis to gain as full a picture as possible about the different the risk groups in order to understand what the co-ordinated care offer needs to be.
- Assessment of our current service model(s) against the model of care to ascertain current impact and outcomes.
- Assessment of the services, scale and pace needed to achieve the model of care targeting those most in need of coordinated care in the community to live longer and better lives.

The Blueprint

Chapter Three – Our System

Blueprint statement: We will develop a health and social care system which commissions and provides more co-ordinated care in the community to enable people to live longer and live better.

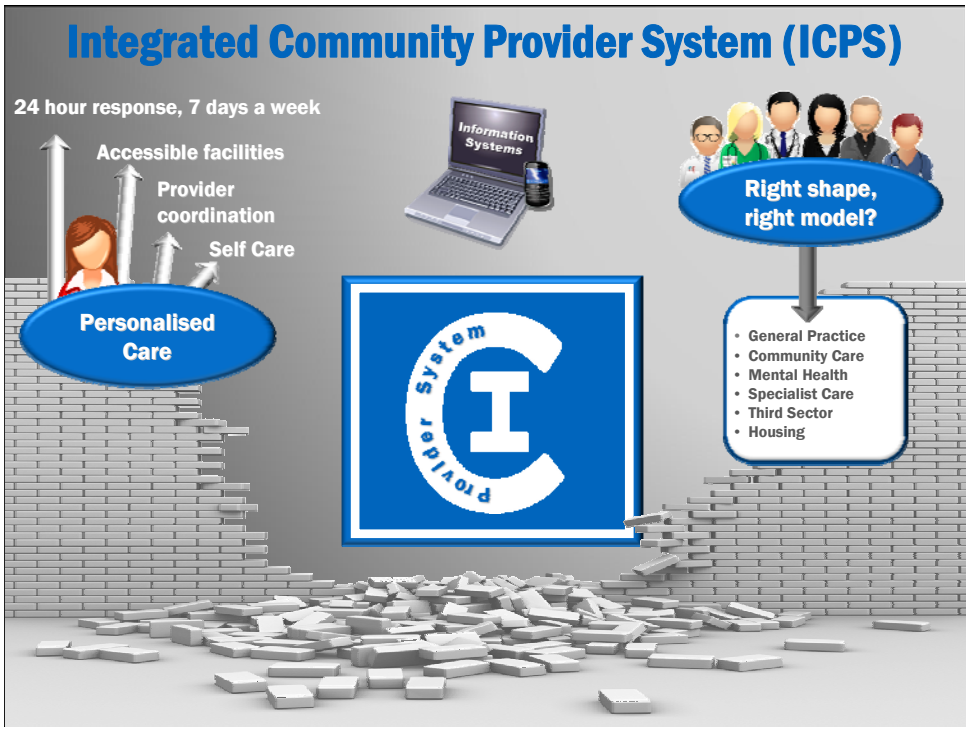
Introduction and Background

3.1 In Manchester there are three distinct health economies in the North, Central and South localities of the city. In 2011 all community services provided by NHS Manchester transferred to the three main acute hospitals, Pennine Acute Hospital Trust, Central Manchester Foundation University Hospitals Foundation Trust, and University Hospitals South Manchester Foundation Trust, with some services transferring to Manchester Mental Health and Social Care Trust. Social care services are provided by Manchester City Council for Manchester residents. Where patients are registered with Manchester GPs but live outside the city boundaries, then social care services are provided by neighbouring local authorities. The majority of community services are provided on the basis of GP registration but some are provided on a resident basis. There are 98 GP practices, of varying sizes, across the city with a mix of self employed and salaried clinicians, with some single handed practitioners. Citizens of Manchester often experience difficulty understanding and navigating the current service models.

3.2 In the new emerging picture of commissioning in Manchester, Manchester City Council, three Clinical Commissioning Groups and the Local Area Team of the National Commissioning Board each will hold commissioning responsibilities for the Manchester population. This creates a complicated picture of commissioning for a geographic population and a key challenge will be for these arrangements to work in such a way that it supports the new system to work effectively.

3.3 Services across the health economies already work collaboratively, but independently, with distinct strategies and approaches to services. This has resulted in the inequality of service offer and quality to develop across the health and care system in the city, due to the fragmented and independent nature of provision. Some services are only available to people living in certain areas of the city.

3.4 Our future Integrated Community Provider System (ICPS) will see health and care services working together to tackle health inequalities in the city, increase life expectancy and improve quality of life measures for its citizens.



Future Direction

3.5 Care is fragmented with individual conditions treated, not addressing the whole needs of the person. The current health and care system places hospitals at the centre, providers working in silos (with adhoc collaboration) and staff working reactively to meet needs typically arising from specific urgent health or care events. With an increasingly ageing population and more people living longer with greater ill health, the current fragmented and reactive system is no longer fit for purpose – if not reshaped it will continue to be high cost and delivering poor outcomes for Manchester people.

3.6 The future direction will see a high quality and consistent primary / community based health and care offer, with system wide collaboration and joint working to deliver excellent patient outcomes and experiences.

How will it be Different?

3.7 Our new System will see a shared focus on improving health outcomes for all Manchester citizens, delivering quality and timely care in our communities and neighbourhoods. Equitable access and equitable service provision will be at its heart.

3.8 Targeted work across the whole health and care system will aim to reduce and slow down the rate of escalation of population needs. More capacity and investment in planned care activities will reduce demand for emergency or urgent care services.

3.9 The ICPS will be based on a high quality and consistent service offer based outside of hospitals. Working as part of, and not separate to, wider communities, with strong working relationships between statutory and third sector providers and groups.

3.10 The ICPS will offer a 24 / 7 planned care response based on need that includes rapid and targeted services as an alternative to hospital attendance for those with long term conditions.

3.11 We need to maximise the opportunities for services to locate together through the creation of community delivery hubs (bringing together services such as primary, social, community, pharmacy, housing, equipment and adaptations etc). Hospitals continuing to provide secondary care as centres of excellence for planned care and major trauma events.

3.12 GP practices and primary care need to further develop emerging collaboration models. Practice federations, for example, deliver a number of significant benefits for providers, patients and communities:

- Strengthening clinical governance and service quality and consistency.
- Increasing training and education capacity.
- Creating shared opportunities to develop out of hospital services.
- Improving efficiency particularly through shared back office support.

3.13 A new approach to incentives and penalties needs to ensure that performance related income to providers is targeted towards people living longer and living better and link to the measures identified to take us there. In addition incentives need to encourage organisations to work more closely together in how they deliver care and to reward them collectively based upon agreed system outcomes measures.

Recommended Next Steps for Strategic Outline Case

- Joint leadership through the HWB executive to create a provider and commissioning system to support the development of co-ordinated care outside of hospital.
- To establish a clear commissioning strategy for jointly commissioning the new models of care.
- To use the established national and international networks available to the organisations in the city to support the programme of work.
- To explore different primary care models including networks and federations for provision.
- To invite other major providers and commissioners to be involved in the Strategic Outline Case.

The Blueprint

Chapter Four – Our Workforce

Blueprint statement: A workforce which is skilled to deliver co-ordinated care in the community to enable people to live longer and live better.

Introduction and Background

4.1 Our overall goal is for the people of Manchester to be living longer living better. To deliver this strategic aim with an ageing population, who have a wide range of health conditions, we need a person centred rather than a profession centred workforce.

4.2 By workforce, we mean all the people who work in the health and care system; including clinicians, professionals, managers and support staff.

4.3 The shape of our workforce needs to be framed in a 'whole offer' approach to our patients and citizens, which mirrors the outcomes we will be targeting in a new service model. A strong emphasis on patient empowerment, self-care, independence, mental and physical health and wellbeing. These drivers need to be shared and embedded throughout the health and social care system - urgent and planned care and primary, community, secondary and social care settings.

4.4 Patients, their carers and families will not be separate from, but will be part of the integrated care model, with clear ownership and responsibilities for their own lives, health and wellbeing.

Future Direction

4.5 Our workforce across all health and social care settings is a key asset for the city. However to move to a person centred health and care system, some of the existing professional boundaries need to be reconfigured and fundamental changes made to some aspects of staff learning, development and aspirations. The definition of excellence in the medical profession is specialism whereas the population needs greater holistic health and care management.

4.6 Too often within health and social care we have focussed on structures, delivery models and financial constructs, failing to invest sufficiently in engaging with staff and embedding change at a citizen level. Similarly, as the blueprint means converging delivery across previous organisational boundaries and silos, a range of different cultures and ways of working will need to come together, a process that takes leadership time, commitment, energy and resource.

4.7 A shared core skill set needs to be rooted in the recruitment, induction and professional development of all staff in the health and care system – clinical, professional, management and business support. Person centred care coordination,

navigation and the ability to work across multiple care settings are fundamental attributes needed across the whole workforce. Each person, including the patient, carer and family, understanding their part and responsibility within the health and care system. A grounding in the core elements of supported self care and health promotion which will underpin our new integrated care model.

4.8 As more care and support will be provided in the community, some of which is currently provided in a hospital, our staff will be supported in developing new skills to enable this shift in care to happen. The workforce will work within community services that may be provided at different and more appropriate times of the day, or days of the week; so that we are able to provide more accessible services as local population needs requires.

4.9 A range of generic and specialist skills is required within the workforce, and both should be valued equally. Workforce planning will have a strong evidence base, using in depth population health analysis to ensure we are recruiting and developing staff to meet citizen's needs, not working to separate professional or organisational plans. This will require strategic collaborative planning across the health and care system.

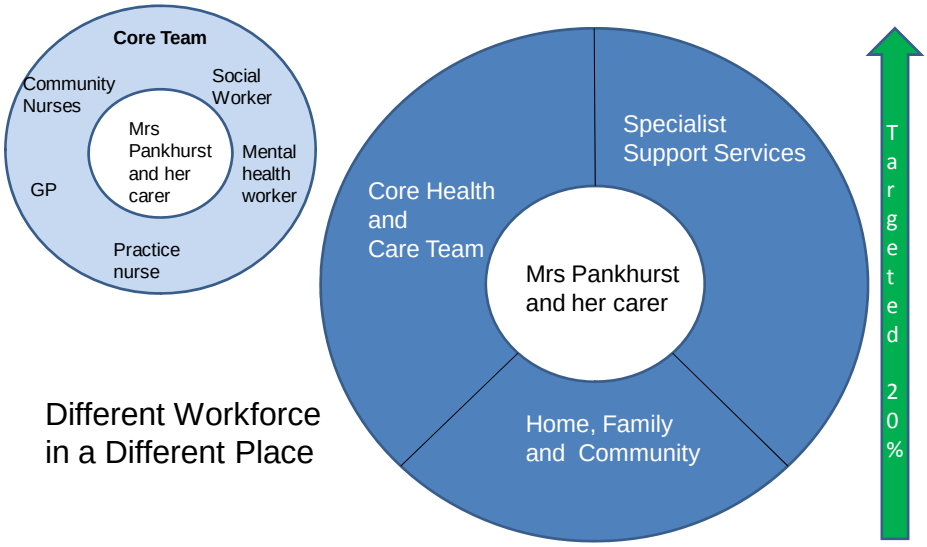
How Will It Be Different?

4.10 The current and future health and care needs of Manchester people will shape the future skills, competencies and attitudes of our workforce.

4.11 Evidence from population analysis will be used to inform and underpin recruitment strategies and collaborative workforce planning. Our population will continue to need specialist support at times, but equal value will be placed on generalists who can provide holistic care management that people with complex health problems, need and value.

4.12 Our workforce will be supported and developed to ensure we can support whole person needs, with equal emphasis and value on mental health, physical health and social care needs.

4.13 Delivering planned care in communities (out of hospital) will be 'the way we do things round here', with generic and specialist workers operating flexibly across different locations, buildings and settings.



4.14 The workforce will meet the needs of the different patient cohorts. For example, for 'Mrs Pankhurst', and her carer; family and community will be a core part of the integrated team, working with health and care professionals and other community resources in partnership. If Mrs Pankhurst develops complex health and care needs then a multi disciplinary team will support her in co-ordinating her planned and urgent care needs to maximise independence and wellbeing in the community.

4.15 For patients whose risk is lower, support will be delivered by a range of services which may be delivered by a range of organisations and workers. These will include for example health trainers, smoking cessation and lower level mental health services. These workers must also be able to view patients holistically and to empower them to self care.

Recommended Next Steps for Strategic Outline Case

- National expertise from appropriate professional bodies will be required to both support the learning and development of the current workforce but also to influence the workforce of the future. Groups such as Skills for Care, College of Social Work, Royal College of Nursing and the North West Deanery will need to be engaged as expert partners in a new Manchester strategic workforce planning team.
- The skills and expertise within Public Health Manchester are also needed, to undertake a sustainable programme of population needs analysis which will inform the strategic workforce planning group.
- This city wide workforce leadership group will shape the future direction for recruitment development and deployment of our workforce across Manchester Health and Social Care.

The Blueprint

Chapter Five – Our Money

Blueprint statement: For resources to be aligned to the person and their needs to support co ordinate care for people to live longer and live better.

Introduction and Background

5.1 The design of funding and contracting arrangements should place no less emphasis upon the goal of Living longer and living better than the design of the model itself. The funding and contracting arrangements need to be driven by the service model put in place to best meet the needs of the population. The financial impacts of reforms upon organisations can make or break the implementation and realisation of benefits. Population led finance and contracting and focus on the goal balanced with management of risk is the key challenge and opportunity within this programme.

5.2 To make a new model of care sustainable we need to:

- Manage a shift of resource to the new care model to make sure it is sustainable and effective.
- Ensure stability of what remains during the transition and beyond.
- Contract and finance in such a way that supports achievement of system goals.

5.3 Current contracting and resourcing arrangements are different across sectors of care. Some are designed locally and some are within nationally determined frameworks which have varying degrees of flexibility. It is not a coherent system reflecting how services should operate individually or collectively.

5.4 Good progress has been made in recent years with local adaptation to contracts, cross agency funding and different reimbursement solutions put in place. These have been shown to be real enablers for change. However, we need to put in place a more ambitious model to achieve a new care system in Manchester.

Future Direction

There are four key areas of development needed:

Virtuous Circle – Developing a Continuous Process of Resource Shift

5.5 To resource service models which reduce the need for hospital care there needs to be funding identified. The virtuous circle demonstrates a continuous process of shift of care and resource for each service model and the system as a whole. For example investing in a community service to people who have fallen will reduce ambulance transfers to A&E. The reduction in activity in the hospital and the ambulance service means a reduction in cost to commissioners which funds and sustains the community falls service. This may also generate an additional

contribution to building community infrastructure or pump priming money for future initiatives. The process is depicted below.

5.6 This model has been used where it can be applied to a defined cohort of people in order to quantify the service impact and the resource to shift. If this model were used for large scale change the level of investment and lead time for return would require significant resource for investment in infrastructure and transitional costs. It would also need to be able to work for a larger less well defined cohort of people.

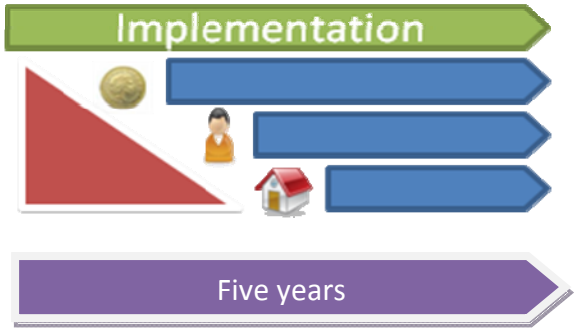
Shifting Resources – Unlocking The Money

5.7 The process of shifting the resource from one part of the system to another, needs to happen in a planned and structured way. Whilst the tariff arrangements for secondary care give a useful currency for shifting resource back to the commissioner for investment into the new service model this leaves a number of challenges.

5.8 If people are living longer and better and being cared for more in the community there will be fewer requirements for hospital capacity. This capacity can either be taken out of the system or used to provide services for other commissioners. If the capacity is used to provide new acute services to Manchester patients then investments out of hospital will not be sustained. Safeguards will be required if the new system is to become sustainable.

5.9 Moving resources in this way is incremental and could not fund large scale infrastructure change required in areas such as information technology or estates.

5.10 There is a period where the costs of the new model are in place before savings are released from the old. This is shown in the chart below. From initial investment there is a period of implementation and a delivery period before the impact upon services occurs. There are then differing periods of time it takes for certain costs to be taken out of the system ranging from variable costs such as consumables which can be reduced immediately to buildings and equipment which could take significantly longer. There will be a need for transitional arrangements to be put in place for these lead times although focus should be placed upon how best to shorten the lead time e.g. by redirecting these resources to the new system or to be funded from alternative income sources.



5.11 For this to work we need to have confidence it will have the impact it intended and be able to share the risk if it doesn't.

5.12 The virtuous circle and any subsequent realignment of resources has been measured on a micro level e.g. admissions relating to COPD but it needs to be evaluated against a large scale change model which manages the shift on a system level against defined targets. From a resource perspective interventions which reduce an acute episode i.e. stop the healthcare need will demonstrate a greater shift in resource than those interventions which move where care is delivered. The lower risk groups identified in the population section are larger numbers of people each with a lower use of the health service. Shifting resource from this larger cohort of patients would be more challenging.

5.13 Shared decision making relating to investments between commissioners and providers can build confidence in organisations to make decisions relating to reducing capacity or changing workforce plans. It also can increase the overall resource focussed upon implementing the change programme.

Commissioning for an Integrated System

5.14 There is a new emerging picture of commissioning in Manchester within Health and Social Care with Manchester City Council, three Clinical Commissioning Groups and the Local Area Team of the National Commissioning Board each holding commissioning responsibilities for the Manchester population. This creates a complicated picture of commissioning for a geographic population and a key challenge will be for these arrangements to work in such a way that the new system works effectively.

5.15 A new system of incentives and penalties needs to ensure that performance related income to providers is targeted towards people living longer and living better and link to the measures identified to take us there. In addition incentives need to encourage organisations to work more closely together in how they deliver care and to reward them collectively based upon system goal outcomes measures.

5.16 We need to address the annual cycle of financial planning and contracting setting, as it exists now, because it hinders implementing the new service model. Currently investments made need to have demonstrated an impact and generated a return on investment, usually greater than the investment, within the same financial year. This limits the scale of investment and, therefore, the pace at which change can happen. Similarly contracting is an annual process which can give a lack of clarity of income to provider organisations and no clear direction of travel for that organisation/service over the medium term. Multi-year contracts with trajectories for reform and outcome improvements would enable a better progression to the new system. Flexibilities of funding between financial years and clarity of annual budgets (including in year allocations) for commissioners would also aid more strategic financial planning and reduce the level of investment risk.

5.17 There is no one size fits all resource model and different methods will suit different service models at different scales. However, a macro level framework based upon the following high level principles should be agreed.

- There is a capitation based budget for the city, held by the five commissioners. The system needs to manage this, upper limit, of funding to create a sustainable model. There needs to be a flow within and, potentially across these budgets to achieve the optimum outcomes.

- Examples locally, and elsewhere, have shown that any resources released should be considered by all the partner organisations involved in that change. This is a key incentive to keep organisations involved and give confidence to the process. This should be balanced with providers accepting some of the risk of the change.

- There should be some proportion of provider incentivisation through performance related aspects to their contracts. These should
  - Be outcome based towards the overall objectives of the programme.
  - Encourage closer integration of service delivery
  - Some incentives should be paid and distributed based upon collective achievement of goals e.g. set a metric for admission rates for >65 year olds. If it is achieved all parties receive the incentive payment and if not no one does.

Best Laid Plans… New Rules, New Games or New System, Better Outcomes?

5.18 The system is too complicated to put foolproof rules in place to ensure that the desired outcomes happen and there are no unintended consequences. A best fit model can be developed for finance and contracting. The challenge to organisations within the system is to work within the principles and intentions of the system and to focus upon the goal of people living longer and living better. Alongside delivery of the system model as a whole this arrangement will be a key challenge of the system's leadership.

5.19 This proposal will be supported by longer term contracts, more targeted and shared financial incentives and upside sharing of benefits and decision making from a resource perspective. In addition this can be supported by different contractual arrangements with varying degrees of formality. For example Alliance contracts have been used in other industries where the purchaser has one contract with a number of separate organisations. An alliance leadership team (including the commissioner) is established which is responsible for delivering on the outcomes of the contract.

5.20 This is as much an approach as it is a contractual arrangement and, in a sense, this has happened with the three CCG areas through local governance arrangements but not in a formalised way or within a legal framework. An alliance contract or similar can be focussed in different ways and at different scales. For instance it could be focussed upon a geographical area (place based), an age group, a condition group e.g. diabetes or a cohort e.g. multiple long term conditions or the homeless. It could be the full income to those providers or a pool of the performance related elements of income. The key is that it brings together agencies to focus their efforts upon delivering the right outcomes.

How Will It Be Different?

- Organisational objectives will be aligned around common goals; organisations will rely upon each other to achieve incentive payments.
- Finance and contracting will be way to make things happen not be the barrier
- A system picture of resources will be developed, risks will be managed, decision making and benefits will be shared.
- Organisations will have more confidence in medium term income streams enabling better investment, less resource tied up in risk reserves and common planning assumptions within organisations' business plans.
- Financial leaders will work more closely together to make the finances work to achieve the programme goals.
- Capacity and demand will be seen collectively to ensure the system remains in balance.
- A higher proportion of Manchester's health and social care budget will fund services provided in the community.

5.21 This is a very complex and high risk part of the programme. It is envisaged that this requires dedicated capacity and specialised knowledge. Due to the high stakes in changing these arrangements a level of independence in putting together the analysis would be of benefit also. Other programmes of work in Greater Manchester may be undertaking similar analysis exercise which this will need to fit with and not duplicate. This will be assessed prior to commissioning any support.

5.22 In addition to external support the Health and Wellbeing Executive should pursue national level discussions relating to financial flexibilities such as three year financial allocations to commissioners, multi-year provider contracts and greater latitude in payment mechanisms.

Recommended Next Steps for Strategic Outline Case

External support would be required to:-

- Understand the potential financial implications in shift based upon further analysis of the 103k people identified in the population section,
- Work up in more detail how the models described could be worked up in more detail to operate with the larger cohort(s) of people described.
- Look at how this might translate into investment requirements for community infrastructure and how to ensure supply management of acute capacity and unlocking the resources to sustain the new system.
- Identify at how health economics support can be used to maximise confidence in proposals for decision making and measure impact most effectively.
- To assess financial and contracting flexibilities might be needed to give the best chance of delivery.

The Blueprint

Chapter Six – Our Buildings

Blueprint Statement: To have quality buildings providing multi agency co-ordinated care to support people to live longer and liver better.

Background

6.1 Manchester's citizens live in a city with a vast range of health and social care buildings. As an illustration we have three hospital trusts with a range of buildings, 98 GP Practices on numerous sites, 50 community centres, and 39 Sure Start Buildings and 6 social care district offices. The city is geographically compact however the distribution of buildings across the city is uneven. There are gaps in provision but in other areas there is duplication.

6.2 The McKinsey report identifies that community facilities are likely to be currently underutilised, often being used for less than 30 hours a week. Services are spread too thinly with a number of small premises unable to provide co-ordinated care services in the future because of the lack of space. We need to explore whether if provision is consolidated onto fewer sites, efficient and co-ordinated services could be delivered more effectively thereby releasing resources for new builds and front line services. In the past we have not been able to make the most of the opportunities across the wider public agencies largely because of the lack of integrated estate planning. Ownership, management and financial rules regarding these buildings is complex. This ownership ranges from private finance initiative hospital facilities at CMFT and UHSM, a range of LIFT buildings for primary and community services through to independently owned GP practices. The majority of premises formally owned by PCTs have now moved to Propco. (appendix 3 outlines estates planning)

6.3 Many buildings are not places that will uplift our citizens' spirits when they walk in the door, be that in the welcoming reception space or the architecture. Many of the buildings struggle to provide adequate space for the current services they run, accommodate staff in an effective working environment. Much of our building space is used to accommodate staff and patient records and many of our buildings operate only during routine working hours. This means we often do not have the potential to provide the facilities to accommodate co-ordinated services around the individual.

6.4 Historically most of our buildings tend to be organised around the service that runs from them rather than the person who needs the care. For patients who may have a number of long term conditions this may mean visiting numerous sites on different days for their care, rather than one where it is co-ordinated around them.

6.5 When we do have buildings that have been designed to enable services to flow around the patient, and the architecture to be part of the well being experience, we are not using them to their full potential in order to move care closer to home and co-ordinating it around the person. This is caused in part by the limitations of the revenue streams that have to be achieved by those organisations that are managing the buildings.

6.6 We know that our citizens do not access our services according to their need; the way we deliver our services through our buildings can affect access. For example, we know that men are less likely to attend their GP practice than women which can lead to late diagnosis and poorer outcomes.

6.7 Our buildings now reinforce our organisational silos, with an artificial and often strong perceptual barrier between care in a building and care in the community. Most people feel comfortable going to a hospital building as it is a visible and tangible asset – people are attached to the building they have, rather than the more conceptual descriptions of integrated care. We need to be able to make co-ordinated care real to people.

Future Direction

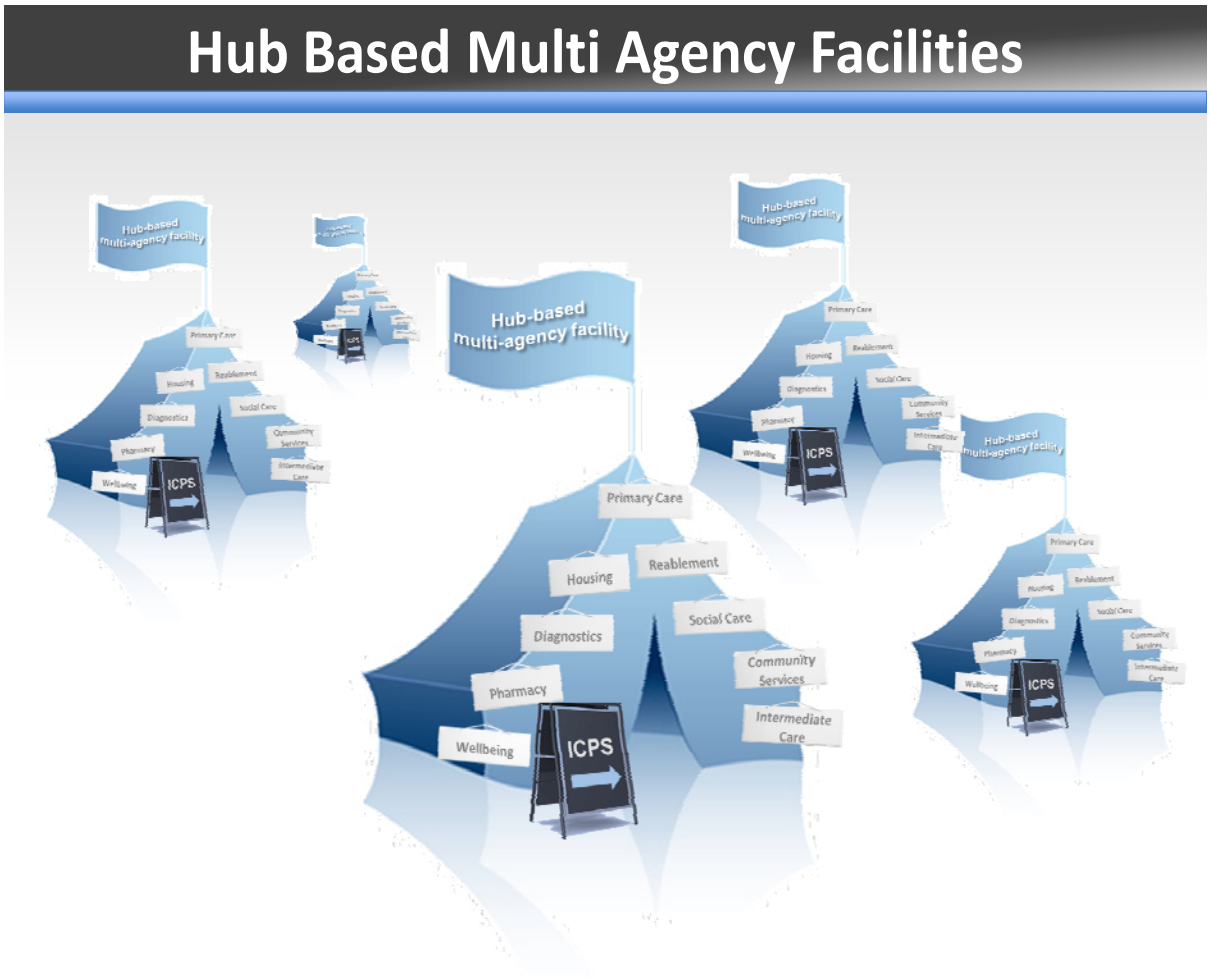
6.8 Manchester citizens need to see our buildings as a positive resource and a useful facility. Our buildings need to be fit for their future purpose. They need to house services that can co ordinate around the individual providing care closer to home, in facilities that support that care, which are safe and designed so that they can be used by community services from all agencies.

6.9 We need to see our buildings as part of the city's regeneration programme and want a city that offers the best facilities regardless of where you live. We need to have a shared and owned buildings strategy for the city, based on buildings the people of Manchester can be proud of and in places that they want to visit and perceive as community assets. Our strategy needs to be built on our staff having the tools to work remotely rather than tying up space in community buildings with fixed desks and computers. If our care records are digitalised and archived we would not need to store them in rooms that could be used for services.

6.10 In the future we need to have fewer buildings that are in a bad state of repair and not fit for purpose and concentrate on providing buildings that are fit for purpose and the future. We would see a future where Manchester had a number of buildings across the city that house multi agency services and were able to care for our residents in a space which adds to their well being and care. Some of our existing buildings are already fit for this purpose, but will need to be utilised differently in the future, however the majority of them are not. Currently some areas of the city have more estates that are in a poor condition than others and this will need to be addressed.

6.11 Our buildings need to be designed around what is needed to provide co-ordinated effective care for residents and that they feel comfortable using. Our hospitals are in

the community and we must see them as an asset if we are to create space in them that could be used differently. With people living longer and living better we need to re-think what we can use them for, for example may see our hospital sites as a campus providing a range of health and social care. Developments in technology may support increases in care in patients' own homes; we need to understand what can and should be provided within the home, what should be provided at a locality level and what should be located on a more central basis. Not all our patients will want their care to be provided at their home, and where is appropriate for them, they may prefer to go to a more local facility on an ambulatory basis to receive their care. Our buildings strategy must be driven by the proposed system model that incorporates buildings that are fit for the future.



6.12 We will need a range of facilities for our population. However in order to provide more multi agency co-ordinated care we will need to explore what buildings we need that can support co-ordinated and co-located care. We want our facilities to become a community hub for local groups and residents for the community to feel that they own the facilities in partnership with the services that are being provided from it.

There are facilities all around the country that provide a range of services in one building which includes primary care, community services, specialist hospital clinics, adult and children services, pharmacists, social care and community groups. We would see these buildings as a network of health and social care campus joined together by the overriding principle of proving quality, co-ordinated multi agency care as close to a person as possible, in an environment that is of the highest quality.

6.13 Publicly funded buildings in the community should be regarded as community assets – 'owned by' and used by the community. Buildings in the community should be able to be used by the community. We need to understand how much of our assets are not being used and whether we can change our programme of working to better suit our citizens. Some services are already delivered from non-traditional health and social care buildings, for example through sports and leisure facilities, libraries and the health bus. We need to explore further opportunities to be imaginative in the buildings used to deliver services. Other services for children, young people or community groups themselves can start to use health and social care buildings as we can start to use theirs; for example, schools, colleges, advice centres, libraries and retail areas. This will support activities to achieve lifestyle changes and support emotional wellbeing and a positive approach to health.

Recommended Next Steps for Strategic Outline Case

- Ownership of the reform of the estate at a Chief Executive level is required for the radical reform needed to engineer our estate around the Blueprint for care in Manchester.
- We need a review of all our estate and what we are currently using it for – whether this is efficient and effective. This needs to build on previous reviews undertaken.
- We need to understand the financial channels that currently fund our estate and the possibilities for doing this differently through mechanisms such as LIFT and Propco.
- We need to have a strategy to be able to assess what buildings we need where to support a future service strategy for Manchester. This strategy should link to the IT strategy and include maximising the opportunities for sharing space, sale of assets and the prioritisation for investment.

The Blueprint

Chapter Seven – Our Information

Blueprint statement: To connect systems and people with up to date information and support co-ordinated care for people to enable them to live longer and live better.

Introduction and Background

7.1 Information, Management and Technology (IM&T) encompasses all of the IT equipment, systems and data that we need to underpin our new service model. IM&T must be an enabler for our workforce to deliver the best health and care system for Manchester citizens to enable them to live longer and live better.

7.2 The focus for IM&T will be making available the right information at the right time to the right person, to enable our workforce to care for citizens. It is important that we consult with our staff, patients and citizens to better understand what information they need, how they want to access this information, and when (how timely does the information need to be).

7.3 For citizens we need to understand what level of information sharing they are comfortable with between those providing care for them. Information governance (IG) ensures necessary safeguards for, and appropriate use of, patient and personal information. IG requirements must be recognised and addressed, but are not a barrier to sharing information and delivering integrated person centred care.

Future Direction

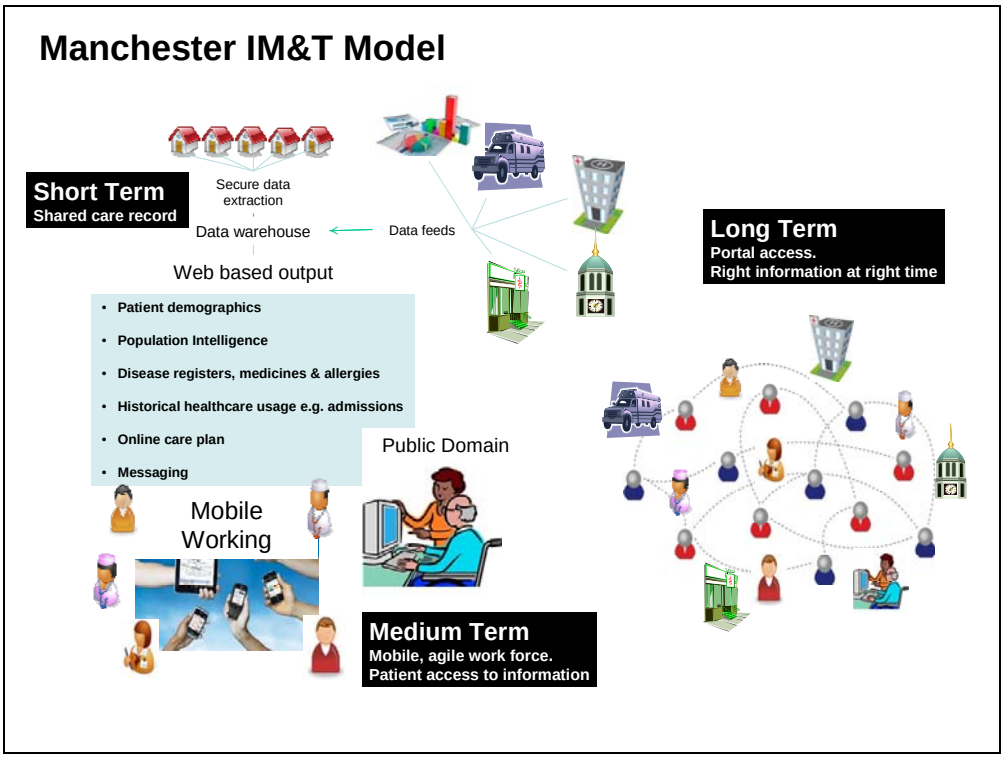
7.4 For those with multiple long term conditions and complex needs, there will be clear targeted work to stop (or reduce) escalation. There are a number of key issues with current IM&T provision cross health and care. Community health teams are still using paper based systems and there is poor linkage of information between different health and care settings – secondary, primary, community and social care. There is universally poor provision for mobile and agile working, for example tablet technology. Put simply the blueprint for health and social care in Manchester is not deliverable without a concerted focus on IM&T as an enabler to make the vision a reality.

7.5 As with other parts of the blueprint, good but small scale progress has been made in terms of a single care record to support the integrated care proof of concept work, but the challenge is scalability and making this business as usual across the systems in Manchester.

7.6 Our future IM&T strategy and development needs to address

- Operational solutions to support all staff working with patients (workflow solutions, patients care solutions as well as records management for example).

- Information delivery solutions for our workforce, patients and citizens.
- Performance management tools to support service improvement / management.
- Population analysis tools to look at whole system outcomes and performance.



7.7 IM&T is not about delivering a single suite of systems across the health and care economy. IM&T will focus on consistent standards and protocols which will enable interoperability. Partners in Manchester do not advocate a big bang IT solution. A city wide IM&T strategy will be developed to underpin delivery of the integrated care strategy and ensure the right information is available at the right time.

How Will It Be Different?

7.8 Patients will be able to access their own health and care information electronically. Subject to explicit patient agreement, health and care information (for example, disease registers, social care record, health care usage) will be available to all health and social care professional supporting them.

7.9 Comprehensive agreed care plans will be available electronically to all those providing care to a patient, with access controlled by the patient to a level they personally feel comfortable with.

7.10 Staff will have high quality, reliable mobile working solutions to enable them to work efficiently and effectively away from fixed office locations. Different organisations will have their own local operational IT solutions. Using portal and information presentation solutions, patient information will be connected and integrated, subject to individual patient consent.

7.11 External expertise is needed to develop a whole city IM&T strategy which will ensure we have an agreed and robust framework on which to build the locality based solutions that we need to underpin our integrated care system.

Recommended Next Steps for Strategic Outline Case

- Explore city wide IM&T strategy for integrated care agreed. City wide implementation of the Graphnet shared care record and care planning tool, for very high and high risk patients.
- Explore local operational systems and mobile working solutions for staff. Consult with patients and citizens regarding health and care information needs and start to deliver IM&T solutions.
- Explore portal access solutions to enable staff, patients and citizens to access the right information at the right time, subject to all statutory information governance requirements and individual consents.

The Blueprint

Chapter Eight – Engagement for Social Change

Blueprint statement: To create a movement for social change to provide a new paradigm for how people view their health, and this programme of change, to live longer and live better.

Introduction and Background

8.1 Our aim is for people in Manchester to live longer and live better. We want Manchester people to be proud of their health and well being. We want to create social movement thinking, whereby we engage with peoples core values and motivations to work together to affect change. We want to engage with Manchester through our shared story. The story is one of our community and how we want to work with Manchester's citizens to create well being, improve quality, minimise the variation in care and provide high quality care that is safe and consistent as close to a person's home as possible.

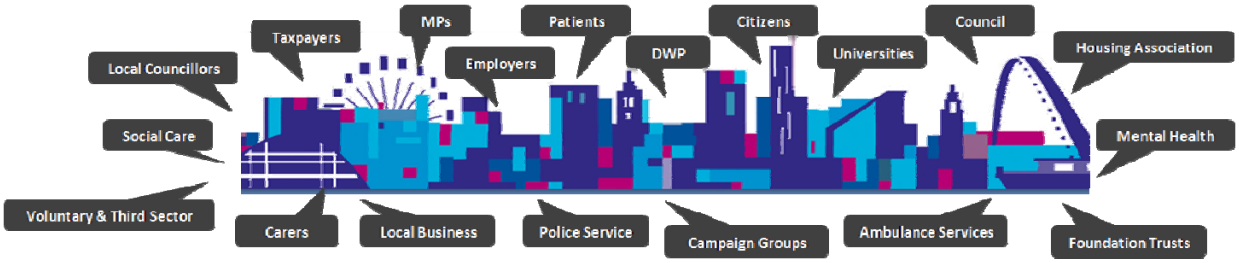
8.2 We want to deliver the same coherent messages across the whole of our health and social care system about how we will live longer and better. We want to make our stakeholder group everyone in Manchester, encompassing those who live in the city and those who work in the city.

Future Direction

8.3 We wish to engage the people of Manchester and the health and social care organisations in Manchester in a social movement for change – we want to aspire to inspire the city. Too much of our engagement in the past has been through known communication channels, associated with individual organisations or specific disease areas.

8.4 We want to communicate our integrated care programme for the city as one programme with three specific delivery localities around North, Central and South Manchester. We want to have specific social movement strategies that address the at risk sections of our community, but also those people that at present do not need to engage with formal care services. We want to reach a generation which is in its early years, to be able to build a health movement that will live with them for a life time, so that they will live longer and live better.

8.5 We need to be able to build the narrative of living longer living better over the next few months so that there is wide engagement of practitioners within all the organisations, and of all those people who will be involved in changing and improving care for the future. We will gain an understanding of the health literacy of our population, so that we learn how they access and interpret health messages, so that we use appropriate methods to engage with them.



How Will It Be Different?

8.6 We will create a shared vision and consensus built on our common purpose, reinforced by engagement and underpinned by collaborative working in the city. We won't have eight separate engagement strategies, but one strategy. It will be coherent in approach, consistent in message and provide the mechanisms for effective engagement with three specific delivery streams around North, Central and South Manchester.

8.7 We won't engage by telling people, we will engage by involving people. Engagement will be a catalyst for change, for the whole city to see living longer living better as the campaign they can be a part of, one that inspires us all to take action and make a positive change.

8.8 We want our collaboration to be not only in the health and social care sector but with individuals and communities, tapping into existing skills, energies, networks and local knowledge. We want to work with businesses big or small, sports teams, Universities or community clubs, TV, music or radio to help us change our paradigm of health.

8.9 We need to ensure that our messages are being heard where people are living and working, coherent messages regardless of where you live or what you do. The quality of care experienced by people must reflect, or exceed the messages they have received about care.

8.10 We aim to support people to change the way people view their health. We need to use our cultural, equality and diversity information to understand what drives behaviours and to prompt positive change. We know we have pockets of local excellence in engagement, we need to build on this making a grass roots movement, using social media, to ensure that we spread what is happening.

8.11 In our service redesign we need to use the levers of engagement and social movement to discourage old behaviours and encourage new ones. Our language will need to change to reflect the population's needs and their use of information. We believe we will need to have a social movement strategy for the city which will incorporate the city wide programme as well as grass roots social change.

8.12 We believe we will need expertise from outside the city to help us in this work so that the aim of living longer living better is a banner by which the integration programme is hung.

Recommended Next Steps for Strategic Outline Case

- Secure expertise for a city wide team in the area of social movement.
- One city wide engagement strategy for social change.
- Full stakeholder analysis and segmentation undertaken.
- Alignment to local, regional and national strategic change programmes.
- Key partners sought from within the wider business, cultural and leisure community.

Section Three

The Way Forward

Chapter Nine: Governance: Leadership and Team

Introduction

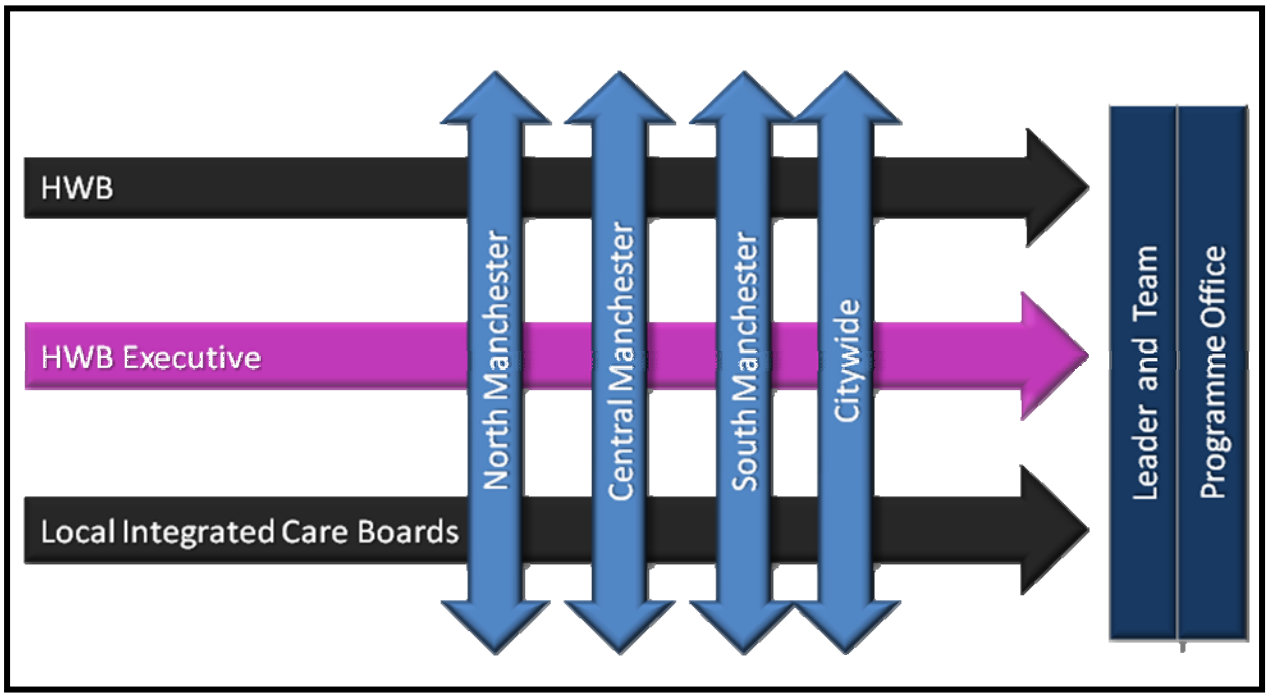
9.1 We believe that a large scale change programme will need to be governed by the city, led by a leader with experience of large scale multi agency change and have a team of individuals who have the talent, skills and influence to deliver.

9.2 This programme of work needs to see organisations having an owned purpose, a collective goal and shared accountability for the success of the entire strategy and not just their organisations piece of it.

Governance

9.3 This change programme has to be governed by a body which includes all the organisations and the work being seen as that body's core business. The body would need to have a collective responsibility for the goal of people in Manchester living longer and living better.

9.4 Therefore, it is proposed that this programme of work is governed by the Health and Well Being Board. The accountability to deliver will be through the Health and Well Being Executive. The responsibility to implement programmes of care delivered in the three health and social care localities in Manchester through their integrated care governance structures.



Leadership

9.5 We believe that such a programme of work needs to be led by an independent person with influence and experience in delivering large scale change. We feel that the independence of such a person is crucial in order for them to be seen as accountable for the programme of work across the city rather than from an organisation.

9.6 The leadership attributes being the ability to:

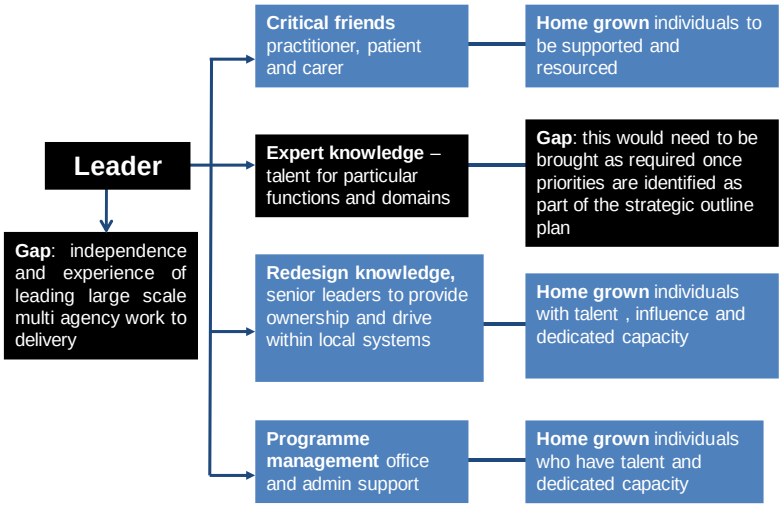
- Lead a high level team from across organisations, and form positive relationships with Executives from across the Manchester organisations, ensuring each organisation is collectively accountable for the success of the entire strategy and not just their piece of it.
- Create a common context for both the "what" and the "why" of the change programme that serves as a critical touchstone for the broader leadership team at the Health and Well Being Executive and Board.
- Be an architect of a strategic programme which combines strategic leadership with analytical rigour across organisations to create 1 shared and owned programme.
- Build capacity for strategic thinking and delivery across the organisations so that change, when it occurs, can be absorbed more quickly and more completely.
- Build a change programme that is widely dispersed across the organisations but carefully coordinated, so it has breadth and depth of understanding and commitment to delivery in each organisation, local system and the city footprint.
- Build a broad participation and sense of citizenship and empowerment among a larger group of people and organisations to deliver the change through a model of social movement.
- Create a change programme which has a clear goal but is a continuing work in process, being shaped as interactions occur with citizens, organisations and wider communities and as new issues and knowledge emerge.
- Create a common vocabulary and set of tools to effectively deliver a large scale change programme across the city.

The Team

9.7 The leader would lead a team of individuals that are released from their host organisations to work on this programme because of their talent and influence in this sphere of work. We also feel that there will be areas of the work programme were skills and competencies will need to be brought in from outside the organisations to provide capacity and expert knowledge e.g. resource modelling, large scale estates planning and information strategy.

9.8 We feel we would also need to have a reference group facility based on the individuals and groups within the city who would be able to give us their expert advice and constructive criticism. This would include clinical leaders as well as patient and third sector groups.

9.9 We would need to establish a programme office from within the city to ensure that the work was managed and administered to plan.



Recommended Next Steps for Strategic Outline Case

- Identification of a leader for the programme of work
- Identification and release of local talent from within the organisations
- Identification of outside expertise to be brought into the team as needed
- Identification of individuals with the skills to run the programme office
- Production of the Strategic Outline Case by June

Chapter Ten: Evaluation

Introduction

10.1 Good evaluation is key to understanding whether the change programme is delivering upon its objectives. Good measurement and reporting will give confidence to decision making, aid design and ultimately determine whether the programme created a better system for the people of Manchester or not.

Aim

10.2 It is important to establish an effective system of measurement to achieve the following:

- Aiding the design and refinement of the new system and the new service models.
- Ensuring the model designed is the one being implemented and delivering at the scale intended.
- Evaluating progress towards, and ultimately the success of, the final system model and new service models.
- A framework by which we measure progress and outcomes which can be aggregated up to a system position, makes best use of resources and results are owned by all organisations.
- Provide tactical information to support the transition period for activities such as capacity or workforce changes.

Evaluation Domains

10.3 The broad domains proposed for evaluation are shown in the chart below.

Method

10.4 Different initiatives and the indicators for the programme as a whole will require different evaluation frameworks dependent upon various factors. Methods could be structured as follows.

- A short period of action learning whereby real time feedback is attained about implementation of service models. This helps refine the model and support the implementation to get it to the point where it is considered to be the definitive model and ready to evaluate.
- Medium term analysis of benefit and cost to ensure the model is delivering upon expected impacts. This can also fulfil the need for tactical information to manage capacity, workforce and resource change.
- A longer term measurement to ensure sustainability of the system/service model and potential to formerly evaluate to a standard which could be classed as an evidence base to be published/shared.

Recommended Next steps for Strategic Outline Case

- The Manchester health and social care system has many connections with academic and other organisations who are experts in the field of evaluation. These should be used to develop a robust framework designed specifically for the programme.
- A common gap in work programmes is capacity of analysts to establish baselines and set up reporting tools. Consideration should be given to bringing in external capacity to do this.

Chapter Eleven: **Next Steps**

The recommended next steps for the Strategic Outline Case have been summarised at the bottom of each chapter of this report. However to summarise, we are asking the HWB to:

- Approve this document and support the progression to a strategic outline case by June 2013, which would include:

  Wider engagement with key partners

  Detailed immediate plans (local and citywide) 1-3 years

  Scoped medium term plans (local and citywide) 3-5 years

  Scoped long term plans (local and citywide) 5-10 years

- Identify a leader to take forward this programme of work.
- Identify a team from within the organisations to be released to undertake this work.
- Support the identification of expertise to be brought into the team as needed.
- Support the governance of this programme through the HWB, its executive and the local structures.

Section Four

Appendices

Appendix One
Names of People Who Attended The Workshops

In addition to the core group this report was developed with a lot of expert input from within the eight partner organisations. A list of contributors is shown below.

Thanks to David Fillingham Chef Executive AQuA and Elizabeth Bradbury Director of AQuA for facilitating the 1st workshop.

Manchester City Council	**North Manchester CCG**
John Vass-de-Zomba	Richard Deacon
Rachel Rosewell	
Sarah Henry	**Central Manchester CCG**
Achille Ramambason	Dr Ivan Benett
Karen Johnson	Tony Ullman
Sue Longden	Kym Green
Neil Bendel	Martin Jones
Diane Eaton	Ben Squires
Carol Culley	Nia Pendleton Watkins
Nicky Parker	
James hand	**South Manchester CCG**
Sara Tomkins	Dr Bill Tamkin
Manchester Mental Health and Social	Dr Paul Wright
Care Trust	Izhar Chaudhary
Ian Henry	
Deborah Goodman	**CCG Citywide teams**
Andrew Harrison	Nick Gomm
Kevin Tomlinson	Graham Hayler
Pennine Acute NHS Trust	**University Hospitals South Manchester**
Karen Hughes	**Foundation Trust**
Gary Thompson	Lindsay Stewart
Steve Taylor	Darren Green
Gabrielle Teague	Stephen Downs
Joanne Moore	
Central Manchester Foundation Trust	
Chris Lamb	
Dr Jon Simpson	
Darren Banks	
Lee Rowlands	

Appendix Two

A Sample of Services : that are being developed in each system to better co-ordinate care across the agencies for people who are at risk of admission to hospital			
Service	Organisations	Targeted Risk Group	Area
Practice Integrated Care Teams	Primary care, community , social care and hospital staff	High and very high	Central full implementation by October 13
IV Therapy	Community	High and very high	Central
Homeless Project	Primary care and hospital	To be determined	Central
LILY	Mental health	High and very high	Central
Intermediate Care assessment Team for falls	Primary, community, social care, hospital and ambulance	Moderate, high and very high	Central
COPD Integrated team	Primary, community, social and hospital	Moderate, high and very high	Central
End of life project in Care Homes	Community and care homes	Very High	Central
LES for heart failure	Primary and hospital	High and very high	Central
ASPIRE integrated respiratory team (incorporating IV therapy)	Community, Primary Care and Acute.	Very high and high	South
Community Integrated Diabetes Team	Acute, Social care, Community and Primary Care	Moderate	South
Integrated Neighbourhood Teams	Acute, Community, Social care, Primary Care and Mental Health.	Very high and high and moderate	South full implementation by x
Integrated Community Stroke Teams	Acute, Community and Primary care	Very high	South
Integrated Discharge Teams	Acute, Social Care and Community	Very high	South
Integrated Neighbourhood Teams	Primary, community and social care	Very high, high and moderate	North – 4 neighbourhoods, 1 live, remaining 3 live during 2013-14
Integrated Hospital	Acute, community	All but	North

Discharge Teams	and social care	particularly very high and high	
Crisis Response Service	Community and social care	All	North - 6 month pilot from April 2013
Implementation of NWAS pathfinder tool	NWAS, community and social care	Moderate, high and very high	North - Initial implementation with patients known to Falls Service and Community Alarms Service response
Primary Care Emergency Centre	Community and hospital	All	Central – established 2005

Appendix Three

Estates Planning

PropCo is a new property company set up by the Department of Health. It will provide strategic estates planning on behalf of Greater Manchester's 12 CCGs and will manage the existing estate which will be transferred from disestablished PCT organisations in April 2013 to PropCo.

This transfer of assets includes all land and existing estate not in use. This client led function will enable each CCG to articulate its future estates requirements alongside service priorities and will be linked to future IT infrastructure and workforce requirements. It is the intention of Government to float PropCo as a private company in 2016.

Community Health Partnerships (CHP) will take full control of existing LIFT estate across nine of the ten GM authorities (Stockport were never part of LIFT). Community Health Partnerships will remain controlled by DH and will retain a 20% share in MAST LIFTCo and all other LIFTCo's across GM. The new leadership of CHP are eager to work with Manchester and GM to understand how they can work with us to lever in resources to modernise community estate inclusive of local authority services.

NHS Foundation Trusts (FTs) and those going through the FT pipeline will take control of existing hospital sites and community facilities where they have more than a 20% service presence. This will see the Manchester hospital trusts retaining control over their estate and possibly taking on some additional community assets. It is not clear what will happen to estate held by hospitals not gaining FT status.

Equitix are the new Private Investment partners for MAST LIFT, they have recently bought into 17 LIFTCo's. Equitix is a company established to deliver and manage infrastructure projects from bidding and closing through to construction and service provision, with £104 million capital commitments sourced from eight local authority and corporate UK pension schemes. New government legislation is likely to relaunch Public Private Sector Partnerships (PPPs) as the way forward to lever in resource to fund future health care estate.

Bibliography

- A Narrative for Person-Centred Coordinated (Integrated) Care - National Voices -2012
- Alliance Contracting - Wragg and Co 2013
- CICB strategic Planning Day - Central Manchester CICB February 2013
- Citywide Integrated Care Blueprint Risk Profile of the GP Practice Population - Neil Bendel Public Health Manchester 2013
- Combined Predictive Model. Final report and Technical Documentation. King's Fund 2006
- Department of Health Community Budget Development Seminar - Tri Boroughs 2013
- Give the Green Light To Go Getters - HSJ Breedon & Edwards -2013
- Health and Social Care Study – Manchester - McKinsey and Co -2012
- Health and Wellbeing Board Strategy – 2012
- Healthier Together - Vision Document - NHS Greater Manchester -2013
- Integration of Care, Holy Grail or Bridge Too Far – British Journal of General Practice 2012
- Integrated Care Business Case - North West London – 2012
- Integrated Care Domains – AQuA – 2012
- Integrated Care For Patients and Populations: Improving Outcomes by Working Together – King's Fund/Nuffield Trust – 2012
- Joint Strategic Needs Assessment - Public Health Manchester
- National Evaluation of the DH Integrated Care Pilots - Ernst and Young -2012
- South Manchester Integrated Teams - South Manchester CCG 2013
- Where next for the NHS Reforms? The Case for Integrated Care - King's Fund
- Shaping A Healthier Future North West London 2012
- Making Integrated Out of Hospital Care A Reality Royal College GPs and NHS Confederation – 2012
- Are Darzi Style Clinics Set To Make a Comeback? Iacobucci G – BMJ - 2013